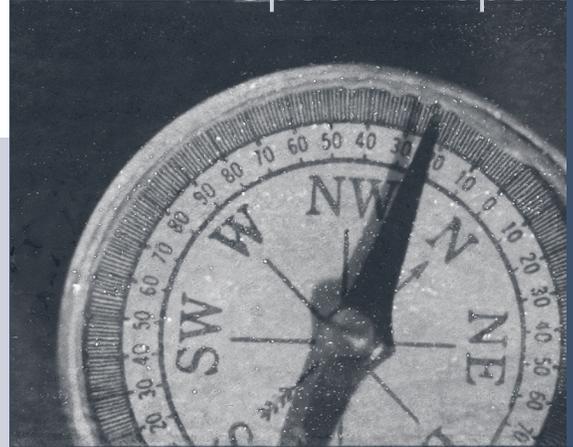


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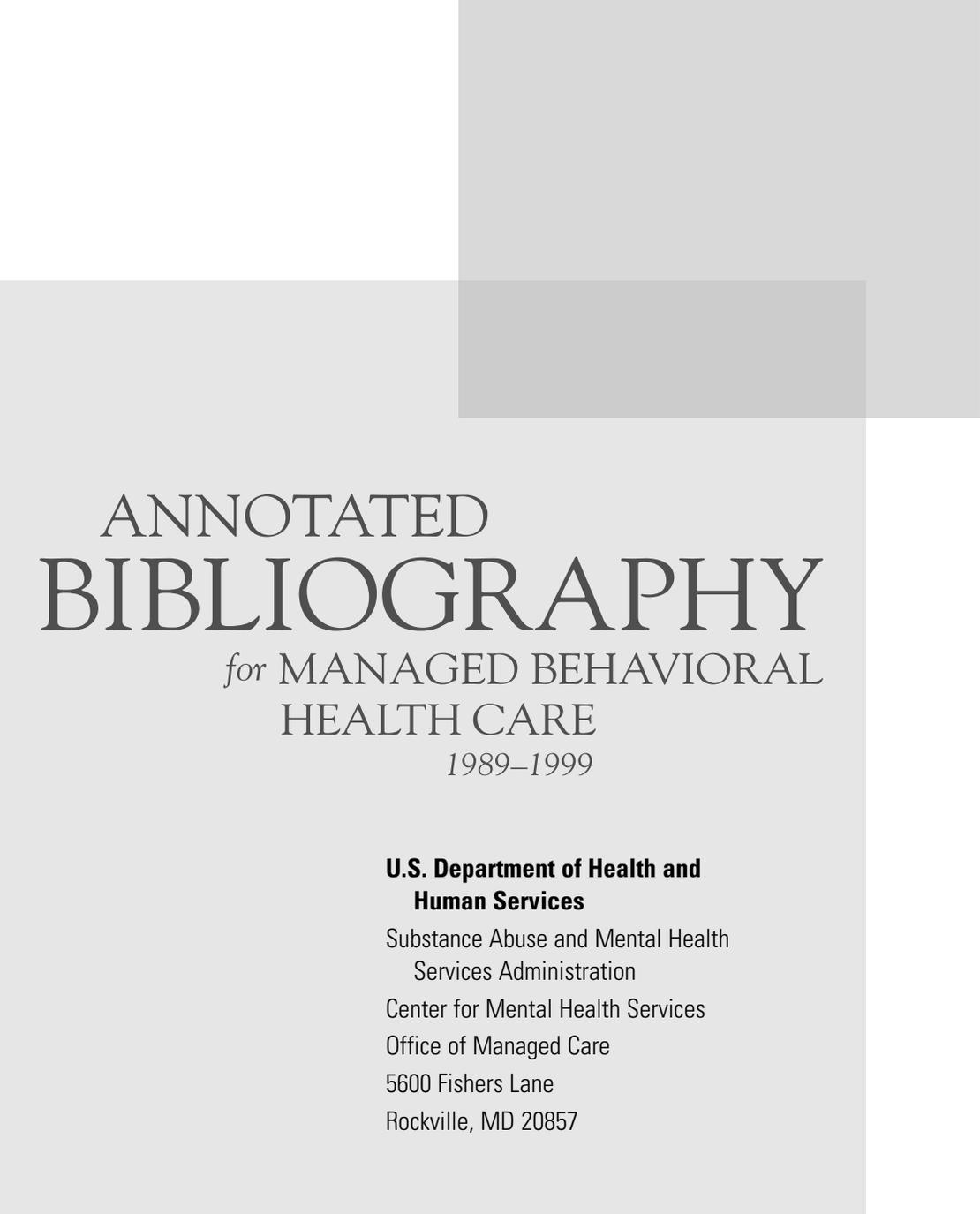


ANNOTATED
BIBLIOGRAPHY
for MANAGED BEHAVIORAL
HEALTH CARE
1989–1999



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services





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**U.S. Department of Health and
Human Services**

Substance Abuse and Mental Health
Services Administration

Center for Mental Health Services

Office of Managed Care

5600 Fishers Lane

Rockville, MD 20857

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Introduction

This publication expands and updates an earlier annotated bibliography on managed behavioral health edited by Jane Kramer and Saul Feldman, published by SAMHSA. The original bibliography included 250 abstracts that covered the published literature on managed behavioral health over a 5-year period from January 1989 through mid-1994.

The current publication updates the bibliography from mid-1994 through June 1999. The additional documents were located through a search of the journal literature and a scan of a number of organizational Web sites. Bibliographic databases searched to identify journal articles include Medline, HealthStar, Psycinfo, ABI/Inform, Insurance Periodicals Index, and Econlit. Web sites include the National Clearinghouse for Alcohol and Drug Abuse Information, CMHS's Knowledge Exchange Network, Georgetown University Center for Child Health and Mental Health Policy, Florida Mental Health Institute, American Psychological Association, American Psychiatric Association, National Alliance

for the Mentally Ill, National Mental Health Association, Bazelon Center for Mental Health Law, the National Council for Community Behavioral Healthcare, Mathematica Policy Research, R.O.W. Sciences, Westat, Research Triangle Institute, and the Institute for Behavioral Health/CentraLink.

For the reader's convenience, this report has two indexes: an Author Index and a Keyword Index. Each abstract has keywords listed and corresponds to the Keyword Index at the end. The Keyword Index lists key topics alphabetically, followed by the abstract numbers for the abstracts that contain these topics.



Benefit and System Design

1. Abrams, H. S. (1993). Harvard Community Health Plan's mental health redesign project: A managerial and clinical partnership. *Psychiatric Quarterly*, 64, 13–31.

The Harvard Community Health Plan (HCHP) redesigned its program in an effort to address high costs and member and clinician dissatisfaction in the delivery of its mental health services. In an extensive needs assessment, members, clinicians, and managers identified a number of problems in the HCHP mental health care delivery system. These included lack of access, inconsistent service delivery between sites, lack of systematic utilization management, and lack of diverse treatment programs and models. On the basis of this assessment, HCHP developed a method of categorizing patients, restructuring the delivery system, and redesigning the mental health benefit. This article describes the process and politics of the redesign effort, including the development of the mental health patient-assessment tool. Also outlined are delivery system changes, such as self-referral and group therapy, and how HCHP communicated its new benefits to members.

Keywords: private sector programs

2. Afield, W. E. (1990). Managed mental health care: Curbing costs in the 1990s. *Medical Interface*, 14, 26–34.

Expenditures on mental health account for almost one-third of total health care dollars spent in this country. This article documents ways in which the insurance industry has led to inappropriate and costly use of mental health benefits. The article endorses managed mental health care (including utilization control and quality assurance) as a solution to both the quality and cost problems plaguing the current system.

Keywords: costs, quality assurance

3. Altman, L., & Price, W. (1993). Alcan Aluminum: Development of a mental health "carve-out." *New Directions for Mental Health Services*, 59, 55–65.

A growing number of companies are interested in "carving out" mental health services. This chapter describes the development and implementation of a carve-out plan at the Alcan Aluminum Corporation. Alcan designed its network-based employee assistance program (EAP) and managed mental health program to reduce costs, standardize its EAPs across the Nation, and enhance the quality of services. Other objectives included enhanced case management for adolescents and increased access for employees in rural areas. The article describes lessons learned, such as building consensus and creating links among vendors, administrators, and employees.

Keywords: carve-outs, EAPs, private sector programs

4. Arons, B. S., Frank, R. G., Goldman, H. H., McGuire, T. G., & Stephens, S. (1994). Mental health and substance abuse coverage under health reform. *Health Affairs, 13*(1), 192–205.

This article, written by several members of the President's Task Force on Health Care Reform, the Working Group on Mental Health, describes the basis for President Clinton's health care reform proposal in which mental health/substance abuse care is integrated with the proposed health alliances. The authors examine the organizational and financing needs of mental health and substance abuse to ensure a successful transition to a fully integrated system at parity with other health services. The article makes a case for full integration, describes the complexity of integration, and defines the financing, administrative, and monitoring steps necessary to implement an integrated plan. The authors examine some of the barriers to plan implementation, and advise that, however problematic, they are not insurmountable obstacles to achieving a fully integrated system before the year 2001. The authors also provide some thoughts on how to assess whether the plan is proceeding on the right track during the transition.

Keywords: integration, legislation, parity, substance abuse

5. Bennett, M. J. (1994). Are competing psychotherapists manageable? *Managed Care Quarterly, 2*(2), 36–42.

This article describes the major changes currently taking place in the way behavioral health care is organized, financed, and delivered. The author argues that while much is uncertain, there is wide commitment to two objectives: to improve access and increase efficiency. Meeting both objectives requires improved coordination of resources on a wide basis and a movement beyond utilization review. The article challenges the notion that market forces alone can overcome the barriers to reform and outlines a detailed five-step strategic plan. The strategies include guaranteeing the right to necessary care, regionalizing resources under capped budgets, replacing fee-for-service reimbursement with prospective payment, aligning continuing education requirements with performance-defined gaps in knowledge, and funding professional retraining.

Keywords: overviews, providers, training, trends

6. Broskowski, A. (1991). Current mental health care environments: Why managed care is necessary. *Professional Psychology: Research and Practice, 22* (1), 1–9.

As inpatient mental health costs have escalated rapidly in recent years, third-party payers and employers have started to demand cost and quality controls on the care provided. This article describes the trends in general and mental health care costs and describes a framework for understanding the structure of managed mental health care. The author illustrates methods for managing mental health costs and examines the evaluation of the impact of managed care on cost and quality of care.

Keywords: costs, overviews, trends

7. Broskowski, A. (1994). Current mental health care environments: Why managed care is necessary. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 1–18). Washington, DC: American Psychological Association.

An earlier version of this chapter appeared in *Professional Psychology: Research and Practice*. Refer to Broskowski, 1991 for annotation.

8. Burton, W. N., & Conti, D. J. (1991). Value-managed mental health benefits. *Journal of Occupational Medicine*, *33*, 311–313.

This article describes the experience of the First National Bank of Chicago's comprehensive plan for mental health services. It contends that by managing a benefit plan assertively rather than cutting it, the quality of mental health services can be enhanced while costs are contained. The plan is based on an employee assistance program (EAP) that provides assessment, short-term counseling and referrals, psychiatric hospital utilization review, and consulting psychiatrists. An internal evaluation of the program showed declines in the number of admissions, the length of stays, and the costs of inpatient mental health.

Keywords: EAPs, evaluation, private sector programs

9. Busch, S. (1997). Carving-out mental health benefits to Medicaid beneficiaries: A shift toward managed care. *Administration and Policy in Mental Health*, *24*(4), 301–321.

Since 1991, a number of states have initiated mental health carve-out programs for at least some of their Medicaid population, providing mental health services through a separate program from physical health care. This paper outlines the choices States face in designing such programs including cost considerations, political considerations, the procurement process, reimbursement, eligibility, risk adjustment, and benefit design. The author relies on examples from Massachusetts and Utah to illustrate differences between public and private models. From the discussion, the author concludes that while carve-out programs have yielded some initial savings, future research needs to focus on their effect on quality of care and general health care costs.

Keywords: carve-outs, Massachusetts, Medicaid, public sector, Utah

10. Dickey, B., & Azeni, H. (1992). Impact of managed care on mental health services. *Health Affairs*, *11*(3), 197–204.

This article describes the use of two types of managed mental health care programs designed to reduce inappropriate use of hospital services and compares their impact on the use of inpatient services. Each of these programs represents a type of utilization review. The first is a mandatory preadmission screening program that requires certification, prior to or within 24 hours of it, that the admission is medically necessary; the program also authorizes a set number of reimbursable days. The second program focuses on discharge planning and requires attending physicians to detail treatment plans as they relate to discharge. Thus, the first program

attempts to reduce the numbers of admissions, while the second focuses on reducing length of stay. Neither program was shown to be effective in reducing mental health spending. The authors hypothesize several reasons for this, including the increase in pressures that drive up the supply of and demand for mental health services, the growth of new psychiatric inpatient programs, and physician noncompliance with reviews. The authors conclude with a discussion of the limitations of the study and future research needs.

Keywords: evaluation, utilization management

11. Duhl, L. J. (1994). Can mental illness be prevented under managed care? *Managed Care Quarterly*, 2(2), 7–9.

The author argues that the movement toward managed mental health care focuses narrowly on intervention techniques and cost containment. These foci are inappropriate and will not lead to an overall improvement in mental health for the majority of people who need and seek mental health care. A more appropriate system would recognize the importance of the social and cultural context of individual lives and their social networks. From the author's perspective, a program that moves beyond the medical model and recognizes the importance of jobs, recreation, and education is more likely to have a positive impact on the mental health of individuals in a community than would the managed care approach.

Keyword: prevention

12. Durham, M. L. (1994). Health care's greatest challenge: Providing services for people with severe mental illness in managed care. *Behavioral Sciences and the Law*, 12(4), 331–439.

This article discusses the fundamental advantages of managed care for persons with severe mental illness (SMI) and examines how this patient population is treated in actual practice. Specifically, the author analyzes the advantages and the actual practice data for this population for three primary aspects of managed care: institutional care, coordination of care, and prevention. Regarding these three principles of managed care, the author notes that SMI individuals do not receive the best care possible, and the author offers solutions on how to best improve care for these individuals within a managed care framework. Some of the solutions which are suggested solely for the SMI population include specialized HMOs, training and support for primary care physicians to better diagnose and refer individuals with SMI to the appropriate treatment, financing schemes that decrease the copayments for SMI individuals, developing risk assessment models specifically for the SMI populations, and developing clearer ethical guidelines for treating SMI patients.

Keywords: serious mental illness

13. England, M. J., & Goff, V. V. (1993). Health reform and organized systems of care. *New Directions for Mental Health Services*, 59, 5–12.

Several major companies are using organized systems of care (OSC), an integrated care financing and delivery system. The authors argue that organized systems of mental health and

substance abuse care can achieve both cost management and quality improvement through the use of a select multidisciplinary panel of providers and the delivery of a continuum of services from prevention and primary care through chronic care. The chapter provides two examples of the development of OSCs. Finally, the chapter describes how OSCs are different from current managed care systems.

Keyword: integration

14. England, M. J., & Vaccaro, V. A. (1991). New systems to manage mental health care. *Health Affairs, 10* (4), 130–137.

Early managed care arrangements focused primarily on reducing costs and only secondarily on improving access or quality of care. This narrow focus contributed to the bitter opposition of managed health care plans by clients and providers of mental health services. More recently, managed mental health care organizations have demonstrated that managing care not only reduces costs, but also potentially enhances early detection of mental health problems, offers a broad range of services, provides continuity of care, reduces the costs shifted to individuals, and prevents unnecessary hospitalization. The authors argue that managed care systems will increasingly be required to demonstrate their quality of services provided in order to successfully compete for contracts with businesses. This article describes six case studies of businesses that have introduced managed systems of care for their employees.

Keywords: private sector programs

15. Feldman, S. (Ed.). (1992). *Managed mental health services* (1st ed.). Springfield, IL: Charles C. Thomas.

This book was written by those involved in or connected to the managed mental health system: as payors, providers, managers, health-benefit consultants, human resources and employee assistance program (EAP) staff, researchers and teachers, and public and private policymakers. The book's wide range of topics includes the genesis of managed mental health and its application to particular settings. Several viewpoints are represented, including those of corporations, of the purchasers of health care, and of the freestanding managed mental health firms. One chapter describes the basics of a mental health evaluation system; another addresses the special quality assurance needs that managed mental health firms have. Finally, the book raises, in separate chapters, clinical, ethical, and legal issues.

Keywords: ethics, managed behavioral health care organizations, overviews, performance measurement, quality assurance

16. Feldman, S. (1998). Behavioral health services: Carved out and managed. *The American Journal of Managed Care, 4*, SP59–SP67.

Mental health and physical health have maintained the same relationship for the past 200 years—separate. The managed behavioral health carve-out (MBHCO) is the most current demonstration of this separation, as it involves the same managed care philosophy that has revamped the physical health industry, but it is not integrated with the physical health care

HMOs. This article examines the financial incentives that led to the development of the MBHCO as well as their common characteristics. The author illustrates such typical components of an MBHCO as contracts, payment mechanisms, and provider networks and data collection, through the example of United Behavioral Health. He also highlights available research on the effects of the MBHCO on cost and utilization, access, quality, and the relationship of behavioral health services to physical health care and other human services. The author also argues for further research in order to evaluate the qualitative aspects of care.

Keywords: carve-outs, managed behavioral health care organizations

17. Fishel, L., Janzen, C., Bemak, F., Ryan, M., & McIntyre, F. (1993). A preliminary study of recidivism under managed mental health care. *Hospital and Community Psychiatry, 44*, 919–920.

This brief article reports on a study to determine the recidivism rates for mental health services provided through HMOs, case-managed programs, and fee-for-service insurance plans. In the article, recidivism rates are considered a proxy for quality of service. The records of all persons ($N=365$) who were referred by an employee assistance program within a 24-month period were examined. Those who made a second request for service at least three months after the initial visit but still within the 24-month study period were considered “recidivists.” The study found a higher rate of recidivism in the managed care programs than in the fee-for-service plans. Limitations of this study are discussed, as are implications for future research.

Keywords: HMOs, performance measurement

18. Fisher, L., & Ransom, D. C. (1997). Developing a strategy for managing behavioral health care within the context of primary care. *Archives of Family Medicine 6*, 324–333.

The authors report on findings of a review of the literature from 1970 to 1996 on factors that predict the use of mental health and substance abuse services. The literature review was conducted as a means to guide the development of behavioral health care programs that are compatible with the primary care environment. The authors develop a framework to represent the main factors associated with mental health services use. They describe each of the domains and summarize the essential research findings. The domains include patient characteristics, primary care physician characteristics, practice settings, and managed care plan characteristics. Based on the findings from the literature review, the authors argue that behavioral health programs work best when they are decentralized to account for variations among primary care patients, physicians, and practices; when they are integrated clinically, financially, and administratively within the primary care setting; and when primary care physicians are active leaders in the design and implementation of these services.

Keywords: integration, primary care

19. Fitzpatrick, R. (1992). The Harvard Community Health Plan: An evolving model of managed mental health care. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 385–399). Washington, DC: American Psychiatric Press.

This chapter describes how the Harvard Community Health Plan (HCHP) reassessed the assumptions, scope, and benefits of their psychiatric and substance abuse services. The 5-year process led to a series of evaluative conclusions on what was and was not working in the mental health program, as well as a set of guiding principles for change, a mission statement, and new treatment modalities. The chapter describes the way in which this process was implemented, some of the findings, and the ways in which the HCHP has begun to implement some of the new clinical, educational, and management programs. It also describes the way in which the HCHP continues to evaluate the relative success of treatment options through clinical algorithms. Reports show increased patient and provider satisfaction as well as decreases in the number of hospital admissions and the length of stay.

Keywords: performance measurement, private sector programs

20. Frank, R. G., Goldman, H. H., & McGuire, T. G. (1992). A model mental health benefit in private health insurance. *Health Affairs*, *11*(3), 98–117.

Mental health benefits in public and private insurance vary widely, from no coverage at all to a wide range of benefits. Many mental health care benefits packages provide incentives for inappropriate types and amounts of treatment. In response to a Congressional request to the National Institute of Mental Health (NIMH), the authors designed a model mental health benefit for the working population. Through both supply- and demand-side incentives, this plan provides financial protection to both beneficiaries and their families, controls costs, and promotes cost-effective care. This article describes five principles that underlie the model plan and outlines the model benefit package itself. The article also proposes a payment system that is consistent with the development of provider networks that form the basis of many managed care programs. One goal of the model benefit is to draw national attention to the need to include mental health care in proposals for national health reform.

Keywords: health care reform, models, private sector programs

21. Frank, R. G., McGuire, T. G., Bae, J. P., & Rupp, A. (1997). Solutions for adverse selection in behavioral health care. *Health Care Financing Review*, *18*(3), 109–122.

In this article the authors address the adverse selection and benefits for behavioral health care in the managed care era. The adverse-selection argument presents evidence that health plans offering “good coverage” for behavioral health benefits attract the bad-risk patients and therefore, behavioral health benefits must be mandated either by a public entity or through some other means. Suggested solutions include risk adjustment of capitation rates, carve-outs, and cost- or risk-sharing between the payer and the plan.

Keywords: capitation, carve-outs, economics

22. Frank, R. G., McGuire, T. G., & Newhouse, J. P. (1995). Risk contracts in managed mental health care. *Health Affairs, 14*(3), 50–64.

This article examines potential implementation methods for mental health/substance abuse managed care coverage. The authors make the case for risk contracting in behavioral health care, describing the economics of risk contracting and its implications for the quality and cost-effectiveness of mental health/substance abuse service delivery. They state that in order to efficiently provide managed behavioral health services, it may be necessary to limit the choice consumers have in behavioral health care plans. As a result, the authors conclude that if behavioral health is to be covered by managed care, recipients will receive different types of care depending upon their payers' emphases on the costs versus the benefits of services.

Keywords: contracting, economics, substance abuse

23. Frank, R. G., McGuire, T. G., & Salkever, D. S. (1991). Benefit flexibility, cost shifting and mandated mental health coverage. *The Journal of Mental Health Administration, 18*, 264–271.

This article demonstrates an approach to evaluating a proposed change in mental health benefit design that was used in the Commonwealth of Virginia. The authors designed a simulation model to allow for an assessment of costs and utilization patterns associated with four potential design options for insurance benefits. After analyzing each option, the authors selected the one they believed has the potential to achieve the greatest gains in the context of the existing mental health mandate. The article describes the methods used for selecting each option, the authors' assumptions when making the evaluation, and the analysis of each option.

Keywords: private sector programs, Virginia

24. Goldman, H. H., Adler, D. A., Berland, J., Docherty, J., Dorwart, R. A., Ellison, J. M., Pajer, K., Siris, S., & Kapur, S. (1993). The case for a services-based approach to payment for mental illness under national health care reform. *Hospital and Community Psychiatry, 44*, 542–544.

In this position paper drafted by a committee of the Group for the Advancement of Psychiatry, the authors describe the advantages and pitfalls of three approaches to achieve equitable coverage for the treatment of mental illness. The three strategies are achieving parity by diagnostic status, by disability status, and by the set of services to be covered. After a comparative analysis of the three approaches, the authors advocate the services-based approach. They believe that a services-based approach is nondiscriminatory, and that costs can be controlled through managed care and through changes in the payment system or benefit design.

Keywords: health care reform, parity

25. Goldman, W. (1994). Myths and potentials. *Managed Care Quarterly, 2*(2), 51–52.

This article describes two competing myths embodied in the health reform debate. The first myth is that the current health care system allows freedom of choice and access to health care. The second is that competing organized health care systems, given economic pressures for cost

containment, will correct the current inequities in the health care system and lead to the same goals (of freedom of choice and access to competent, compassionate practitioners). The author of this viewpoint piece argues that both myths obscure reality. He puts forth his vision of how the shared goals of both camps can be reached through managed mental health care.

Keywords: health care reform, overviews

26. Goran, M. J. (1992). Managed mental health and group health insurance. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 27–44). Springfield, IL: Charles C. Thomas.

This chapter provides an overview of the evolution of managed care and how it affects mental health service delivery. Group health insurance organizations are expanding their efforts to control costs through aggressive use of managed care. A number of large employers have determined that fee-for-service plans are not containing costs as well as managed care networks that are similar to HMOs. Although most employers are reducing the number of options they offer, they are not inclined to “lock” employees into one choice. The chapter describes the key features of HMOs, preferred provider organizations (PPOs) and “carve-outs.” Also discussed are criteria for deciding whether to use an HMO or a conventional indemnity plan.

Keywords: carve-outs, HMOs, overviews, PPOs, private sector programs

27. Grazier, K. L., & Eselius, L. L. (1999). Mental health carve-outs: Effects and implications. *Medical Care Research and Review*, 56 (Supplement 2), 37–59.

An increasing number of employers and states are carving out behavioral health services, separating the provision of mental health and substance abuse services out from that of general medical services. In this article, the authors examine various models for a carve-out and describe the advantages and disadvantages of carve-outs as opposed to integrated models of care. The paper summarizes recent public and private sector research on the impact of carve-outs on access and utilization, cost savings and shifting, and quality of care. From this review of previous research, the authors suggest that carve-out strategies may lead to increased access to behavioral health services (particularly outpatient services) as well as to significant cost savings to sponsors through decreased inpatient utilization.

Keyword: carve-outs

28. Iglehart, J. K. (1996). Managed care and mental health. *New England Journal of Medicine*, 334(2), 131–135.

The author provides a brief overview of the managed behavioral health care market, in which he discusses operating techniques, quality of care, the views of mental health professionals, and the movement toward Medicaid-managed care. This report highlights the trade-off between the substantial savings achieved by managed care and the potential that these lower cost treatments are adversely affecting the lives of the mentally ill, by focusing on the outcomes of certain American corporations that have used managed behavioral health care services.

Keywords: economics, overviews

29. Judge David L. Bazelon Center for Mental Health Law & Legal Action Center (1998). *Partners in planning: Consumers' role in contracting for public-sector managed mental health and addiction services: Vol. 10. Managed care technical assistance series*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

As public-sector managed mental health care and substance abuse services increasingly enter into managed care arrangements, consumer groups have a unique opportunity to become involved in the formulation of contract policies. This guide is geared toward enabling consumers, families, and advocates to identify and advocate for the most rewarding managed care practices. The authors describe the intricacies of the contracting process, address the substance and key provisions with respect to rights issues in a contract, identify critical issues with respect to children and adolescents, suggest how consumer advocates can become involved, and provide examples of good practices from current public managed care contracts. The guide offers seven appendices including a glossary and a list of mental health and drug and alcohol addiction organizations with state-based contacts.

Keywords: children, contracting, public sector, substance abuse, technical assistance

30. Kihlstrom, L. C. (1998). Managed care and medication compliance: Implications for chronic depression. *The Journal of Behavioral Health Services & Research*, 25(4), 367–376.

In an effort to better manage treatment compliance for chronically mentally ill patients, some managed care organizations have initiated disease management (DM) programs for chronically depressed individuals. By focusing on education, measuring patient outcomes when practice guidelines are followed, and providing feedback to providers, DM programs claim to reduce variations in care and to result in cost savings. This article examines the success of DM programs used by pharmaceutical benefit management firms (PBMs) in the management of prescription drugs. The author provides a brief overview of the basic functions and attributes of PBMs, including a description of their disease management practices. The article then presents and critiques five different theories regarding the issue of treatment adherence as well as findings from relevant studies in this area. Finally, the article discusses implications for behavioral health services and directions for future research.

Keywords: depression, serious mental illness

31. Kunnes, R. (1992). Managed mental health: The insurer's perspective. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 101–126). Springfield, IL: Charles C. Thomas.

Mental health costs have risen dramatically for a number of reasons: growing incidence of mental health problems, “psychiatricization” of problems, expanding benefits for inpatient psychiatric and substance abuse disorders, growth of inpatient chains and franchised vendors, and more generous inpatient than outpatient coverage. Insurers have responded through the use of reduced benefits, telephone utilization review and case management, claims management, and preferred provider organizations (PPOs). The author argues that none of these

approaches has reduced costs, and outlines an ideal system from an insurer's perspective. Such a system would emphasize alternatives to inpatient care and provide for individualized treatment plans. The system would feature a sole entry point; effective triage; use of alternative services; coordinated services and settings; and experienced, specialized providers.

Keyword: models

32. Lee, F. C. (1991). Managing mental health care. *Benefits Quarterly*, 7(4), 91–100.

This article discusses new developments in the \$500-million-a-year managed mental health care industry. Managed mental health vendors are having a major impact on reducing length of stay in inpatient alcohol rehabilitation programs. Several initiatives are under way to develop alternatives to inpatient care for adolescents, and to increase oversight of those admissions. Managed mental health firms are also managing carve-outs of mental health benefits and undertaking efforts to reduce worker's compensation and disability claims. To address rising mental health costs, corporations are using employee assistance programs, capitation, utilization review, alternatives to inpatient care, and specialty carve-outs. The author also predicts several trends in managed care, such as self-regulation and the increased use of technology.

Keywords: managed behavioral health organizations, private sector programs, trends

33. Levin, B. L., Glasser, J. H., & Jaffee, C. L. (1988). National trends in coverage and utilization of mental health, alcohol, and substance abuse services within managed health care systems. *American Journal of Public Health*, 78, 1222–1223.

This study reports the results of a 1986 national survey of mental health, substance abuse, and alcohol services within HMOs in the United States. Ninety-seven percent of HMOs surveyed offered mental health service coverage and two-thirds of these offered alcohol and substance abuse service coverage, an increase since the 1982 survey. Annual mean mental health hospitalization was 36.90 days per 1,000 members and annual mean ambulatory mental health utilization was 0.29 physician encounters per member. Hospital and ambulatory costs for mental health services nearly doubled since 1982.

Keywords: HMOs, substance abuse, trends

34. Lizanich-Aro, S., & Goldstein, L. (1988). A successful approach to the start up of a mental health case management program. *Quality Assurance Utilization Review*, 3(3), 90–94.

This paper describes how mental health professionals can design and implement a case management program. Quality assurance, which is based on the use of standards and normative criteria for clinical decision making and review, is a key component of such a program. The authors briefly outline examples of such criteria and their development, and discuss how to design a peer-developed utilization review framework that fills in current gaps in mental health review approaches. Using these criteria, reviewers should be better able to address a number of case management questions, such as whether or not a treatment is appropriate.

Keywords: case management, quality assurance, utilization management

35. Lowman, R. L. (1994). Mental health claims experience: Analysis and benefit redesign. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 119–136). Washington, DC: American Psychological Association.

This chapter provides extensive mental health benefit analyses of corporate data, which demonstrate cost problems and the financial effects of treating patients over time. The intention through these analyses is to assist psychologists in understanding the forces that promote the growth of managed care. Four major issues are addressed: (1) national trends in health care costs and in health service delivery; (2) comparable trends in mental health and substance abuse treatment costs and service delivery; (3) the argument that managed care is a marketplace response to concerns on the part of employers and insurers; and (4) suggested opportunities for cost-effective services in a competitive market.

Keywords: costs, economics, overviews, trends

36. Mahoney, J. J. (1988). Future trends and emerging issues in alternative delivery systems: A purchaser's perspective. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (pp. 139–154). Washington, DC: American Psychiatric Association.

This article provides a historical overview of the business community's growing role in providing employee health care. The author describes the search for alternatives to fee-for-service reimbursement and discusses advantages and shortcomings of HMOs and preferred provider organizations for the business community. He concludes with a discussion of why managed care holds great promise for the provision of quality and cost-effective mental health and substance abuse care.

Keywords: private sector programs, overviews, trends

37. Mayhugh, S. L., & Shueman, S. A. (1994). The development and maintenance of provider networks. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 49–64). Springfield, IL: Charles C. Thomas.

This chapter describes the development, rationale, and maintenance of a provider network for a managed behavioral health care program. The authors focus on recruitment and selection, network monitoring, and improvement of provider performance. The authors conclude that only through collaborative efforts between the industry and professional mental health training programs will providers acquire the skills and attitudes necessary in the managed care environment.

Keyword: providers

38. McGuire, T. G., & Fairbank, A. (1988). Patterns of mental health utilization over time in a fee-for-service population. *American Journal of Public Health, 78*, 134–136.

This study of Massachusetts Blue Shield beneficiaries' ambulatory mental health use found that almost 70 percent of the individuals who received services in 1980 also used mental

health services in 1981 or 1982. These beneficiaries were also likely to have higher costs for medical services, which then decreased when therapy was terminated. A comparison of these findings with a similar multiyear study in an HMO revealed that patients were more likely to continue ambulatory mental health care in a fee-for-service system than in an HMO, but found no difference between the two settings in the likelihood of initiating ambulatory mental health care.

Keyword: utilization

39. Mechanic, D. (1997). Approaches for coordinating primary and specialty care for persons with mental illness. *General Hospital Psychiatry, 19*, 395–402.

In this era of increasing managed care penetration, primary care doctors are often the main source of treatment for a person with a psychological disorder. This paper examines six different models for integrating behavioral health with primary care in an effort to better manage patients' care: mainstreaming, the liaison psychiatry/collaboration model, new practitioner models, independent carve-outs, functionally integrated carve-outs, and extended care models. The author discusses the benefits and limitations of each model, noting that certain models may be more successful with some patient populations and not as successful with others. The author also identifies five barriers that often hamper primary care physicians in managing psychological disorders. These are limited training in disorder diagnosis, lack of time to deal with psychological issues, limited experience with psychiatric drugs, fear of treating patients with psychiatric disorders, and difficulty getting patients to disclose symptoms of psychiatric disorders.

Keywords: integration, models, primary care

40. Mechanic, D. (1998). Emerging trends in mental health policy and practice. *Health Affairs, 17*(6), 82–98.

This article presents an in-depth analysis of the issues surrounding managed care and mental health services. The author describes current trends in the mental health care system that provide a challenging context for the management of mental health services; these trends include deinstitutionalization and the shift of patients into community care programs and other residential facilities, parity of insurance coverage between mental and physical illness, and integration between behavioral and general health services. Serious problems exist in ensuring an appropriate range of services and programs for the seriously mentally ill residing in community settings. The author argues for increased coordination between hospital and community care and for the integration of hospital care into a more balanced system of services. Managed care organizations do not have full responsibility for the future of mental health services; these responsibilities are shared by purchasers, professionals, patient advocates, and the government.

Keywords: integration, overviews, parity, serious mental illness, trends

41. Mechanic, D. (Ed.). (1998). *New Directions for Mental Health Services*, 78.

The purpose of this book is to more carefully describe the developing system of managed care in order to guide its future design. A collection of authors helped to compose this sourcebook; initially, they present the current context of managed care by looking at a variety of issues such as utilization review and carve-outs. The second section concentrates on special issues such as contracting and special needs populations. The third section presents case study analyses from Utah, Colorado, and Massachusetts, all of which are states that have implemented Medicaid behavioral health managed care programs. The final section highlights arguments made in the prior sections and presents some observations about the future of managed care. Ultimately, the editor of this book looks to present an analysis that balances the views of managed behavioral health care critics and industry representatives. This effort intends to provide a clearer understanding of the industry in order to more effectively improve it in the future.

Keywords: carve-outs, Colorado, contracting, Massachusetts, Medicaid, public sector, Utah, utilization management

42. Mechanic, D., Schlesinger, M., & McAlpine, D. D. (1995). Management of mental health and substance abuse services: State of the art and early results. *The Milbank Quarterly*, 73(1), 19–55.

This article is a review of research literature and anecdotal reports on mental health and substance abuse managed care programs. The authors conclude that managed mental health care has the potential to reduce treatment costs and to apply uniform standards of appropriate treatment for patients. While noting potential obstacles that managed mental health care plans might encounter, the authors state that some forms of managed care have been successful at incorporating more flexible benefits and more innovative treatment programs for private and public mental health patients. The article encourages further research on the quality and cost-effectiveness of managed mental health care.

Keyword: outcomes

43. Milhalik, G., & Scherer, M. (1998). Fundamental mechanisms of managed behavioral health care. *Journal of Health Care Finance*, 24(3), 1–15.

In this article, the authors describe the individual structures and components of managed behavioral health care organizations (MBHOs) as a means of understanding the trend in the evolution of behavioral managed care. In particular, the authors examine the advantages and disadvantages of both carving in and carving out mental health care services, various payment mechanisms and contracts between MBHOs and payers and the contracts between MBHOs and their providers (including case rate contracts and withholds), utilization management systems, and models for the management and delivery of behavioral health care.

Keywords: carve-outs, contracting, managed behavioral health care organizations

44. Moss, S. (1998). *Contracting for managed substance abuse and mental health services: A guide for public purchasers: Vol. 22. Technical assistance publication series*. Rockville, MD: Center for Substance Abuse Treatment.

In response to the importance of establishing strong contracts between purchasers of health care services and managed care organizations in the development of managed behavioral health systems, this document provides information for public purchasers regarding the design of requests for proposals (RFPs) and contracts in managed behavioral health care. The guide includes eight separate chapters: (1) an overview of managed care and the importance of a good contract, (2) a step-by-step process for designing and implementing a managed care system, (3) a discussion on essential decisions concerning services and medical necessity, (4) an examination of the establishment and maintenance of provider networks, (5) an analysis of key features of a management information system, (6) a discussion of issues pertaining to quality of care, (7) an analysis of different aspects of financing in a managed care environment, and (8) a look at consumer protection issues. The guide also provides a resource list of organizations involved in managed behavioral health care, a glossary, and nine appendices with examples of proposals, sample bidder letters, definitions of different services, criteria for the use of block grant funds, outcome measures, and contract language.

Keywords: contracting, managed behavioral health care organizations, public sector, substance abuse, technical assistance

45. Nauert, R. C. (1997). Managed behavioral health care: A key component of integrated regional delivery systems. *Journal of Health Care Finance* 23(3), 49–61.

This article discusses the importance, in the current business environment, of a strong managed behavioral health care component within regional integrated health systems. The author discusses current trends in the business environment and addresses a number of issues that need to be considered when pursuing the behavioral health care market. The author provides an overview of the alternative roles large hospitals and medical centers can take in responding to market demands for managed behavioral health care. The author also discusses planning assumptions and reviews the strengths and weaknesses of academic medical centers and large hospitals, which can impact the successful development of behavioral health care. The author provides a prototype of a managed behavioral health care strategic business unit as part of a regional health system and discusses its advantages and pitfalls. The author concludes with a discussion of capitation contracts, risk control and quality assurance, and the importance of data tracking systems.

Keywords: integration, overviews

46. Ogles, B. M., Trout, S. C., Gillespie, D. K., & Penkert, K. S. (1998). Managed care as a platform for cross-system integration. *The Journal of Behavioral Health Services & Research*, 25(3), 252–268.

The implementation of managed care into public sector mental health care has raised concerns about the ability of this previously private-sector strategy to provide services consistent with

the core values of an integrated system of care. This paper examines the basic arguments on both sides of this debate, focusing on the recent changes in the mental health care system and the potential benefits and drawbacks of incorporating into it managed care principles. Using the example of Integrated Services for Youth, a private, nonprofit corporation in Ohio designed to manage the care of children and adolescents who are involved with multiple public-sector service systems, the authors demonstrate how managed care principles and system-of-care values are not necessarily mutually exclusive and may even facilitate cross-system integration of services for children and youth.

Keywords: children, integration, Ohio

47. Padgett, D. K., Patrick, C., Burns, B. J., Schlesinger, H. J., & Cohen, J. (1993). The effect of insurance benefit changes on use of child and adolescent outpatient mental health services. *Medical Care*, 31, 96–110.

This study examines the responsiveness of benefit changes on the use of outpatient mental health benefits for children and adolescents. Between 1978 and 1983, Blue Cross and Blue Shield Federal Employees Plan (FEP) benefits for dependent children and adolescents were cut, and there was a shift from high- to low-option plan enrollment. During this time, there was a slight increase in the proportion of clients who received outpatient benefits; however, the average number of visits decreased from 18.9 to 12.8. While benefit coverage was a strong predictor of the use of mental health benefits, ethnicity, parent's education, type of provider, and type of treatment setting were also significant predictors of use. The study found that 2.76 percent of children in FEP used outpatient mental health services in 1983, representing approximately one-half of the proportion of U.S. children estimated to be in acute need. These findings' implications are discussed in the context of changes in the financing and delivery of mental health services, especially with regard to managed care, and also in the context of the growing pressures for national health insurance.

Keyword: children

48. Patterson, D. Y. (1993). Twenty-first century managed mental health: Point-of service treatment networks. *Administration and Policy in Mental Health*, 21, 27–33.

Many public and private employers now favor the point-of-service (POS) plan that allows the prospective patient to decide at the point of service delivery whether to use a contracted or non-network provider. This article describes the nature of the POS plan and its impact on employers and employees. The author argues that only by developing a POS choice that is cost-neutral to the employer does a managed care network gain the moral authority and leverage to design a high-quality and cost-effective system. The article describes the principles guiding a rationally planned POS system and offers suggestions for internal and external oversight and quality assurance.

Keywords: models, providers

49. Patterson, D. Y. (1990). Managed care: An approach to rational psychiatric treatment. *Hospital and Community Psychiatry, 41*, 1092–1095.

According to this author, managed care is not necessarily bureaucratic and dehumanizing, nor is it a stop on an inevitable route toward health care rationing or a national health care service. In contrast, he argues, the partnership of the right delivery model and the right providers with the right financial incentives and proper management-consumer oversight can lead to the most rational mental health care delivery possible. A rational mental health care plan requires that a managed system be able to construct the right delivery model, select the appropriate providers, employ judicious financial incentives, and undertake adequate oversight. The author describes the principles that he would include in an effective delivery model for mental health care.

Keyword: models

50. Patterson, D. Y., & Berman, W. H. (1991). Organizational and service delivery issues in managed mental health services. In C. S. Austad & W. H. Berman (Eds.), *Psychotherapy in managed health care: The optimal use of time and resources* (1st ed., pp. 19–32). Washington, DC: American Psychological Association.

In this chapter, the authors outline the organizational and structural components of managed mental health care. They examine the types of managed mental health systems and their advantages and disadvantages, the types of benefits and limitations that are likely under various plans, and professional roles and conflicts in managed mental health service delivery. These include referral procedures, staffing patterns, and inpatient and outpatient services.

Keywords: models, staffing

51. Pearson, J. (1992). Managed mental health: The buyer's perspective. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 127–142). Springfield, IL: Charles C. Thomas.

Employers are finding that generic utilization review approaches are neither reducing mental health costs nor delivering quality care. The author presents options that exist in managed care, and the questions that employers should consider in deciding whether or not to implement such an approach. This chapter describes the advantages and disadvantages of employee assistance programs, benefit redesign, strengthened existing utilization review, specialty case management, and contracts with a preferred provider organization or exclusive provider organization. The chapter discusses the factors and decision-making process that shape a company's managed mental health program. The author states that good cost and utilization data are essential in determining how to reimburse a managed care firm and discusses the critical role consultants play in the process of educating their client companies and helping them to select an appropriate managed care firm.

Keywords: overviews, private sector programs

52. Penner, N. R. (1994). The road from peer review to managed care: Historical perspective. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 29–44). Springfield, IL: Charles C. Thomas.

This chapter describes the ways in which both the American Psychiatric Association and American Psychological Association were pioneers in the managed mental health field through the development of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The authors highlight the program's potential to provide the professions with the opportunity to shape the development of both public and private mental health service delivery systems, as well as the program's potential to create a system of public accountability. The chapter describes the associations' loss of this program and reduced influence in shaping current managed systems.

Keyword: overviews

53. Pfaum, B. B. (1991). Seeking sane solutions: Managing mental health and chemical dependency costs. *Employee Benefits Journal*, 31–40.

Studies have shown that mental illness and chemical dependency disorders are undertreated and that treatment for these disorders is generally not delivered efficiently. Increasingly, employers are recognizing the indirect costs of mental illness and chemical dependency disorders, such as increased absenteeism, lower productivity, and increased utilization of other health plan benefits. This article discusses some of the factors that companies should consider in designing a managed care program. Such a program should provide full coverage, control access to care, facilitate early intervention, use alternative care to assist “high” users, and apply appropriate screening criteria. The article also discusses factors to consider in using an employee assistance program, a utilization review, a preferred provider organization, or a carve-out are also discussed. The author argues that these options can be used together, and outlines the issues employers should consider in using HMOs to control mental health and chemical dependency treatment costs.

Keywords: costs, overviews, private sector programs, substance abuse

54. Rodriguez, A. R. (1994). Mental health services under health reform: The less government, the better. *Managed Care Quarterly*, 2(2), 10–12.

The author of this viewpoint article asserts that current health care reform proposals in favor of government-backed managed competition are not in the best interest of patients. Such proposals will lead to increased cost and inefficiencies and decreased access to care. The author advocates for privately managed mental health programs which he believes have already demonstrated their efficiency in decision making, their economies of operation, their accountability to multiple constituencies, and their commitment to quality of service.

Keywords: health care reform

55. Rogerson, C. L. (1994). Information system requirements for managed care programs. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 193–204). Springfield, IL: Charles C. Thomas.

This chapter describes the importance of automating operations and program activities for managed care companies. The author discusses several functions of an automated system and offers guidelines for setting up such a system. He argues that while it is possible to operate a small managed care program without an integrated information system, efficiency will be nevertheless hampered.

Keywords: information systems

56. Rosenbaum, S., Shin, P., Zakheim, M. H., Shaw, K., & Teitelbaum, J. B. (1998). *Special report of negotiating the new health system: A nationwide study of Medicaid managed care contracts*. Washington, DC: George Washington University Center for Health Policy Research.

This special report analyzes Medicaid managed care contracts specific to mental illness and addiction disorders. The report analyzes 54 contracts and related documents, 12 of which were managed behavioral health care contracts that were in effect at the beginning of 1997. Although this report considers Medicaid contracts, the authors contend that its findings are relevant to all public purchasers of managed care services for mental illness and substance abuse populations because, like Medicaid, these other sources of third-party payment have traditionally supported services that may or may not be customary for the insurance industry to support. The report's findings indicate that States are making an effort to design managed care systems that function well for children and adults, but it also highlights the perceived inadequacies in the contracting abilities of public purchasers such as managed behavioral health care carve-out contracts, which are frequently vague.

Keywords: contracting, Medicaid, public sector, substance abuse

57. Rosenbaum, S., Silver, K., & Wehr, E. (1997). *An evaluation of contracts between managed care organizations and community mental health and substance abuse treatment and prevention agencies: Vol. 1. Managed care technical assistance series*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

This study is designed to help public policymakers, group purchasers, providers, and consumers understand the structure and content of provider network agreements between managed care organizations and community mental health and substance abuse treatment and prevention agencies. From their in-depth analysis of 50 selected contracts, the researchers explain various aspects of contract provisions, including services, the duty to treat patients, the necessity of prior authorization, medical necessity, capitation agreements, fee-for-service agreements, coordination of benefits, and numerous other clauses of the contracts. The paper includes con-

clusions, recommendations, and two appendices covering methodology; the paper also has 28 different tables portraying the results of the study.

Keywords: community providers, contracting, managed behavioral health care organizations, substance abuse, technical assistance

58. Roy-Byrne, P., Russo, J., Rabin, L., Fuller, K., Jaffe, C., Ries, R., Dagadakis, C., & Avery, D. (1998). A brief medical necessity scale for mental disorders: Reliability, validity, and clinical utility. *The Journal of Behavioral Health Services & Research*, 25(4), 412–424.

While managed care organizations (MCOs) use the concept of “medical necessity” to determine whether to authorize treatment for an individual, there is currently no consistent measurement of medical necessity for a mental health condition. To address this need, the authors have developed an instrument of 13 items relevant to the concept of medical necessity. In this paper, they describe the medical necessity scale and present findings from their pilot testing of this scale. In a study of 205 patients, they found that the internal consistency reliability and the interrater reliability of the instrument were both acceptable. They conclude that the instrument is able to measure the multiple aspects of a patient’s condition needed to make decisions on medical necessity, although they advocate further studies with different patient populations and staff interviewers to determine whether the reliability results are generalizable.

Keywords: medical necessity

59. Savitz, S. A., Grace, J. D., & Brown, G. S. (1993). “Parity” for mental health: Can it be achieved? *Administration and Policy in Mental Health*, 21, 7–14.

Parity of insurance coverage for psychiatric and physical illness is a major issue in health care reform. Proponents of parity and partial parity, such as the American Psychiatric Association and the National Alliance for the Mentally Ill, argue that coverage for psychiatric and physical illness should be equal with respect to dollar limits, deductibles, and coinsurance. Such an approach is expensive. The authors describe strategies for achieving parity, such as capitation, case management, and the use of provider networks. They propose a model to reduce high utilization of unnecessary care, that incorporates managed care strategies for the cost-effective and equitable provision of behavioral health care.

Keyword: parity

60. Schwartz, B. J., & Wetzler, S. (1998). A new approach to managed care: The provider-run organization. *Psychiatric Quarterly*, 69(4), 345–353.

For many psychiatric hospitals and teaching facilities, managed care has become synonymous with shortened lengths of stay, reduced reimbursement, and the invasion of third-party care managers into the client–patient relationship. In this paper, the authors describe an alternative model to managed care, in which providers contract with HMOs directly, thereby eliminating the need for intermediary managed care organizations. This provider-run, hospital-based approach allows providers to regain control over service delivery. Through the example of

one such organization, the authors discuss the philosophy behind this model, the legal structures created to assume the financial risk, provider relationships, recruitment, management, reimbursement, the treatment paradigm, and the marketing strategies the new model involves. From the utilization data already collected on this organization, the authors demonstrate that utilization in the provider-run approach is consistent with that of a highly managed population.

Keywords: models, providers

61. Sederer, L. I., & Bennett, M. J., (1996). Managed mental health care in the United States: A status report. *Administration and Policy in Mental Health, 23*(4), 289–306.

The authors review managed mental health care in the United States. The report begins with a brief history of managed mental health care and proceeds to concentrate on six major issues: what is insurable, carve-ins, networks, contract and professional liability, ethics, and support for teaching and research. The report's final section discusses factors such as utilization management and economies of scale: factors that allowed managed care to achieve savings through 1996. The authors conclude with recommendations to the managed care industry and policymakers on how best to sustain these cost savings into the future.

Keywords: ethics, liability, overviews, utilization management

62. Sharfstein, S. S. (1988). Changing insurance markets. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (pp. 121–128). Washington, DC: American Psychiatric Association.

The author describes the major trends in third-party financing of health care, in which the third parties are government and business, and not only the insurance industry. These trends include the growth of prospective payment, employer self-insurance, data gathering, both vertically and horizontally integrated systems (such as HMOs and hospital chains), and subspecialization in the insurance market. The author discusses cutbacks in private coverage resulting from industry fears of adverse selection and moral hazard. Other issues raised in this piece include lack of access, high administrative costs, and the decline of professional autonomy.

Keyword: trends

63. Shueman, S. A., & Troy, W. G. (1994). The use of practice guidelines in managed behavioral health programs. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 149–164). Springfield, IL: Charles C. Thomas.

This chapter provides a historical perspective on the use of practice guidelines in managed behavioral health programs. The authors discuss the evolution of practice guidelines and the rationale for their use. They describe current professional guidelines and their uses in managed behavioral care programs. The chapter also describes implications of practice guidelines in

managed mental health programs. The authors speculate about the future development and implementation of practice guidelines.

Keywords: quality assurance, standards of care

64. Shueman, S. A., Troy, W. G., & Mayhugh, S. L. (1994). Principles and issues in managed behavioral health care. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 7–28). Springfield, IL: Charles C. Thomas.

This chapter focuses on the basic principles and key issues in managed behavioral health care. The authors discuss the health services and financing environment that was in place before the 1980s, which provided the foundation for managed care. Some specific cost and quality-of-care issues are discussed as well as innovative strategies to manage the behavioral health service system. The chapter concludes with a discussion of some of the challenges to managed behavioral health care companies.

Keyword: overviews

65. Smukler, M., Sherman, P. S., Srebnik, D. S., & Uehara, E. S. (1996). Developing local service standards for managed mental health services. *Administration and Policy in Mental Health, 24*(2), 101–116.

Capitated community mental health models may create incentives to withhold care. This study describes a method for eliminating this problem by creating standards for minimal levels of care. These standards, or Recommended Service Levels (RSLs), were created to test for the minimum, appropriate services for consumers at several levels of need. The RSL project was executed in five stages: (1) organizing the project participants, including an oversight committee and a clinical-expert panel; (2) developing RSLs based on provider recommendations for specific consumer groups and the appropriate level of services for them, in order to achieve acceptable outcomes for these groups; (3) creating an assessment instrument that could categorize consumer groups based on the level of services; (4) creating a decision tree that would allow assessment data to categorize a consumer for the appropriate RSL; and (5) testing the RSL in a sample of consumers. The field-test results showed that the RSL method has promise, but that it needed to include the consumer in the RSL process; manage the tension between developers of local standards and the managed care entity responsible for funding the service system; and validate the RSL standards through outcomes data.

Keywords: standards of care

66. Spiro, A. H. & Stokes, L. Q. (1991). A multifaceted approach to managed mental health care. *American College of Medical Quality, 6*(2), 54–58.

This article describes how an Independent Physicians Association (IPA) Model HMO with approximately 100,000 members manages its own mental health utilization. The system revolves around highly trained case managers who are granted tremendous leeway in directing patients toward appropriate care. These care managers use flexible benefits, such as 100 per-

cent outpatient care coverage, to reduce hospital use. The program also implements PATH (Projects for Assistance in Transition from Homelessness), a crisis intervention team of clinical psychologists that provides care in the home. An outside psychiatrist reviewer and psychiatric case manager monitor inpatient care, authorize lengths of stay, and precertify admissions. The program has resulted in dramatic decreases in hospital utilization.

Keywords: case management, utilization management

67. Sturm, R. (1997). How expensive is unlimited mental health care coverage under managed care? *Journal of the American Medical Association*, 278(18), 1533–1537.

This article analyzes data on behavioral health utilization for 24 new managed care plans in 1995 and 1996 and estimates the costs of removing different coverage limits for behavioral health as required by the Mental Health Parity Act. The data were obtained from the UCLA/RAND Research Center on Managed Care and purposely analyze managed behavioral health carve-out plans that offered more generous coverage than discussed during the parity legislation debate. The author concludes that the policy decisions that gave rise to the Mental Health Parity Act might have been based on incorrect assumptions and outdated data, which led to dramatic overestimates. For mental health care, the consequences of improved coverage under managed care are relatively minor.

Keywords: carve-outs, costs, economics, legislation, parity

68. Substance Abuse and Mental Health Services Administration. (1997). *An evaluation of contracts between state Medicaid agencies and managed care organizations for the prevention and treatment of mental illness and substance abuse disorders: Vol. 2. Managed care technical assistance series*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

This study provides a point-in-time examination of service agreements in operation at the end of 1995 between State Medicaid agencies and managed care organizations to provide mental health and substance abuse services. This study represents a review of Medicaid comprehensive-risk agreements and requests for proposals from approximately 35 States. The contracts reviewed include general service agreements covering primary health and several behavioral health care carve-out contracts. This study concludes that the behavioral health care market would benefit from the development of recommended specifications for managed care on treating and preventing mental health and substance abuse disorders, since these treatment initiatives were not in the normal domain of older commercial insurance concepts of coverage.

Keywords: carve-outs, contracting, Medicaid, public sector, substance abuse, technical assistance

69. Weiner, R. B., & Siegel, D. (1989). Managed mental health care issues and strategies. *Benefits Quarterly*, 5(3), 21–31.

This article examines the scope of the problem of rising mental health and substance abuse costs and the strategies that employers can use to reduce these costs. Cost increases, both direct and indirect, are attributed to several causes: increased demand for expanded benefits, excess supply of providers, ineffective benefit design, and lack of standards for diagnosis and treatment. The authors describe five cost containment strategies—restrictive/limited benefits, utilization management, employee assistance programs, carve-outs, and provider networks—and the factors employers should consider in selecting a strategy. Employers are urged to be flexible so that strategies reflect the changing needs of their workers.

Keyword: costs

70. Wells, K. B., Hosek, S. D., & Marquis, M. S. (1992). The effects of preferred provider options in fee-for-service plans on use of outpatient mental health services by three employee groups. *Medical Care*, 30, 412–424.

This quasi-experimental comparison-group study tests two hypotheses. The first is that employees who use preferred provider organizations (PPOs) are more likely than those enrolled in fee-for-service plans to use outpatient mental health care. The second hypothesis is that employees enrolled in PPOs will use less mental health services in general than those in fee-for-service plans. Use patterns before and after PPO implementation are compared for three PPOs. A survey of 8,828 employees was conducted to evaluate intentions to use PPO providers. Intention was measured using a battery to determine each respondent's usual source of medical care before and after PPO implementation. The study found that intent to use PPOs did not significantly affect the probability of use of outpatient mental health services because of access barriers and referral patterns by PPOs. Finally, the study found that PPO members use less outpatient mental health services than non-PPO members, despite lower cost-sharing for services received from PPO providers.

Keywords: PPOs, utilization

71. Wells, K. B., Manning, W. G., & Valdez, R. B. (1990). The effects of a prepaid group practice on mental health outcomes. *Health Services Research*, 25, 615–625.

The study uses data from the RAND Health Insurance Experiment to test the hypothesis that there is a difference in mental health outcome between those enrolled in HMOs and those enrolled in comparable fee-for-service plans. Families in the Seattle area were randomly assigned to either the Group Health Cooperative of Puget Sound (a prepaid group practice), to a fee-for-service plan with a family coinsurance rate of 0 percent, or to family pay plans with coinsurance rates of 25 percent, 30 percent, or 95 percent for outpatient mental health services. Mental health status was assessed at enrollment and at the end of each year of participation. The study found no statistically significant or clinically meaningful differences in

mental health outcomes among these groups. The authors argue that the less intensive style of treatment in the prepaid group practice was not associated with noticeably worse mental health outcomes.

Keywords: HMOs, outcomes

72. Wells, K. B., Marquis, M. S., & Hosek, S. D. (1991). Mental health and selection of preferred providers: Experience in three employee groups. *Medical Care, 29*, 911–924.

This study examines the effects of mental health status and the prior use of mental health services on provider selection by employees enrolled in fee-for-service plans with a preferred provider organization (PPO). For the study, claims and survey data were obtained from three large employee groups. The authors found that among persons who used mental health services after implementation of the PPO, those who had previously visited providers who subsequently became part of the PPO panel tended to stay with those PPO providers. On the other hand, those who previously visited providers who did not later join the panel did not select from PPO providers for mental health care. The study demonstrates the importance of the patient-provider relationship in the selection of a mental health provider.

Keywords: PPOs, providers

73. White, K., & Shields, J. (1991). Conversion of inpatient mental health benefits to outpatient benefits. *Hospital and Community Psychiatry, 42*, 570–572.

This article uses a case-study approach to describe how the conversion of inpatient to outpatient mental health benefits can lead to cost savings as well as to improved mental health outcomes. In 1987, Blue Cross-Blue Shield of Massachusetts revised the contract of a beneficiary who had used extensive inpatient treatment for multiple psychiatric diagnoses. During 1986 alone she had admissions costing over \$100,000. In-between hospitalizations, she used day treatment and lived in a halfway house. In 1987, her contract was revised to cover a variety of outpatient services including the halfway house, supplementary day treatment, and an activity program. This revision eventually led to a cost of approximately \$33,000 that year: a considerable savings compared to the previous contract. The patient also showed marked improvement. The authors attribute this to several factors including the use of new drugs and behavioral therapy, an individualized program at the halfway house, and the use of a nurse case manager both to assess treatment successes and failures and to work with the patient's family. The authors conclude that better funding and utilization of outpatient services may be cost-effective and also lead to improved outcomes.

Keywords: costs, outcomes

74. Wise, R. A. (1992). Managed care of the acutely ill psychiatric patient: Development of a new delivery system. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 375–384). Washington, DC: American Psychiatric Press.

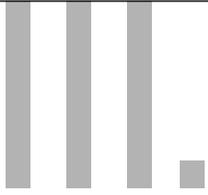
This chapter focuses on the challenging problems of caring for the acutely psychiatrically ill patient who often consumes a disproportionate percentage of treatment time and resources. The author reviews some current methods for managing the inpatient benefit for these patients. He suggests a new system that can improve efficiency by more closely matching resources to patient needs through alternative-to-hospital programs in conjunction with hospital care. He describes the specific goals and some effective strategies that were developed at a staff model HMO. He argues that managed care settings are best suited to explore alternative-to-hospital programs, and that as the success of these programs is better documented, other payors will be more willing to reimburse for this type of care.

Keywords: serious mental illness

75. Wolfe, H. L., Astrachan, B. M., & Scherl, D. J. (1988). Psychiatric practice in organized health and proprietary care systems. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care*. Washington, DC: American Psychiatric Association.

This chapter summarizes organized systems of care approaches to controlling mental health costs. The authors describe the development, strengths and weaknesses of HMOs, preferred provider organizations, employee assistance programs, and “multis” (multi-institutional corporations). The authors describe the practical and ethical implications of these payment systems for psychiatrists, patients, and society at large. They conclude that the American Psychiatric Association must focus attention on the issues of practice in organized settings and on the nature and ethics of organizational practice.

Keywords: costs, EAPs, ethics, HMOs, PPOs



Capitation

76. Babigian, H. M., & Reed, S. K. (1992). Capitation and management of mental health in the public sector. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 111–124). Washington, DC: American Psychiatric Press.

The authors of this chapter describe a 5-year demonstration project to address inadequacies in caring for seriously and persistently mentally ill people in Monroe and Livingston Counties in New York. As part of this demonstration project, both counties and the State delegated many of their responsibilities for the chronically mentally ill to a corporation that assumed both management of the publicly funded mental health system and coordination of the involved parties. The chapter discusses the evolution of the capitation payment system (CPS), the problems it addressed, and the main features of the system. The chapter describes an experimental evaluation of the CPS program, with preliminary findings indicating that the experimental group is using fewer hospitalization resources than the control group. On the basis of this project, the authors conclude that capitation shows promise in providing cost-effective quality care for persons who are chronically mentally ill.

Keywords: capitation, New York, public sector, serious mental illness

77. Babigian, H. M., Cole, R. E., Reed, S. K., Brown, S. W., & Lehman, A. F. (1991). Methodology for evaluating the Monroe-Livingston capitation system. *Hospital and Community Psychiatry, 42*, 913–919.

The Monroe-Livingston demonstration project was initiated in 1987 to coordinate the quality and cost of mental health services to chronically mentally ill patients. This paper presents the methodology for evaluating the Monroe-Livingston demonstration project's capitation payment system. The authors note that because random assignment produced equivalent groups, attrition was kept to a minimum and excellent interrater reliability was achieved. The evaluation design appears sound. This study should increase our understanding of the impact of capitation on families and patients.

Keywords: capitation, evaluation, New York, public sector, serious mental illness

78. Babigian, H. M., & Marshall, P. E. (1989). Rochester: A comprehensive capitation experiment. *New Directions for Mental Health Services, 43*, 43–54.

This chapter describes a demonstration project that examines whether persons who are chronically mentally ill can be served effectively in a capitated-financing model. The authors

discuss the project design, which includes a central coordinating agency, prospective payment, capitation, and management information systems. Examples are given to illustrate how clients are deemed eligible. The article describes the issues and challenges that arose in implementation, such as determining capitation rates and ensuring that state hospital employees received job security assurances. An evaluation has been undertaken to study the project's effect on mental health outcomes and costs.

Keywords: capitation, New York, public sector, serious mental illness

79. Brach, C. (1998). *Designing substance abuse and mental health capitation projects: Vol. 3. Managed care technical assistance series*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

This guide is meant as a reference tool for public officials in State and county substance abuse and mental health agencies as they design capitation projects. With its overview of capitation and answers to questions about capitation features, the guide also provides a useful foundation to anyone interested in mental health or substance abuse capitation. The researchers identify four relevant goals of substance abuse and mental health capitation and a 10-step plan to becoming a purchaser of capitated substance abuse and mental health services. Each step represents a separate task for designers of capitation projects, who in considering each step review the merits and drawbacks of different options. Steps include identifying goals, defining eligible populations, determining the scope of services, assigning responsibilities, contracting, managing risk, setting rates, enrolling clients, ensuring quality, and implementing the project. The guide also includes a decision checklist as a separate appendix.

Keywords: capitation, contracting, public sector, substance abuse, technical assistance

80. Burns, B. J., Smith, J., Goldman, H. H., Barth, L. E., & Coulam, R. F. (1989). The CHAMPUS Tidewater Demonstration Project. *New Directions for Mental Health Services*, 43, 77–86.

Concern about high costs and overutilization of mental health benefits led the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) to design and implement a demonstration project. This project places a contractor at risk for the cost of care, while granting the contractor leeway to manage the care using less costly forms of delivery. Under this contractor provider arrangement, CHAMPUS hired a contractor to provide all mental health benefits for its members. OCHAMPUS retains ultimate responsibility and performs oversight to maintain quality control. The chapter describes the functions performed by the contractor such as case management, processing claims, and establishing a network of providers. The authors identify the problems that arose in implementing the project and the questions to be answered in evaluating the project.

Keyword: capitation

81. Chandler, D., Meisel, J., Hu, T., McGowen, M., & Madison, K. (1998). A capitated model for a cross-section of severely mentally ill clients: Hospitalization. *Community Mental Health Journal, 34*(1), 13–26.

This 3-year study of the severely mentally ill (SMI) population examines hospitalization outcomes for two capitated integrated service agencies (ISAs), one urban and one rural, in California. The study focuses on the effectiveness of capitation and assertive treatment teams to limit hospital admissions, lengths of stay, mean mental health costs, and other factors for the SMI population. Using the flexibility of capitated funding and assertive treatment teams, both ISAs established crisis response and continuity of care procedures. According to the authors, at neither site were clients' outcomes on hospitalization uniformly superior to those of clients in the "usual system." However, the authors concluded that, in these two ISAs, elements of the capitated model produced both some clinically appropriate and less costly uses of inpatient services.

Keywords: California, capitation, evaluation, outcomes, public sector, serious mental illness

82. Christianson, J. B., & Gray, D. Z. (1994). What CMHCs can learn from two States' efforts to capitate Medicaid benefits. *Hospital and Community Psychiatry, 45*, 777–781.

The authors compare the Minnesota (Hennepin County) mental health capitation project with the Utah Prepaid Health Plan. In this study, Medicaid beneficiaries were enrolled in HMOs and the Utah Prepaid Health Plan which contracted with community mental health centers to provide care for Medicaid eligible clients. The authors discuss pros and cons of contracting with medical vs. mental health HMOs. They also present preliminary findings from these demonstration projects.

Keywords: capitation, HMOs, Medicaid, Minnesota, public sector, Utah

83. Christianson, J. B., Lurie, N., Finch, M., & Moscovice, I. S. (1989). Mainstreaming the mentally ill in HMOs. *New Directions for Mental Health Services, 43*, 19–28.

The Health Care Financing Administration (HCFA) undertook a demonstration project in Hennepin County, Minnesota, in order to study the ability of HMOs to cost-effectively serve seriously mentally ill clients. For this project, Medicaid beneficiaries were randomly assigned to receive 1 year of treatment in a prepaid health plan. The issues identified by the project included disruption of treatment; the ability of health plans, in spite of their lack of experience, to use community resources effectively; and adverse patient selection. Although the authors conclude that these concerns can be addressed, they raise questions as to how States can address the problem of adverse selection if they cannot make retrospective payments to compensate health plans that experience financial difficulties.

Keywords: capitation, HMOs, Minnesota, public sector, serious mental illness

84. Cole, R. E., Reed, S. K., Babigian, H. M., Brown, S. W., & Fray, J. (1994). A mental health capitation program: I. Patient outcomes. *Hospital and Community Psychiatry, 45*(11), 1090–1096.

Proponents of capitation have suggested that capitating payment for mental health services both restrains high mental health care costs and improves the flexibility and responsiveness of care. In this study, the authors evaluate the Monroe-Livingston demonstration project's capitation payment system (CPS). The experiment randomized patients into either the capitated-funding program (experimental group) or the fee-for-service program (control group). The authors conducted followup interviews with patients 1 and 2 years after enrollment to assess changes in their symptoms and functioning. Additionally, the authors reviewed data files of the membership corporation to measure patients' utilization of inpatient care. The results show that while patients in the experimental group utilized inpatient days less frequently than the control group, the two groups did not differ significantly in respect to functioning or level of symptoms.

Keywords: capitation, evaluation, New York, outcomes, public sector, serious mental illness

85. Cutler, D. L., Bentson, H., & Winthrop, K. (1998). Mental health in the Oregon health plan: Fragmentation or integration? *Administration and Policy in Mental Health, 25*(4), 361–386.

Between 1994 and 1998, Oregon experienced a rapid change in its health care system. Since the implementation of the Oregon Health Plan, Medicaid enrollment has expanded 50 percent to include some of the working poor. In addition, since then over 75 percent of individuals receiving Medicaid have enrolled in HMOs, and demonstration projects have experimented with capitated behavioral health services. In this paper, the researchers examine the effects of the transition to capitation as well as the integration of behavioral and physical health care, using interviews with various stakeholders in the community. The paper discusses the background of Medicaid expansion and capitation in Oregon, the development of mental health payment rates and rate setting, the variations in both carved out and integrated mental health models, and, using interviews with stakeholders, the successes and challenges of implementing the new health plan. These interviews have revealed that the greatest challenge has been the attempted integration of public sector behavioral health services with private sector health plans, while the expansion and transition to capitation have been more successful.

Keywords: capitation, integration, Medicaid, Oregon, public sector

86. Dobmeyer, T. W., McKee, P. A., Miller, R. D., & Westcott, J. S. (1990). The effect of enrollment in a prepaid health plan on utilization of a community crisis intervention center by chronically mentally ill individuals. *Community Mental Health Journal, 26*(2), 129–137.

The advent of a Medicaid Demonstration Project to enroll Medicaid beneficiaries in a prepaid plan raised concerns among county mental health agencies in Hennepin County, Minnesota, that the new system might lead to underprovision of mental health services by prepaid plans,

and might therefore create an extra burden on county-funded mental health agencies. The authors randomized a sample of eligible recipients into a prepaid or fee-for-service group and examined how the effect of enrollment in a prepaid plan affected use of an emergency crisis center by chronically mentally ill Medicaid recipients. This center had not contracted with the prepaid plan as a service provider. The study found that the use of the center by those enrolled in the prepaid group was slightly (statistically insignificant) lower than for the fee-for-service group. The authors conclude that this finding may be an indication of successful case management by prepaid health plans in serving chronically mentally ill patients.

Keywords: capitation, local governments, Medicaid, Minnesota, public sector, serious mental illness, utilization

87. Hadley, T. R., & Glover, R. (1989). Philadelphia: Using Medicaid as a basis for capitation. *New Directions for Mental Health Services, 43*, 65–76.

Philadelphia was one of nine cities selected by the Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development to develop innovative and improved ways of providing mental health care to the chronically mentally ill population. As part of this initiative, Philadelphia designed a Medicaid capitation demonstration project for financing and managing mental health services. This capitated arrangement includes all Medicaid-reimbursed psychiatric services for Philadelphia residents. This article describes the project's design and early implementation, and also discusses early difficulties and future goals.

Keywords: capitation, local governments, Medicaid, Pennsylvania, public sector

88. Hargreaves, W. A. (1992). A capitation model for providing mental health services in California. *Hospital and Community Psychiatry, 43*, 275–277.

In 1988, the California legislature adopted and funded an integrated services agency (ISA) model of providing mental health services. State funds were appropriated for two sites, one in rural Stanislaus County and the other in the city of Long Beach. Each site serves people who are disabled because of their mental disorder, who show substantial functional impairment, and who are considered public fiscal liabilities. This includes people who are being treated for a first psychotic episode. The ISA model attempts to go beyond the strict capitation model by providing incentives for providers to offer optimal services while maintaining cost-effectiveness. A controlled, randomized comparison of ISAs and usual services is being conducted to evaluate whether ISAs indeed control costs while enhancing outcomes for mentally disabled patients.

Keywords: California, capitation, public sector, serious mental illness

89. Lurie, N., Moscovice, I. S., Finch, M., Christianson, J. B., & Popkin, M. K. (1992). Does capitation affect the health of the chronically mentally ill? Results from a randomized trial. *Journal of the American Medical Association, 267*, 3300–3304.

This study evaluated the effect on health outcomes of enrollment of chronically mentally ill Medicaid recipients in prepaid plans and fee-for-service Medicaid. Seven hundred thirty-nine

chronically mentally ill Medicaid clients were randomly assigned into either one of four capitation plans or into a control group that continued to use fee-for-service care. Outcomes measured included general health status, physical and social functioning, and psychiatric symptoms. Pre- and postdata were collected on both the client and control groups. The study found that there was no consistent evidence of short-term adverse health effects in prepaid plan enrollees, and it recommends conducting long-term outcome studies.

Keywords: capitation, Medicaid, outcomes, public sector, serious mental illness

90. Mauch, D. (1989). Rhode Island: An early effort at managed care. *New Directions for Mental Health Services, 43*, 55–64.

This chapter describes the Rhode Island Division of Mental Health's use of partial capitation to discharge long-term psychiatric patients from the State mental hospital to the community. The Transfer I program provided \$4,500 per patient per year to community agencies to serve clients who had been hospitalized continuously for at least 1 year. The Transfer II program was initiated 5 years after Transfer I started, following a review of the limitations and accomplishments of Transfer I. Transfer II clients must have been hospitalized continuously for 2 years or longer. In both programs, providers were required to become their clients' single, designated manager of care. The capitated cost for Transfer II clients was set at \$20,000 each. To guard against inadequate service, community programs were required to provide core services over and above those funded by capitation, to assign a care manager, and to track and evaluate client functioning. The strategy resulted in the cost-effective transfer of a number of patients. The author identifies a number of problems with this approach: lack of adequate community care options; disincentives to serve clients with shorter lengths of stay; and inflexible capitation rates, which lead to system instability. The author nonetheless argues that these programs have been successful in helping individual clients live in the community and in bringing about system change.

Keywords: capitation, public sector, Rhode Island, serious mental illness

91. McGovern, M. P., Lyons, J. S., & Pomp, H. C. (1990). Capitation payment systems and public mental health care: Implications for psychotherapy with the seriously mentally ill. *American Journal of Orthopsychiatry, 60*, 298–304.

Two types of prospective payment have been used to control mental health costs: case-mix models (such as diagnosis-related groups) and capitation. According to this article's authors, capitation models offer the most promise for cost-effectively serving chronically mentally ill persons. The article discusses the advantages of the capitation strategy, such as integrating resources and service provision and providing a spectrum of services including medical care. This approach has important implications for treatment. It can result in better linkage among treatment modalities, greater emphasis on psychosocial versus medical care, the use of rehabilitation and social skills training, and an emphasis on involving the patient's family and support network. The authors also identify potential disadvantages to using capitation, such as inade-

quate care, reliance on unskilled paraprofessionals, and an emphasis on maintenance rather than rehabilitation.

Keywords: capitation, serious mental illness

92. Mechanic, D., & Aiken, L. H. (Eds.). (1989). *New Directions for Mental Health Services*, 43.

This volume of *New Directions for Mental Health Services* presents a case study approach to capitation programs of mental health services. This work represents the perspectives of both theoreticians and implementors. The editors specifically include both capitation “success” as well as “failure” stories because each offer the reader unique learning opportunities.

Keywords: capitation

93. Mechanic, D., & Aiken, L. H. (1989). Capitation in mental health: Potentials and cautions. *New Directions for Mental Health Services*, 43, 5–18.

Capitation is increasingly advocated as a means of solving cost and quality problems in mental health care for chronically mentally ill persons. The authors provide examples and the history of this strategy and discuss its limitations. Among the risks to a capitation strategy are underserving populations, or a lack of service entirely. There are also significant problems in “mainstreaming” chronically mentally ill persons in HMOs as well as in serving them using separate mental health HMOs. Under capitation, certain subsets of this population are neglected and poorly treated. There are obstacles to using capitation to consolidate financing, such as determining “fair” capitation rates; there is also reluctance by funding agencies to surrender control of their budgets. The authors conclude that capitation holds promise as a strategy for consolidating major sources of funding and contributing toward a coherent system of managed care for the most needy patients.

Keywords: capitation, serious mental illness

94. Reed, S. K., Hennessy, K. D., Brown, S. W., & Fray, J. (1992). Capitation from a provider’s prospective. *Hospital and Community Psychiatry*, 43, 1173–1175.

This article explores providers’ experiences with the capitation payments system (CPS), a component of a mental health demonstration project in Monroe and Livingston Counties, New York. As part of the evaluation of the impact of CPS, interviews were conducted with administrators, program managers, and direct-care staff from both CPS lead agencies and the State hospital. Providers interviewed identified a number of ways in which CPS enhanced care of seriously mentally ill persons. CPS, in which funding “follows” patients, facilitates effective use of community mental health resources, and increases staff and client empowerment and collaboration among agencies. The authors also discuss provider recommendations to improve CPS and providers’ efforts to advocate for this managed care strategy’s expanded use.

Keywords: capitation, New York, public sector, serious mental illness

95. Reed, S. K., Hennessy, K. D., Mitchell, O. S., & Babigian, H. M. (1994). A mental health capitation program: II. Cost-benefit analysis. *Hospital and Community Psychiatry, 45*, 1097–1193.

In this study, the authors examined the costs and benefits associated with a capitation demonstration program. The authors analyzed total costs and benefits of care for individuals in the Monroe-Livingston demonstration project's capitated funding program, and compared them to the costs and benefits in a traditional fee-for-service system of care. The study distinguished between those patients enrolled in the comprehensive plan (continuous care) and those enrolled in the partial plan. From the results, all groups showed improvements over the previous 2 years, but continuous patients in the capitated plan were hospitalized less frequently and experienced more case management and transportation services than continuous patients in the fee-for-service plans. The patients continuously in the capitated plan were also more likely to live in unsupervised settings and experienced higher levels of victimization. Subjects in the partial plan for both the capitation and fee-for-service plans differed from each other on fewer measures, and both groups reported high levels of case management and social support services and lower levels of supervised housing. The authors conclude that the capitation payments system resulted in major improvements in the communities' mental health services and in decreased utilization in inpatient services.

Keywords: capitation, costs, evaluation, New York, outcomes, serious mental illness

96. Reidy, W. J. (1993). Staff model HMOs and managed mental health care: One plan's experience. *Psychiatric Quarterly, 64*(1), 33–43.

The Community Health Plan (CHP) is a not-for-profit staff model HMO that has provided inpatient and outpatient mental health benefits for its beneficiaries for the past 15 years. The mental health program is organized into interdisciplinary teams of mental health professionals. Wherever possible, the program provides outpatient over inpatient care, goal-limited rather than long-term psychotherapy, group therapy, and psycho-educational programs. For members with major psychiatric disorders, CHP staff provide ongoing maintenance care and case management. This article describes the structure and function of the CHP and the lessons learned through the provision of this model of managed care.

Keywords: capitation, HMOs

97. Roth, D., Snapp, M. B., Lauber, B. G. & Clark, J. A. (1998). Consumer turnover in service utilization patterns: Implications for capitated payment. *Administration and Policy in Mental Health, 25*(3), 241–255.

The authors report the findings from a multiyear, National Institute for Mental Health (NIMH)-funded study in Ohio, "Services in Systems: Impact on Client Outcomes," that explored the effect of the changing mental health system on services for the severely mentally ill (SMI) population. The study uses past service utilization to classify people by level of risk, and then uses these findings to hypothesize on the development of risk-adjusted capitation rates for SMI individuals. This article describes the cluster statistical analysis technique which

was used on a random sample of 4,346 consumers of mental health services over a 5-year period. The findings of this study, according to the authors, suggest caution in the implementation of risk-adjusted capitated reimbursement plans for people with SMI, because retrospective assessment of service utilization is of limited value.

Keywords: capitation, evaluation, Ohio, outcomes, public sector, serious mental illness

98. Rothbard, A. B., Hadley, T. R., Schinnar, A. P., Morgan, D., & Whitehill, B. (1989). Philadelphia's capitation plan for mental health services. *Hospital and Community Psychiatry, 40*, 356–358.

This article describes a capitation demonstration project to deliver services cost-effectively to Philadelphia's chronically mentally ill Medicaid recipients. The project is overseen by a central authority, a nonprofit corporation created by the city's Office of Mental Health/Mental Retardation. The authority uses strategies such as case management to control costs. Capitation will be implemented in order to lower costs associated with high-user clients. The authority will also use performance contracts for moderate user services.

Keywords: capitation, local governments, Medicaid, Pennsylvania, public sector, serious mental illness

99. Santiago, J. M., & Berren, M. R. (1989). Arizona: Struggles and resistance in implementing capitation. *New Directions for Mental Health Services, 43*, 87–96.

In this chapter, the authors describe capitation pilot projects to reform Arizona's public mental health system. The Arizona experiment implemented four projects in Tucson and Phoenix and one in rural Yuma. Each site received a fixed amount of money to provide mental health services to randomly selected, indigent, mentally ill patients. The project clinical team performed case management and delivered other services and was financially at risk for the costs of inpatient and outpatient care. The authors discuss a number of barriers to implementation, including insufficient capitation rates, provider resistance, lack of market competition, and absence of safeguards against underserving populations.

Keyword: Arizona, capitation, public sector

100. Schinnar, A. P., & Rothbard, A. B. (1989). Evaluation questions for Philadelphia's capitation plan for mental health services. *Hospital and Community Psychiatry, 40*, 681–683.

This report of the Philadelphia experiment to capitate psychiatric services for Medicaid clients focuses on the anticipated impact of capitation on the cost, quality, and accessibility of care to chronically mentally ill patients. The authors argue that the experience of this large-scale demonstration in capitation financing should be watched closely by policymakers across the country for the project's potential impact on the substitution of outpatient for inpatient services, on continuity of care, and on cost-shifting. Other project aspects to be

observed closely include its spillover effects as well as its impact on providers and client care. The authors argue for timely evaluation of the impact of the experiment.

Keywords: capitation, local governments, Medicaid, Pennsylvania, serious mental illness

101. Schinnar, A. P., Rothbard, A. B., & Hadley, T. R. (1989). Opportunities and risks in Philadelphia's capitation financing of public psychiatric services. *Community Mental Health Journal, 25*, 255–266.

This article examines the risks and benefits inherent in the reorganization of Philadelphia's mental health service system under a capitation financing model. The authors focus on cost and utilization patterns, providers and their staffing patterns, treatment outcomes, and the impact of capitation on clients. Philadelphia plans to restructure its delivery and reimbursement system, creating a not-for-profit central authority to finance and manage service delivery.

Keywords: capitation, local governments, Medicaid, Pennsylvania, public sector, serious mental illness

102. Schlesinger, M. (1989). Striking a balance: Capitation, the mentally ill, and public policy. *New Directions for Mental Health Services, 43*, 97–116.

The author argues that in order to meet the needs of both publicly and privately insured chronically mentally ill persons, capitation must balance several incentives and interests. He describes two types of incentives to limit resource use: provider capitation related to providers' income and nonfinancial limits on treatment. These incentives to restrict use are counterbalanced by pressures to intervene early through practice norms favoring excessive utilization and consumer actions. Although these are each limited, together they may counterbalance incentives to cut costs. However, these countervailing pressures are less likely to protect chronic mentally ill persons, and this population may be subject to arbitrary denials of care, lack of access, nonrandom distribution of risk, and inadequate monitoring. The author suggests several remedies, including state-administered ombudsman programs and greater risk-sharing by HMOs.

Keywords: capitation, serious mental illness

103. Substance Abuse and Mental Health Services Administration (1998). *Estimating and managing risks for the utilization and cost of mental health and substance abuse services in a managed care environment: Vol. 4. Managed care technical assistance series*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

This manual is meant for mental health and substance abuse provider organizations to gain a better understanding of the principles and development of risk-sharing provider payment systems used in a managed care system. SAMHSA means for this manual to be used as a training tool, and thus, it emphasizes examples and exercises allowing the reader to understand the terminology of risk management. This manual is based on the premise that as the trend toward capitation for mental health and substance abuse services continues, risk-sharing arrangements

will become an increasingly prevalent form of provider reimbursement. The appendix includes blank worksheets, contact information, bibliography, and examples of risk-sharing calculations to guide the reader toward a clearer understanding of the issues.

Keywords: capitation, substance abuse, technical assistance

104. Warner, R., & Huxley, P. (1998). Outcomes for people with schizophrenia before and after Medicaid capitation at a community agency in Colorado. *Psychiatric Services, 49*(6), 802–807.

This article examines the psychiatric care of Medicaid recipients under a capitated funding mechanism. Outcomes, satisfaction, and service utilization are compared between two random samples of 100 clients, one a year before capitation was introduced and one a year after. The authors' results show that hospitalization rates were generally lower after capitation and that clients reported improved quality of life. In this study, the findings suggest that Medicaid capitation led to an efficient use of treatment resources.

Keywords: capitation, Colorado, community providers, Medicaid, outcomes, public sector, schizophrenia, serious mental illness, utilization

105. Wyant, D., Christianson, J., & Coleman, B. (1999). The financial impact on community mental health centers of capitated contracts with Medicaid: The Utah Prepaid Mental Health Plan. *Community Mental Health Journal, 35*(2), 135–152.

Sparked by Medicaid's movement toward managed care in many States, this study examines the financial impact of contracting with a State Medicaid program on a community mental health center (CMHC). In particular, the researchers compared the financial experience of three CMHCs that entered into capitated contracts with the Utah Medicaid plan with a subset of CMHCs in Utah that maintained the traditional method of reimbursement over a 6-year period. The analysis compared the two types of CMHCs on profitability, liquidity, and patterns of investment and financing. From the results, there were relatively few differences between the contracting and noncontracting CMHCs that did not exist prior to the change in reimbursement options. At worst, the decision to contract had a neutral impact on financial performance.

Keywords: capitation, community providers, Medicaid, public sector, Utah

106. Ziemann, G. L. (Ed.). (1995). *The complete capitation handbook: How to design and implement at-risk contracts for behavioral healthcare*. Tiburon, CA: Centralink Publications.

This book is an installment of the National Behavioral Healthcare Library series and describes behavioral health care financing and delivery systems of the short and intermediate future. The first part of this book gives the history of capitation and risk, and the next part describes business organization and management solutions that arose to deal with risk in the managed behavioral health care delivery system. The third section includes specific instructions on how to provide health care under capitation and the fourth and fifth sections cover

special topics and present case studies where capitation has been used for mental health service delivery. This book is intended to aid mental health professionals in the development, negotiation, and management of at-risk contracts in managed behavioral health care delivery.

Keywords: capitation, contracting, providers, technical assistance

IV. Community Mental Health Services

107. Christianson, J. B., Lurie, N., Finch, M., Moscovice, I. S., & Hartley, D. (1992). Use of community-based mental health programs by HMOs: Evidence from a Medicaid demonstration. *American Journal of Public Health, 82*, 790–796.

This article tests the hypothesis that Medicaid beneficiaries in HMOs reduce their use of mental health treatment programs in their communities, thereby jeopardizing the financial viability of these programs. A randomized trial of two groups of severely mentally ill Medicaid beneficiaries (one with traditional Medicaid benefits and one with HMO benefits) showed no significant short-term difference in the use of community-based programs. The authors suggest that Medicaid program administrators can minimize the disruption of ongoing treatment for beneficiaries who join prepaid groups by offering beneficiaries a choice among prepaid plans and encouraging community treatment programs to contract with plans to serve beneficiaries.

Keywords: community providers, evaluation, HMOs, Medicaid, serious mental illness

108. Cypres, A., Landsberg, G., & Spellman, M. (1997). The impact of managed care on community mental health outpatient services in New York State. *Administration and Policy in Mental Health, 24*(6), 509–521.

This article explores the impact of managed care on community mental health centers. It reports the results of a survey that was administered to the directors of all licensed outpatient mental health facilities (clinics, day treatment, and intensive outpatient psychiatric rehabilitation) in New York State. Indeed, these facilities reported extensive changes in the past as well as predicted changes in the future as a result of the impact of managed care. These changes occurred in a variety of areas — staffing patterns, rate at which various services are offered, revenue sources, joining managed care panels, advertising, and training — and differed depending upon size, region, and type of facility. The survey also inquired into respondents' experiences with and attitudes toward managed care. The study reports that directors predict declines in the number of staff other than psychiatrists (psychologists in particular), that they document a shift away from open-ended treatment and toward more acute and short-term care, and that they have a variety of concerns and frustrations arising from their experiences with managed care.

Keywords: community providers, New York

109. Feldman, S. (1994). Managed mental health — Community mental health revisited? *Managed Care Quarterly*, 2(2), 13–18.

The author argues that despite the superficial differences between the community mental health movement of the 1960s and the current managed care movement, there may be a greater commonality in processes, values, and objectives between them than is readily apparent. Both focus on alternatives to hospitalization; both appear to have in common a belief in the value of continuity of care, the responsibility for a defined population, and recognition of the importance of easy access and early intervention. Because of these similarities, lessons from community mental health may be applicable to managed care, and, in particular, the importance of an academic base for training and research and the potentially negative impact of oversell and inflated expectations.

Keywords: community providers

110. Ray, C., & Oss, M. (1993). Community mental health and managed care. *New Directions for Mental Health Services*, 59, 89–98.

Community mental health centers (CMHCs) face a number of challenges if they are to function effectively in an era of managed care. The authors argue that CMHCs must balance their social mission to provide mental health care to high-risk populations with a new sophistication about finance, marketing, and operating in a managed environment. Using examples from the experiences of Massachusetts CMHCs, the authors lay out options for CMHCs in their attempt to survive in this new environment. The article concludes with a discussion of the opportunities for CMHCs to be major participants in the movement toward managed mental health care.

Keywords: community providers

111. Young, A. S., Sullivan, G., Murata, D., Sturm, R., & Koegel, P. (1998). Implementing publicly funded risk contracts with community mental health organizations. *Psychiatric Services*, 49(12), 1579–1584.

This article presents a case study of the Los Angeles County Partners Program, a contractual arrangement for services for severely mentally ill individuals between Los Angeles County Department of Mental Health and community mental health organizations. By providing a fixed annual rate per enrolled patient, the program shifted the financial risk for treatment to community organizations. From both qualitative and quantitative data, the researchers found that the new approach geared toward the most expensive patients enhanced programs' flexibility and accountability and increased their emphasis on principles of psychosocial rehabilitation. The article discusses challenges in implementation including disenrollment, limitations with existing information systems, and changes necessitated by risk contracting in general. They conclude that although mental health authorities planning to institute risk contracts need to balance fiscal incentives with performance guarantees, risk contracting offers great opportunity to improve service delivery.

Keywords: California, capitation, community providers, local governments, public sector, serious mental illness

V. ■ Diagnosis-Related Groups (DRGs)

112. Ashcraft, M. L. F., Fries, B. E., Nerenz, D. R., et al. (1989). A psychiatric patient classification system: An alternative to diagnostic-related groups. *Medical Care*, 27, 543–555.

This article reports on a project to construct a diagnostic classification system more appropriate for alcohol, drug, and mental disorders than the DRG system. The authors used data from the Veterans Administration (VA) to construct 12 psychiatric diagnostic groupings from which a psychiatric patient classification (PCC) system was derived. They found that this new classification system accounts for significantly more of the variation in length of stay than the DRGs. Moreover, they conclude that this system is more useful for hospital payment purposes because PCCs are clinically useful. They argue that PCCs appear to be valuable candidates for inclusion into the VA's resource allocation system, and warrant exploration of its applicability to female and non-VA populations.

Keyword: DRGs

113. Dorwart, R. A., & Chartock, L. R. (1988). Psychiatry and the resource-based relative value scale. *American Journal of Psychiatry*, 145, 1237–1242.

Recent attempts to control medical costs for inpatient psychiatric services focus on regulating hospital reimbursement through the use of DRGs. This article focuses attention on other methods to control mental health inpatient costs through regulating reimbursements received by physicians. The authors review the resource-based relative value scale (RBRVS) as an alternative to other proposed reimbursement methods, such as physician DRGs. The RBRVS uses the setting, time spent, difficulty in treating the patient, training, and psychiatrist's role to determine reimbursement rates for psychiatrists. The authors suggest that the RBRVS has several advantages over both the DRG approach and capitation and may be useful in a variety of health care settings such as in HMOs and in the public sector.

Keyword: DRGs

114. English, J. T., Sharfstein, S. S., Scherl, D. J., Astrachan, B. M., & Muszynski, I. L. (1988). Diagnosis-related groups and general hospital psychiatry: The American Psychiatric Association Study. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (1st ed., pp. 19–40). Washington, DC: American Psychiatric Association.

This chapter reviews the context in which psychiatric diagnoses were exempt from the original DRG system and reports on the findings of the Task Force on Prospective Payment, established by the American Psychiatric Association (APA) to examine the implications of the DRG system for psychiatry. The authors report the findings of this study which concluded that the DRG system is not accurate or fair for psychiatric diagnoses. Based on 1.67 million Medicare cases, the study found that there is substantial variation between hospital type in resource use by patients within a given psychiatric DRG. For example, the mean length of stay in hospitals with psychiatric units was 38 percent higher than that in general hospitals. The authors urge that any system be introduced incrementally, as part of a mixed retrospective and prospective payment approach and that levels of payment should consider the facility's historical costs and the diversity of treatment models.

Keyword: DRGs

115. Essock, S., & Norquist, G. S. (1988). Toward a fairer prospective payment system. *Archives of General Psychiatry, 45*, 1041–1044.

An underlying assumption of the Medicare prospective payment system (PPS) is that characteristics of patients such as diagnosis and of hospitals can be used to predict costs. The authors challenge the assumption that the current system based on DRGs is an adequate predictor of cost for psychiatric care. They claim that the psychiatric payment categories are poor predictors of cost, accounting for between 2 percent and 15 percent of the variability in the length of stay. They examine variables that might be added to the equations to make for a more equitable and effective reimbursement system for inpatient psychiatric care including additional facility and patient characteristics. Finally, they explore incentives that can be built into a payment system to counteract the impetus to minimize care provided.

Keyword: DRGs.

116. Freiman, M. P., Mitchell, J. B., Taube, C. A., & Harrow, B. S. (1988). The 1985 National Institute of Mental Health/Health Care Financing Administration study of payment for psychiatric admissions under Medicare: Overview and a look ahead. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (1st ed., pp. 91–106). Washington, DC: American Psychiatric Association.

This chapter describes a study conducted by the National Institute of Mental Health (NIMH) and the Health Care Financing Administration to examine issues relating to the classification of alcohol, drug abuse, and mental health (ADM) admissions under prospective payment, and the impact of modifications to this system on both exempt and nonexempt facilities. Medicare

claims in four states were used to develop “clinically related groups” (CRGs), an alternative classification system. This system was found to perform better than the DRG system in explaining variation in hospital costs and length of stay, but 90 percent of the variation was still unexplained by CRGs. The use of disease staging did not help to improve predictive power. The study also simulated DRG-related payments for ADM admissions to general hospitals with and without exempt units, and found that the average simulated payment to hospitals with exempt units was several hundred dollars higher than the average payment for an admission to a nonexempt unit. Substantial inter-state variation was found, as well as between exempt and nonexempt hospital outlier rates. A follow-up study by the NIMH is described.

Keyword: DRGs

117. Goldman, H. H. (1988). Overview of studies on psychiatric hospital care under a prospective payment system. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (1st ed., pp. 172). Washington, DC: American Psychiatric Association.

This chapter reviews several studies examining the usefulness of case mix measures in prospective payment. The author argues that there is no viable classification system whose impact has been tested on the heavily differentiated mental health system. Given this, and the fact that alternative systems may be worse than a prospective payment system (PPS), the author urges psychiatry to play a key role in implementing an effective PPS. He argues that psychiatry should not overemphasize the differences between health and mental health care, as similarities are the basis for its claims for reimbursement under health insurance. An equitable and efficient reimbursement system for mental health care can be viewed as an opportunity for psychiatry rather than a necessary evil.

Keyword: DRGs

118. Namerow, M. J., & Gibson, R. W. (1988). Prospective payment for private psychiatric specialty hospitals: The National Association of Private Psychiatric Hospitals prospective payment study. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care*, (1st ed., pp. 41–54). Washington, DC: American Psychiatric Association.

This chapter describes a study conducted by the National Association of Private Psychiatric Hospitals to test the adequacy of the psychiatric DRGs and alternative systems to pay hospitals, and to assess the financial impact of these systems on private psychiatric specialty hospitals. Thirty hospitals were randomly selected for the study, which included retrospective chart review for patient-specific data, a questionnaire survey for hospital organization and financial information, and site visits. Data were analyzed in order to determine the variables correlated with length of stay and cost of care. The study found that both the original 15 DRGs and its modified version allow for inadequate grouping for setting payment rates for private psychiatric hospital stays. This chapter discusses the implications of this and other findings.

Keyword: DRGs

119. Rosenheck, R., Massari, L., & Astrachan, B. M. (1990). The impact of DRG-based budgeting on inpatient psychiatric care in Veterans Administration medical centers. *Medical Care*, 28(2), 124–132.

This study examines the impact of a DRG-based resource allocation methodology (RAM) on inpatient psychiatric care in the Veterans Administration (VA) hospitals. The authors reviewed data on discharge for psychiatric and substance abuse disorders before and after the implementation of DRG-based budgeting in the VA system. They found a significant decline in lengths of stay, total annual bed days per patient, and total expenditures after DRGs were instituted. The authors conclude that RAM is a potent management tool and discuss the reasons why these changes are attributable to this payment method and not other factors.

Keyword: DRGs

120. Ruggie, M. (1990). Retrenchment or realignment? U.S. mental health policy and DRGs. *Journal of Health Politics, Policy and Law*, 15(1), 145–167.

This article examines the rise of DRGs as part of a major reorganization of the delivery of health services in the United States. The author argues that there have been two major institutional shifts in the state's provision of mental health services; from main provider to retrospective buyer, and from retrospective payer to prospective buyer. The impact of this shift on providers and organizations is discussed.

Keyword: DRGs

121. Sargent, S. C., Scherl, D. J., & Muszynski, I. L. (1988). The New Jersey experience with diagnostic-related groups. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (1st ed., pp. 172). Washington, DC: American Psychiatric Association.

New Jersey has long been an important laboratory for experiments with prospective reimbursement of hospital services. This chapter reports on a study conducted by the American Psychiatric Association to explore the effect of the state's DRG-based system on its psychiatric hospitals. Interviews and focus groups with State government officials, hospital administrators, and provider associations identified a number of problems with this system. Participants were concerned that the DRG system would lead to reduction or closure of psychiatric units, admissions based on anticipated reimbursement rather than on need, frequent utilization review, and downgrading of staff. The authors conclude that the DRG system favors private psychiatric hospitals which are exempt from such payment and that psychiatric DRGs should reflect severity of illness, complications, and the costs of indigent care.

Keywords: DRGs, New Jersey

122. Schinnar, A. P., Rothbard, A. B., & Hadley, T. R. (1992). A prospective management approach to the delivery of public health services. *Administration and Policy in Mental Health, 19*, 291–308.

The authors describe a prospective payment model for use in managing mental health in the public sector. The model consists of three components: a single-stream funded prepayment system, psychiatric and needs assessment data to gauge demand for services, and targeting of care to reduce unnecessary hospitalization and lengthy stays. Taken together, these components address both supply and demand and achieve an equilibrium between them. The article identifies the challenges inherent in implementing each component, and describes a study in which the authors were able to predict the patients' risk of becoming high users. Since mental health crises appear to be highly predictable events, prospective payment holds promise for controlling costs. Relevant literature on prospective payment and major studies are also briefly discussed.

Keyword: DRGs

123. Zwanziger, J., Davis, L., Bamezai, A., & Hosek, S. D. (1991). Using DRGs to pay for inpatient substance abuse services: An assessment of the CHAMPUS reimbursement system. *Medical Care, 29*, 565–577.

Studies have shown that DRGs and similar classification systems poorly predict inpatient resource use, especially mental health services. Previous studies have also demonstrated that certain types of providers are systematically under- (or over-) reimbursed. This study assessed how well the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) DRG system explains variation in costs at the individual level and predicts resource use across hospitals. The study found that substance abuse DRGs are only partially successful in classifying CHAMPUS patients according to their resource use, explaining only 4.2 percent of the total variance. The source of this variation might be lack of consensus on treatment, or differences among mental health providers regarding delivery of services. The study also found substantial variation in the impact of the DRG system on hospital revenue. General hospitals were reimbursed at a higher level than substance abuse specialty hospitals. This may reflect differences in coding practices, or severity of patients in the two settings.

Keywords: DRGs, substance abuse

VI. Economics, Forecasting, and Pricing

124. Cummings, N. A. (1994). The successful application of medical offset in program planning and in clinical delivery. *Managed Care Quarterly*, 2(2), 1–6.

Medical offset research comprises some of the earliest outcome studies in mental health. In this article the author, one of the originators of medical offset studies, describes the evolution of such studies, reflects on 30 years of research, and summarizes some of the early literature on this subject. He demonstrates that evidence in favor of the offsetting of medical costs by providing psychological services has been replicated widely over the years in varied health care systems. The absence of a psychotherapy benefit leads to increased medical and hospital costs to the health care plan. Evidence that patients translate stress, anxiety, and other psychological symptoms into physical ones is so strong that the author argues that no comprehensive health plan can afford to be without an effective psychotherapy benefit.

Keyword: costs

125. DuVal, M. K. (1988). Changing reimbursement patterns and the realities of health care finance. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (1st ed., pp. 1–8). Washington, DC: American Psychiatric Association.

The author provides a historic overview of changing health care reimbursement patterns over the past 50 years. He focuses on the past five years and describes the impact of these changes on the practice of medicine, on academic medical research, and on health care coverage for the uninsured. With practitioners at increasing economic risk, he is concerned that incentives to undertreat may prevail. He describes the movement toward prospective pricing as the biggest contemporary challenges to psychiatry.

Keywords: economics, trends

126. Frank, R. G., Huskamp, H. A., McGuire, T. G., & Newhouse, J. P. (1996). Some economics of mental health 'carve-outs'. *Archives of General Psychiatry*, 53(10), 933–937.

This article discusses the economic rationale of carve-out contracts in general and for mental health and substance abuse (MH/SA) in particular. The authors focus on the control of a plan's adverse selection of the insured population as the primary factor for the conception of behavioral health carve-outs as well as the moral hazard phenomenon, where utilization of mental health services is twice as responsive to cost-sharing provisions as is utilization of general

health services. The authors first present the economic theory of carve-outs as determined by the problems of moral hazard and adverse selection; second, they present evidence of these economic explanations; and third, they analyze the incentives of the buyers and the vendors of mental health services. The conclusion finds that adverse selection has long undermined the insurance market for MH/SA coverage, and that, according to the authors, carve-outs are a suitable economic solution to the failures of this insurance market.

Keywords: carve-outs, economics, substance abuse

127. Frank, R. G., & Lave, J. R. (1992). Economics of managed mental health. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 83–100). Springfield, IL: Charles C. Thomas.

This chapter discusses the promises and pitfalls of using managed care to control costs and utilization in a private insurance setting. The authors explain the traditional demand-side approaches (such as limits on coverage and cost-sharing) and supply-side approaches (such as prospective payment), and identify several undesirable consequences of these approaches. The promises of managed care include the potential to reduce inappropriate care while constraining utilization to appropriate levels. Potential problems include lack of clarity regarding respective responsibilities of employer, provider, and managed care firm; lack of standards for care; little research on effectiveness of managed care; and inefficient use of the tort system to address accountability problems. The authors conclude that while managed mental health care offers some promise for controlling utilization and cost of mental health services, it should be only one of the tools in the cost-containment toolbox.

Keywords: costs, economics

128. Frank, R. G., & McGuire, T. G. (1998). The economic functions of carve outs in managed care. *The American Journal of Managed Care*, 4, SP31–SP39.

This paper examines the economic tenets of carve-outs. The authors discuss four broad forms of carve-outs: (1) payer specialty carve-outs from all health plans, (2) payer specialty carve-outs from only indemnity and preferred provider organization arrangements, (3) individual health plan carve-outs to specialty vendors, and (4) group practice carve-outs to specialty organizations. The efficiency, adverse selection, and costs of these different carve-out options are considered without many specific qualitative examples being given. In the conclusion the authors argue that the decision to carve out services must be made based on the individual services being provided and the population being served. However, for some payers, it may be more efficient to obtain the necessary expertise from a carve-out which specializes in management of one of these services and has a sufficient volume of cases in order to have a strong bargaining position in the market.

Keywords: carve-outs, economics

129. Goldman, H. H., & Taube, C. A. (1988). High users of outpatient mental health services, II: Implications for practice and policy. *American Journal of Psychiatry*, 145, 24–28.

This article examines four stereotypes of outpatient mental health use: (1) all use is alike, (2) any use leads to high use, (3) all high use is discretionary, and (4) insurance encourages excessive use. The authors provide data to refute the first three assumptions and argue that these stereotypes ignore the diversity of outpatient mental health services and the individuals who use them. They favor a combination of pricing strategies that would not impede initial treatment but would limit excessive use of mental health services. The authors argue that the same principles of insurance and public health apply to the financing of mental health care as to general health care.

Keywords: economics, utilization

130. Ma, C. A., & McGuire, T. G. (1998). Costs and incentives in a behavioral health carve-out. *Health Affairs* 17(2), 53–69.

Implementing managed care arrangements has proven to be a highly effective cost-saving strategy for the behavioral health arena, and many States have chosen to take advantage of this fact for both their employee benefit programs and for beneficiaries of their public programs. At the same time, there is evidence that some managed care systems achieve these cost-savings at the expense of quality. These authors examine the behavioral health managed care carve-out established by the Massachusetts GIC (Group Insurance Commission), which supplies insurance to State employees, as a model from which to determine the nature of cost-savings in this type of arrangement. The authors present a detailed analysis of changes in cost, incentives contained in the carve-out contract, and eligibility and claims data to determine the source and nature of cost savings. The data they examine show significant cost-savings (30–40 percent) after the implementation of the carve-out, even beyond that of their pre-set cost targets/contract incentives. As a result they speculate further that there may be a “reputation effect,” or desire on the part of contractors to show especially good results in the interest of attracting future business in the rapidly expanding managed care market.

Keywords: carve-outs, costs, economics, Massachusetts, public sector

131. National Advisory Mental Health Council (1998). *Parity financing mental health services: Managed care effects on cost, access, and quality*. An Interim Report to Congress. Rockville, MD: National Institute of Mental Health.

This National Advisory Mental Health Council workgroup paper discusses the cost implications of parity, and in response to more recent charges from the Senate, has amplified its domain to include how managed care affects both access to mental health services and the quality of those services. The summary findings show that as the overall managed care population increases, the projected cost of parity declines, and that the introduction of parity laws would accelerate the trend toward increased management of mental health services.

Also, parity alone does not guarantee improved access to mental health care because of the counteracting effects of managed care. Measurement of the quality of care with the advent of management shows considerable variability in the results, and further research is needed in this area.

Keywords: costs, parity

132. Olfson, M., Sing, M., & Schlesinger, H. J. (1999). Mental health/medical care cost offsets: Opportunities for managed care. *Health Affairs, 18*(2), 79–90.

This paper examines the potential for managed care companies to take advantage of the “cost-offset effect,” the phenomenon where the provision of mental health services can lead to a decrease in utilization of general medical services. The authors introduce the debate, reviewing possible pathways to achieve cost offsets, how cost offsets arise, and the relationship between mental health status and use of medical services. They identify three patient groups with high potentials to yield cost offsets, including distressed elderly medical inpatients, primary care outpatients with multiple unexplained somatic complaints, and nonelderly adults with alcoholism. The paper discusses previous research in the subject and implications for delivery and financing. Three possible structures for achieving cost offsets are to integrate medical and mental health financing and management, to train utilization managers to identify target populations and facilitate their access to mental health care, and to combine pricing policies with utilization management to increase access within managed care plans.

Keywords: costs, utilization

133. Pallak, M. S., Cummings, N. A., Dörken, H., & Henke, C. J. (1993). Managed mental health, Medicaid, and medical cost offset. *New Directions for Mental Health Services, 59*, 27–40.

Studies have demonstrated that mental health treatment may reduce the use and cost of medical services (the “cost-offset” effect). This study uses a quasi-experimental design to test the cost-offset hypothesis on a Medicaid population in Hawaii. Results showed that managed mental health services consistently resulted in declines in both inpatient and outpatient medical costs for Medicaid enrollees. In contrast, traditional unmanaged mental health services had little effect on overall medical costs. The authors conclude that managed mental health care can lead to a cost-effective provision of total medical services.

Keywords: costs, Hawaii, Medicaid, public sector

134. Pallak, M. S., Cummings, N. A., Dörken, H., & Henke, C. J. (1994). Medical costs, Medicaid, and managed mental health treatment: The Hawaii study. *Managed Care Quarterly, 2*(2), 64–70.

This article reports on a randomized, prospective study to examine the impacts of mental health care on medical utilization and costs. The study found that medical costs of a Medicaid population in Hawaii were reduced by 23 percent to 40 percent compared to control groups.

The study analyzed the impact of managed mental health services separately for people with and without chronic health conditions. The authors demonstrate that the costs of managed mental health care are recovered in 6 to 24 months. They conclude that managed mental health treatment is associated with declines in medical costs.

Keywords: costs, Hawaii, evaluation, Medicaid, public sector, utilization

135. Sharfstein, S. S. (1991). Prospective cost allocations for the chronic schizophrenic patient. *Schizophrenia Bulletin*, 17, 395–400.

The author presents a life-course longitudinal model for financing care of patients with schizophrenia. The model, which is being tested in a demonstration project in Rochester, New York, is based on a prospective cost allocation method using capitation payments that are “risk adjusted” to reflect patient’s past use of services, current health status, and level of disability. The purpose of this approach is to provide incentives to develop outpatient services, to encourage early intervention, and to integrate public and private funding streams. The author calls for a new social policy to address the needs of this population. Such a policy would provide comprehensive care, adequate funding, incentives for innovation, and patient choice. The author outlines a proposal to integrate Federal and State funding for chronic mental illness.

Keyword: capitation, New York, public sector, schizophrenia, serious mental illness

136. Smith, M. E., & Loftus-Rueckheim, P. (1993). Service utilization patterns as determinants of capitation rates. *Hospital and Community Psychiatry*, 44, 49–53.

This study examined the service use of 55 clients of a psychosocial rehabilitation outpatient program at a hospital-based community mental health center. The purpose of the study was to identify different patterns of service use and associated patient characteristics. Treatment cost and services provided were tracked for each patient for one year. Cluster analysis revealed that service use may be determined by factors other than clinical need. The authors argue that setting capitation rates based on previous use of services may inaccurately predict the cost of services needed to serve patients with severe mental illness. Findings from this study led the authors to develop an alternative strategy for estimating service need based on comprehensive service planning models for subgroups of seriously mentally ill persons.

Keywords: capitation, serious mental illness

137. Sterman, P. (1997). The costs of behavioral health care coverage. *Employee Benefits Journal*, 22(1), 2–10.

This article reports on the significant financial implications psychiatric and chemical dependency conditions can have on the plan sponsor and how to control the cost with managed behavioral health care protocols and benefit designs. Conditions that contribute to the high costs include absence of price regulation, shifting cost from patients with less coverage to those with more coverage, a bias for inpatient reimbursement-in-full, destigmatization of psychiatric and substance abuse treatment, and an increase in the number of psychiatric beds

and the consequent increase in demand for patients. The author discusses several strategies to contain behavioral health care costs such as modifying benefit plans to restrict services covered, imposing benefit limitations, refining and developing provider networks, implementing managed care approaches, early identification and prevention of behavioral health conditions, and improving treatment outcomes.

Keywords: costs, substance abuse

VII. Employee Assistance Programs (EAPs)

138. Kent, J. (1990). The role of employee assistance programs in managed mental health care. *Medical Interface, 14*, 25–28.

Mental health problems of employees can be extremely costly to employers in terms of lost productivity, low morale, and worker's compensation. Employee Assistance Programs (EAPs) were developed as a way for employers to provide cost-effective mental health services to their employees. This article provides criteria for evaluating EAPs and describes a typical EAP service package and an effective psychiatric review process.

Keywords: EAPs

139. Major, C. (1993). EAPs as customers of managed mental health. *Administration and Policy in Mental Health, 21*, 35–39.

This article describes AT&T's internal employee assistance program and its efforts to promote quality care by monitoring the managed care provider network and using clinical practice guidelines to evaluate client needs and treatment outcomes. The author suggests ways of obtaining and maintaining a high-quality panel of providers and describes the benefits of clinical practice guidelines. In addition to providing a flexible method for consistent but individualized clinical decision-making, guidelines also are the basis for clinical outcome studies to measure effectiveness and appropriateness of treatment decisions and become the foundation for continuous quality improvement.

Keywords: EAPs

140. Masi, D. A., & Caplan, R. (1992). Employee assistance programs. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 321–333). Washington, DC: American Psychiatric Press.

This chapter describes the evolution of employee assistance programs (EAPs) from the 1940s when they were designed in response to alcoholism among employees. The authors describe several models of employee assistance programs and ingredients of effective EAPs. They describe the differences and similarities between EAPs and HMOs and show why the interface between the two is sometimes conflictual. The three major problems between HMOs and EAPs arise over clashes in the gatekeeping role, in choice of preferred provider, and through general lack of communication. The authors describe current trends that have implications for the future of EAPs. They argue that the four factors that will have direct impact on the future of EAPs are (1) the role of EAPs in managed mental health; (2) the focus on drug abuse in the

workplace; (3) the increasing number of persons affected by AIDS; and (4) the growing need for quality management and clinical evaluation by third parties.

Keywords: EAPs, overviews, trends

141. Miller, N. A. (1992). An evaluation of substance misuse treatment providers used by an employee assistance program. *The International Journal of the Addictions*, 27, 533–559.

Thirty fee-for-service (FFS) facilities and nine HMOs were analyzed to determine the provider characteristics that are most likely to increase access and improve outcomes for people referred for substance abuse problems. This article evaluates measures of access to care, continuity, and quality of treatment programs to which 243 employees of one public sector program were referred by their employee assistance program (EAP). The study recommends that EAPs develop a mechanism to evaluate providers on an ongoing basis. One mechanism suggested is a precontract request for proposals in which treatment providers document that they provide those characteristics shown to increase access and improve treatment outcomes. Some of these characteristics include use of a multidisciplinary treatment team, provision of coordinated treatment services, and provision of a treatment program that enables an employee to directly contact and enter a treatment program.

Keywords: EAPs, evaluation, substance abuse

VIII. Health Maintenance Organizations (HMOs)

142. Altman, L., & Goldstein, J. M. (1988). Impact of HMO model type on mental health service delivery: Variation in treatment and approaches. *Administration in Mental Health, 15*, 246–261.

This paper reports on a descriptive and exploratory study that compares mental health services availability and actual clinical practice across different HMO models. The authors hypothesize that differences in the financial and institutional feature of HMOs influence treatment and practice. Clinicians, managers, and chiefs in six HMOs in a Northeastern State were interviewed. HMOs were stratified and randomly selected to represent three model types: staff, group (including network model), and independent practice association. There were no significant differences between HMO model types in mental health benefits, except in number of days for outpatient substance abuse treatment. There were differences, however, in organizational characteristics, provider characteristics, and benefit design. Findings from this research are consistent with other studies that show that in comparison to fee-for-service models, the organizational and financial structure of HMOs influences provider response and utilization patterns.

Keyword: HMOs

143. Barglow, P., Chandler, S., Molitor, N., & Offer, D. (1992). Managed psychiatric care for adolescents: Problems and possibilities. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 261–271). Washington, DC: American Psychiatric Press.

The authors of this chapter describe the philosophy and psychiatric benefits for adolescents in the Humana Michael Reese HMO. They argue that with carefully managed inpatient and 57outpatient treatment plans, the vast majority of adolescents who need psychiatric care can benefit from short-term interventions. They describe the characteristics of the psychiatric acute care unit and the adolescent intensive treatment program that comprise the core of treatment options for this client population. The results of a client (adult care providers) satisfaction survey are presented as are several components that the authors feel are responsible for good client outcomes.

Keywords: children, HMOs

144. Bennett, M. J. (1988). The greening of the HMO: Implications for prepaid psychiatry. *American Journal of Psychiatry*, 145, 1544–1549.

This article discusses the history of the HMO, focusing on its evolution from a social to an economic movement. In particular, the author describes the role of psychiatry within a prepaid structure. He anticipates the ways in which psychiatry may change in the future and suggests that psychiatrists be trained in order to adapt to the growing emphasis on cost control, outcomes, and the economics of health care.

Keywords: HMOs, overviews, trends

145. Bennett, M. J. (1992). Managed mental health in health maintenance organizations. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 61–82). Springfield, IL: Charles C. Thomas.

Current trends in managed mental health are discussed in the context of the history of the HMO concept and movement. Prepayment and group practice developed in the late nineteenth century to deliver service to workers in rural areas and union laborers. HMOs became legitimate with the passage of the 1973 HMO Act. Mental health benefits and services gradually expanded because of legislative mandates and research demonstrating its effectiveness. The closed-panel HMO became a distinct form of mental health practice, emphasizing brief treatment and collaboration. The chapter describes trends in HMO structure, such as the proliferation of “open systems” (Independent Physicians Associations and preferred provider organizations) and the implications of managed care and subcontracting. HMOs are increasingly profit driven and professionalized. The current patterns of mental health care provision and use are discussed. The author anticipates that there will be increasing emphasis on population-based care and consumer education, and states that the goals of accessibility and affordability have yet to be realized.

Keywords: HMOs, overviews, trends

146. Bennett, M. J. (1993). View from the bridge: Reflections of a recovering staff model HMO psychiatrist. *Psychiatric Quarterly*, 64(1), 45–75.

This article reviews the origin and development of managed mental health care, from the “pure” prepaid practice paradigm to the current focus on utilization review, case management, discounted fees, and network development and management. The second part of the article describes the current emphasis in health care that reflects a shift from containing costs to assessing and monitoring outcomes. In response, managed care companies are shifting from quality assurance to quality enhancement. The article concludes by anticipating seven future trends and describing the pitfalls that we must overcome in order to create a mental health system that is equitable, efficient, and effective.

Keywords: HMOs, trends

147. Bloom, B. L. (1990). Managing mental health services: Some comments for the overdue debate in psychology. *Community Mental Health Journal, 26*, 107–124.

This article describes the similarities and differences between the three most prominent models of mental health services: the preferred provider organization (PPO), the comprehensive HMO, and the managed mental health care organization (MMHCO) in terms of organization, services provided, and degree of choice provided to the patient. The author suggests that of the three, the HMO model, because of its integration of physical and mental health services and focus on a managed model of service delivery, may have the greatest potential for survival as a model of health care delivery. He concludes with a discussion of the types of training and skills that psychologists must have in order to survive in this era of managed mental health care.

Keywords: HMOs, managed behavioral health care organization, training

148. Bonstedt, T. (1992). Managing psychiatric exclusions. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 69–82). Washington, DC: American Psychiatric Press.

This chapter examines the types of psychiatric exclusions that exist in HMOs. These include exclusions based on diagnosis, duration of illness, number/duration of hospitalizations, recent utilization of psychiatric benefits in the plan, degree of disability, substance abuse, and others. The author reviews the ideological premises and the impact of exclusions. He argues that in the current managed care climate, psychiatric exclusions are likely to proliferate unless research demonstrates that providing psychiatric care for specific clinical conditions produces a significant offset effect. The author concludes that psychiatric exclusions are a necessary but unfortunate “cap” on clinical care in a managed system.

Keyword: HMOs

149. Carson, D. (1992). Setting up provider networks and PPOs. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 99–109). Washington, DC: American Psychiatric Press.

This chapter describes the features of preferred provider organizations (PPOs) that distinguish them from health maintenance organizations (HMOs). The two most basic ways in which PPOs differ from HMOs is that they reimburse providers on a fee-for-service basis and they offer subscribers the opportunity to select a designated or nonparticipating provider. Some components of PPOs are the financial incentives to influence provider choice, discount pricing for hospital rates, utilization review, and emphasis on reducing inpatient treatment through comprehensive and accessible outpatient services. The author explores some of the unanswered questions regarding the effectiveness of PPOs and addresses some of the inherent problems of PPOs.

Keywords: HMOs, PPOs

150. Christianson, J. B., & Osher, F. C. (1994). Health maintenance organizations, health care reform, and persons with serious mental illness. *Hospital and Community Psychiatry, 45*(9), 898–905.

Under the Clinton Administration's 1994 Health Security Act, Medicaid-eligible individuals who did not receive cash assistance would be represented by regional alliances that would contract with health plans. Because this population has a relatively high incidence of serious mental illness and HMOs would be the lowest cost alternative, it seemed the Health Security Act could result in an increase of HMO enrollment for the seriously mentally ill. In this paper, the authors examine studies of the mental health status and outcomes of seriously mentally ill individuals treated by HMOs, focusing on the limitations in the available research for predicting the likely effects of health care reform. They also describe the specific components of the Health Security Act that would influence individuals with serious mental illness who were treated within an HMO. In order to gain a more complete understanding of the impact of health care reform on mental health care for individuals with serious mental illness, the authors argue for additional research in the areas of current service capacity of HMOs, treatment approaches and outcomes in different HMO models, whether seriously mentally ill individuals would choose to enroll in an HMO, and whether HMO enrollees with higher incomes would seek care outside the networks.

Keywords: HMOs, outcomes, serious mental illness

151. Christianson, J. B., Wholey, D., & Peterson, M. S. (1997). Strategies for managing service delivery in HMOs: An application to mental health care. *Medical Care Research and Review, 54*(2), 200–222.

In this article, the researchers examine the problems facing HMO managers as they develop strategies that combine financial incentives for providers with other mechanisms to influence service delivery. Through two empirical analyses, they identify strategies used by HMOs in managing service delivery, as well as explain the relationship of HMO strategies with market characteristics. In the first part of the analysis, the authors highlight market strategies including payment methods, supervision of service delivery, limitations in coverage, and restrictions on access. The authors conclude that HMOs do not rely on one mechanism to manage care, but instead choose clusters of tactics that form one set of organizational strategies. From the second part of the analysis, the authors find that strategies used by HMOs to manage mental health care are related to the interaction of HMO-type and various market characteristics, including competition and utilization of care.

Keywords: HMOs, overviews

152. DeLeon, P. H, Bulatao, E. Q., & VandenBos, G. R. (1994). Federal government initiatives in managed health care. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 97–112). Springfield, IL: Charles C. Thomas.

See DeLeon, VandenBos, and Bulatao, 1991 (reference number 154) for annotation.

153. DeLeon, P. H., & VandenBos, G. R. (1991). Psychotherapy in managed health care: Integrating federal policy with clinical practice. In C. S. Austad & W. H. Berman (Eds.), *Psychotherapy in managed health care: The optimal use of time and resources* (1st ed., pp. 251–263). Washington, DC: American Psychological Association.

This chapter is a version of the article “Managed mental health care: A history of the federal policy initiative” by Patrick H. DeLeon, Gary VandenBos, and Elizabeth Q. Bulatao, which was published in 1991. The section on clinical practice in HMOs is expanded in this chapter. See DeLeon, VandenBos, and Bulatao, 1991 (reference number 154) for the annotation.

154. DeLeon, P. H., VandenBos, G. R., & Bulatao, E. Q. (1991). Managed mental health care: A history of the federal policy initiative. *Professional Psychology Research and Practice*, 22, 15–25.

This article traces the history of HMOs, focusing on key Federal legislative efforts to promote and shape HMOs. The HMO Act of 1973 provided funding for the development of new HMOs, and subsequent amendments of the Act addressed the need to ensure quality and to help HMOs be competitive in the marketplace. The article also describes the CHAMPUS Reform Initiative of 1986, in which the Department of Defense successfully reduced its mental health costs. Studies of the trends in HMOs are reviewed, such as the growth of for-profit HMOs, and the shift from local to multistate HMO networks. The authors discuss the provision of mental health in HMOs and the concerns of psychologists such as limits on number of sessions, poor utilization review, and lack of educational efforts to help members use the system. They also review several major studies demonstrating that mental health care in HMOs is equally or more effective than mental health care in other settings, and may help reduce medical costs.

Keywords: HMOs, overviews

155. DeLeon, P. H., VandenBos, G. R., & Bulatao, E. Q. (1994). Managed mental health care: A history of the federal policy initiative. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 19–40). Washington, DC: American Psychological Association.

See DeLeon, VandenBos, and Bulatao, 1991 (reference number 154) for annotation.

156. Dial, T. H., Bergsten, C., Kantor, A., Buck, J. A., & Chalk, M. E. (1996). Behavioral health care in HMOs. In R. W. Manderscheid & M. A. Sonnenschein, (Eds.), *Mental Health, United States, 1996* (pp. 45–57). Rockville, MD: Center for Mental Health Services.

This chapter describes the delivery system of HMOs and specifically explores two topics related to HMOs' provision of behavioral health care. The first concerns clinical staffing levels of physicians and nonphysician mental health providers in HMOs. The authors report on a study conducted by the Group Health Association of America on clinical staffing ratios in a representative sample of staff- and group-model HMOs, and present data on the ratio of full-time-equivalent (FTE) psychiatrists per 100,000 HMO members, of FTE nonphysician mental health providers per 100,000 HMO members, and of nonphysician mental health providers to psychiatrists in those HMOs. In the second part of the chapter, the authors provide information on HMO benefits for mental health care and on the utilization of such services for 1989 and 1993.

Keywords: HMOs, staffing, trends

157. Dorwart, R. A., & Epstein, S. S. (1992). Economics and managed mental health care: The HMO as a crucible for cost-effective care. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 11–27). Washington, DC: American Psychiatric Press.

This chapter provides an overview of the economics of mental health care with special attention to the dynamics of the HMO model of service provision. The authors describe several economic concepts, distinguish between need and demand for medical services, and discuss the more recent methods to control supply of services. They discuss several major trends in mental health care such as deinstitutionalization and community mental health care, privatization and growth of private psychiatric hospitals, and investor-owned companies. The authors argue for more and better studies of HMO psychiatry that include measures of quality of care in order to assess whether HMO psychiatry is a healthy trend that will improve services, or an unhealthy one that reduces utilization rates but has little beneficial impact on clients' well-being.

Keywords: economics, HMOs, trends

158. Durham, M. L. (1995). Commentary: Can HMOs manage the mental health benefit? *Health Affairs*, 14(3), 116–123.

This author raises concerns about the impact of managed care on the treatment of mental illness based on the following factors: these services present a high degree of financial risk to HMOs, more responsibility is shifted to primary care providers (PCPs) to diagnose and treat mental illness in HMOs, and there is evidence that PCPs in HMOs are less likely to detect mental illness in their patients. The author goes on to discuss lessons that have been learned thus far in the shift to managed mental health care. Managed care's potential for population-based management is described as a potential advantage for effective screening for conditions and planning of staffing levels, treatment resources, etc. With regard to financing, the author sees systems that link payment to outcomes data as being advantageous, while raising concerns about financial barriers created by HMOs. As HMOs take in more and more members of high-risk populations, the author argues that the system will need to adapt itself to one that can provide the specialized services needed by these individuals.

Keyword: HMOs

159. Fink, P. J., & Dubin, W. R. (1991). No free lunch: Limitations on psychiatric care in HMOs. *Hospital and Community Psychiatry*, 42, 363–365.

This article is a case study of the experiences of a private psychiatric hospital that subcontracted with a psychology group for hospital care for HMO patients. Severe problems arose as the number of admissions to the hospital from contracted outpatient therapists was twice as much as the number of admissions that was expected. This unexpected number of admissions was in part due to the lack of a hospital-based evaluation unit for triage, expectations by patients and their families that their HMO benefits guaranteed 30 days of hospital care, and the inability of the hospital to exert control over referrals from the community-based therapists. These factors contributed to a breakdown in communications between the hospital and HMO. The article describes the authors' understanding of the pitfalls of capitation arrangements for psychiatric hospitals and for beneficiaries with severe mental illness.

Keywords: capitation, HMOs, serious mental illness

160. Goldman, W. (1988). Mental health and substance abuse services in HMOs. *Administration in Mental Health*, 15, 189–200.

This article collates and presents current information about how mental health and substance abuse care is being designed and provided in HMOs. The author provides an overview of HMOs including type of benefits generally offered, locus of care, staff and staff mix, treatment type, patterns of utilization, and cost. The chapter concludes that HMOs have the potential for providing high-quality and comprehensive mental health and substance abuse services that are also cost-effective.

Keywords: HMOs, overviews, substance abuse

161. Hodgkin, D., Horgan, C. M., & Garnick, D. W. (1997). Make or buy: HMOs' contracting arrangements for mental health care. *Administration and Policy in Mental Health, 24*(4), 359–376.

This article explores HMO contracts with external vendors for mental health care versus an internal mental health care department. The first part of the article covers the content of external contracts and the current reasons for external contracting of mental health services. Then the authors develop factors that will influence the HMO's decisions about internal or external mental health care. The factors, which are based on economic theory, include operating costs, administration costs, monitoring costs, the shift of risk onto vendors, how contracting choices affect value to purchaser, and competitive pressure from emerging managed behavioral health firms. Lastly, factors are used to create a new hypothesis and evidence to explain HMO contracting choices and their implications in cost and quality of care.

Keywords: carve-outs, contracting, HMOs, integration

162. Hornbrook, M. C. (1988). Mental health services in HMOs: An oxymoron? *Administration in Mental Health, 15*, 236–245.

The author describes the significant difference in the level of HMO coverage of alcoholism, drug abuse, and mental illness (ADM) and medical care. He argues that the “medical-mental schism” may prevent development of integrated biopsychosocial treatments; thus HMOs may be more like fee-for-service arrangements. The author identifies four approaches to rationing ADM services including omitting coverage of mental illness; pricing copayments so as to discourage use; using queues to encourage drop-outs; and using professional criteria ration services on the basis of expected therapeutic benefit. He concludes that HMOs should work toward the goal of parity in coverage of mental and medical conditions, and argues that the costs of this relative expansion can be met through the offset effect and increases in charges for medical services.

Keyword: HMOs

163. Hyde, P. (1996). Creating incentives for the delivery of services. *New Directions for Mental Health Services, 27*, 25–33.

This article discusses four measures that are being explored to provide incentives to HMOs to take responsibility for providing care to populations with the most difficult and costly disorders: adults with serious and persistent mental illness, children and adolescents who are seriously emotionally disturbed, and addicted individuals. These measures are eligibility standards, structural approaches to system organization, financial incentives, and advocacy. The authors discuss a number of techniques for implementing eligibility standards and several different approaches to system organization that provide positive incentives to care for these high-need individuals. The authors go on to provide examples of eight financial arrangements which, when used in combination with eligibility standards and structural approaches, can encourage providers to provide services to those most in need. Lastly, mechanisms must be in place that allow consumers and their families to advocate for appropriate and adequate

services, such as representation on governing boards and advisory groups, education, and grievance and appeal processes.

Keywords: economics, HMOs, serious mental illness

164. Johnson, R. E., & McFarland, B. H. (1994). Treated prevalence rates of severe mental illness among HMO members. *Hospital and Community Psychiatry, 45*(9), 919–924.

The debate concerning the ability of HMOs to adequately provide for mental health services for individuals with severe and chronic mental illness exists throughout the health care system. Are HMOs skimming off healthy individuals for membership and excluding those with chronic conditions like serious mental illness (SMI)? In this study, the researchers examine the treated prevalence rates of two serious mental illnesses—schizophrenia and bipolar disorder—among members of a large, group practice HMO and compare these rates with national rates from the Epidemiologic Catchment Area (ECA) survey. Results indicate that there is a significantly lower treated prevalence rate of schizophrenia among HMO members than in the ECA survey. The treated prevalence rate of bipolar disorder is also lower among HMO members, but the difference is not significant. The researchers conclude that the differences in treatment prevalence rates result from both different study methodologies and different factors influencing HMO membership. They argue for additional research of the course of SMI among HMO members.

Keywords: HMOs, serious mental illness

165. Langman-Dorwart, N., & Peebles, T. (1988). A comprehensive approach to managed care for mental health. *Administration in Mental Health, 15*, 226–235.

This paper discusses the key components of a comprehensive mental health management approach. The authors argue that maintaining quality of care while containing costs is a challenge; however, it is one that can be met with a comprehensive approach that includes these three components: prescreening of admissions; maintaining a network of preferred provider contracts; and concurrent utilization review and individual case management. The article uses a case study approach to describe the ways in which one group network model HMO improved access for clients, maintained consistent criteria of care, reduced costs, and improved treatment outcomes. The HMO created a separate mental health and substance abuse department, which established a preferred provider network and offered case management to patients in contracted facilities. They report that savings to the plan for the first year of operation was approximately \$300,000 in saved admissions alone.

Keywords: case management, HMOs, PPOs, utilization management

166. Lazarus, A. (1994). Disputes over payment for hospitalization under mental health “carve-out” programs. *Hospital and Community Psychiatry*, 45, 115–116.

Five cases are employed to demonstrate the potential problems with the carve-out approach to mental health care. In three of these cases, a patient was admitted to a general hospital for medical problems. Psychiatric problems either were present at hospitalization or developed subsequently while the patient was still in the hospital. In each of these cases, the HMO felt that the managed mental health care company was responsible for some or all of the cost of treatment, arguing that the patient’s condition did not warrant acute medical attention. The author concludes that these vignettes demonstrate the downside of carve-outs, that HMOs and their managed care vendors must strive to overcome the barriers to integration, and that more empiric research is needed to determine the nature and frequency of such problems and mechanisms for resolving these disputes.

Keywords: carve-outs, HMOs, managed behavioral health care organizations

167. Levin, B. L., & Glasser, J. H. (1992). Comparing mental health benefits, utilization patterns, and costs. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 29–52). Washington, DC: American Psychiatric Press.

The authors report recent findings from a national study that examined the organizational structure, benefits coverage, costs, and utilization of mental health services within HMOs. This study examined levels of participation by HMOs in providing mental health benefits, reviewed the kinds of organizational models used by HMOs that provide mental health services, and identified factors associated with the level of coverage, costs, and utilization of these services. Out of 424, 324 HMO administrators responded to a 36-question mail questionnaire that asked about HMO characteristics, mental health service coverage and benefits, organizational structure, costs, and utilization of services. The authors found that while most HMOs provide a minimum level of mental health coverage, the fiscal, organizational, and service delivery arrangements for providing coverage reflect a great deal of diversity among organizations.

Keywords: costs, HMOs, utilization

168. Marshall, P. E. (1992). The mental health HMO: Capitation funding for the chronically mentally ill. Why an HMO? *Community Mental Health Journal*, 28, 111–120.

This article describes an HMO capitation project for chronically mentally ill persons currently being tested in Monroe and Livingston Counties in New York State. The author reports that the project can remain financially solvent because the projected expenses are based on known costs of services needed by seriously mentally ill patients, with the capitation rate based on a “sickest person” scenario rather than insurance industry actuarial data. This approach uses both case management in addition to a financial system with funding that follows patients into

the community. The project has shown to improve patient functioning and reduce the cost of community care for chronically mentally ill persons.

Keywords: capitation, HMOs, New York, public sector, serious mental illness

169. McFarland, B. H. (1994). Health maintenance organizations and persons with severe mental illness. *Community Mental Health Journal*, 30(3), 221–242.

In an era of health care reform, one of the only apparent certainties is the continuation of the rapid growth of HMOs. Although HMOs currently focus on treatment for physical health services, the mental health industry is facing the same rapid increase in costs. This paper examines the impact that HMOs could have on the mental health industry and, in particular, how HMO penetration could affect treatment for the seriously mentally ill (SMI) population. The author reviews the basic components of an HMO, the current structure for provision of mental health services, and the results of studies concerning the impact of capitated rates on mental health care for SMI. He concludes that while integrating mental health services for persons with serious and persistent mental disorders can be challenging to an HMO, it is possible if the public and private components are well coordinated and adequately funded. He argues for further research concerning the level of consumption of care by the SMI when enrolled in HMOs, the likelihood of HMOs “dumping” the SMI population into the public stream, and the method for developing capitated rates for such treatment.

Keywords: capitation, HMOs, serious mental illness

170. McFarland, B. H., Johnson, R. E., & Hornbrook, M. C. (1996). Enrollment duration, service use, and costs of care for severely mentally ill members of a health maintenance organization. *Archives of General Psychiatry*, 53, 938–944.

This study attempts to address increasing concerns about the adequacy of capitated health plans in providing services to the seriously mentally ill (SMI). The researchers compare HMO enrollment duration, private and public service utilization, and HMO costs of care for a target group of 250 adults enrolled in Kaiser Permanente in 1986 or 1987 with control HMO members with and without diabetes mellitus over a 4-year follow-up period. The results suggest that SMI individuals within an HMO have longer enrollment duration than controls without diabetes mellitus and only slightly shorter duration than members with diabetes mellitus. Additionally, those SMI individuals with longer enrollment durations utilize community mental health service at a greater level without leading to higher HMO costs of care. The researchers find no evidence of early termination of HMO members because of chronic and severe mental illness.

Keywords: capitation, costs, HMOs, serious mental illness

171. Norquist, G. S., & Wells, K. B. (1991). How do HMOs reduce outpatient mental health care costs? *American Journal of Psychiatry*, *148*, 96–101.

Previous studies have demonstrated that HMOs reduce expenditures for mental health services. It has been hypothesized that HMOs may achieve these savings by excluding individuals with psychiatric disorders. To test this hypothesis, this study examines differences in the prevalence of psychiatric disorders and the use of outpatient mental health services for adults enrolled in HMOs and fee-for-service plans. The data used are from the National Institute of Mental Health Epidemiological Catchment Area survey (or study). The study found that there are no significant differences between the HMO clients and those in private groups in prevalence or use of services and that the most likely explanation for lower mental health costs in HMOs is a less intensive style of care for a comparable population.

Keywords: HMOs, utilization

172. Rosenberg, S. (1996). Health maintenance organization penetration and general hospital psychiatric services: Expenditure and utilization trends. *Professional Psychology*, *27*(4), 345–348.

This study examines the relationship between mental health and substance abuse treatment utilization and HMO penetration on a State-by-State level, as well as the relationship between expenditures for inpatient and outpatient psychiatric services provided through general hospitals. Findings suggest considerable variability in HMO penetration across the United States between 1983 and 1990, with high levels of HMO penetration associated with lower rates of expenditure growth. Outpatient use for general hospitals increased substantially for States with high HMO penetration but decreased for States with low HMO penetration. Such findings imply that HMOs encourage outpatient alternatives to inpatient treatment while at the same time restraining the growth of general hospital expenditures.

Keywords: costs, HMOs, substance abuse, trends, utilization

173. Scheffler, R., Grogan, C., Cuffel, B., & Penner, S. (1993). A specialized mental health plan for persons with severe mental illness under managed competition. *Hospital and Community Psychiatry*, *44*, 937–942.

The authors summarize the major characteristics of managed competition proposals and recommend the development of special mental health maintenance organizations (MHMOs) to serve only persons with severe mental illness. In this model, the MHMO would provide case management in the community and a fixed point of responsibility for clinical care of these patients. Two methods of reimbursement are proposed as are specific plan characteristics that should be part of MHMOs. The authors also discuss possible systematic reforms that would be necessary to facilitate the integration of MHMOs into a managed health care system.

Keywords: HMOs, serious mental illness

174. Schneider-Braus, K. (1992). Managing a mental health department in a staff model HMO. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 125–141). Washington, DC: American Psychiatric Press.

In this chapter, the author discusses the philosophical and practical issues relevant to the management of a staff model mental health department. In particular, she addresses importance of purpose and mission, role of the director, designing a spectrum of services, staffing patterns, utilization and gatekeeping, centralization versus decentralization, medical records, and patient service. The author concludes that mental health professionals should educate themselves in these areas so they can have an impact on providing cost-effective, high-quality mental health services.

Keywords: HMOs, overviews

175. Shadle, M., & Christianson, J. B. (1988). The organization of mental health care delivery in HMOs. *Administration in Mental Health, 15*, 201–225.

This article presents an overview of the status of the HMO industry and focuses on how HMOs structure and deliver mental health care. The authors describe a nationwide study in which directors of 286 HMOs (representing staff, group, network, and Independent Physicians Association [IPA] models) were surveyed. The study found that mental health services were delivered internally by 70 percent of the HMOs. Over half of the HMOs had designated coordinators of mental health services other than the medical director, and the presence of a designated mental health coordinator was significantly related to the age, size, and model type. Older and larger not-for-profit HMOs were most likely to have designated directors. The study also reported on types of providers used, the percentage of time different types of providers spent in service delivery, and staffing ratios for various categories of providers. Finally, the study reports on use of external alcoholism, drug abuse, and mental illness providers by HMO type, referral patterns, and access to services. The article concludes with a comparison of IPAs with other types of HMO models.

Keywords: HMOs, overviews

176. Shadle, M., & Christianson, J. B. (1989). The impact of HMO development on mental health and chemical dependency services. *Hospital and Community Psychiatry, 40*, 1145–1151.

In this article the authors examine the ways in which the five major HMOs in the Minnesota–St. Paul area have reduced their members' use of inpatient mental health and chemical dependency services. They are particularly interested in the impact of these HMOs on the way that other providers in the community organize and deliver services. Data were collected through structured interviews with 19 HMO representatives and individuals associated with

government, community-based organizations, and provider groups. The authors also analyzed data provided by the HMOs to the State of Minnesota and hospital utilization data.

Keywords: HMOs, utilization

177. Simon, G. E., Grothaus, L., Durham, M. L., VonKorff, M., & Pabiniak, C. (1996). Impact of visit copayments on outpatient mental health utilization by members of a health maintenance organization. *American Journal of Psychiatry*, 153(3), 331–338.

With the need for mental health services exceeding available resources at a time when pressures for cost containment are high, many researchers are attempting to identify a way to decrease costs without preventing the most needy people from accessing care. Several mechanisms for limiting outpatient mental health services exist, including cost-sharing, restrictions on the number of visits, restrictions by diagnosis, and restrictions by type of treatment. In this study, the authors examine the effect of two stepwise increases in visit copayments on outpatient mental health utilization within an HMO. From their results, they conclude that implementing copayments significantly reduces initial access to mental health services and has a smaller impact on treatment intensity. Cost-sharing restricts access to care regardless of the level of clinical need.

Keywords: economics, HMOs, utilization

178. Stelovich, S. (1996). Evolution of services for the chronically mentally ill in a managed care setting: A case study. *Managed Care Quarterly*, 4(3), 78–84.

The author uses the experience of Harvard Pilgrim Health Care, a Boston HMO, to illustrate key factors in the evolution of mental health and substance abuse care in HMOs and managed care environments. These factors include the development of a broad spectrum of services, the use of algorithms to guide patient treatment decisions, and the implementation of outcome measurement. The author also discusses other factors, less directly related to clinical practice, which have had a significant impact on program development: dollars allocated to mental health services, the influence of different service delivery models, and the use of diverse payment models.

Keywords: HMOs, overviews, serious mental illness

179. Stoil, M. J., & Hill, G. A. (1998). Survey results on behavioral health promotion in managed primary health care. *Journal of Public Health Management Practice*, 4(1), 101–109.

This article reports on a 1995–1996 survey of HMOs that gathered information about the nature of their health promotion services related to lifestyle and behavioral health. Using the survey results, the authors describe eight distinct models for the delivery of preventive services. The distinguishing features of the models are based on how services are provided: for example, whether they are directly purchased by the buyer from the HMO, provided by in-network primary care providers versus through a subcontractor, provided by way of

referral to an external source, provided through long-term community investment, or provided by way of philanthropic commitment of either the managed care provider or its contractors.

Keywords: HMOs, models, prevention

180. Unutzer, J., Simon, G., Pabiniak, C., Bond, K., & Katon, W. (1998). The treated prevalence of bipolar disorder in a large staff-model HMO. *Psychiatric Services, 49*(8), 1072–1078.

This article examines the treated prevalence of bipolar disorder in a large staff-model HMO in western Washington State. The HMO's patient database was used to determine the number and identity of patients treated for bipolar disorder. The patient records showed a somewhat higher treatment prevalence for women, younger enrollees, and enrollees in the State's Basic Health Plan program for low-income residents. Of the patients treated for bipolar disorder, only a small percentage received treatment with an antidepressant, antipsychotic, or a benzodiazepine without having a mood stabilizer prescribed. Overall, this study finds the treated-prevalence rate found in this HMO population to be somewhat higher than previously reported rates for prepaid health plans.

Keywords: HMOs, serious mental illness

181. Wainstock, E. J. (1993). How HMOs can effectively manage mental health services in the 1990s. *Administration and Policy in Mental Health, 21*, 15–26.

This article describes the ways in which HMOs have responded to increased demand for cost-effective and quality mental health and chemical dependency (MH/CD) services. The author argues that HMOs should not contract or carve out mental health service to managed mental health care companies but should restructure internally to provide these services. In this way, HMOs can ensure comprehensive, integrated, and continuous services to their clients. The author suggests how and why HMOs should restructure. Some goals of restructuring include the establishment of a separate MH/CD department or unit, redesign of the benefit plan to allow for flexible benefits, the use of case management and improved access to services through decreased waiting times, 24-hour/7-day-a-week telephone service, and maintenance of a multidisciplinary staff.

Keywords: HMOs, integration

182. Wholey, D., Christianson, J., & Peterson, M. (1996). Organization of mental health care in HMOs. *Administration and Policy in Mental Health, 23*(4), 307–328.

The internal organization of an HMO can greatly affect the integration of service delivery. This article examines the relationship between the structure of an HMO's delivery system and the way in which it provides for mental health services. On the basis of a survey of 405 HMOs in 1990, the authors conclude that certain variables internal to an HMO's structure significantly impact that HMO's level of integration of mental health services. In particular,

group-based HMOs are more likely than Independent Physicians Associations to contract for mental health care provision, and both are more likely to contract as overall enrollment increases. Competition within a market area also influences the likelihood that an HMO will contract for mental health services, with HMOs in a more competitive market being more likely to contract than those in a less competitive market.

Keywords: carve-outs, HMOs

IX. Law and Ethics

183. Appelbaum, P. S. (1993). Legal liability and managed care. *American Psychologist, 48*, 251–257.

Clinicians and managed care companies will incur new legal duties as a result of their activities in a managed care environment. This article discusses potential legal responsibilities of clinicians. These include the duty to appeal adverse decisions of a managed care company; to discuss the potential economic consequences of treatment decisions; and to continue treatment without payment or at a reduced rate. The article describes several legal cases involving managed care. The author concludes that clinicians may be reassured by the tendency of courts to recognize the legal responsibilities of both clinicians and care reviewers for their activities in managed mental health care.

Keyword: liability

184. Becker, J., Tiano, L., & Marshall, S. (1992). Legal issues in managed mental health. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 159–184). Washington, DC: American Psychiatric Press.

This chapter discusses some of the legal and ethical issues that arise in connection with managed mental health care programs (MMHPs). The authors confine the scope of the chapter to five major issues: State laws relating to managed mental health organizations; confidentiality issues; risk management; selection of providers; and the impact of rules relating to affiliated service groups. The chapter uses legal cases to demonstrate the areas in which a managed care organization may be held liable and makes some suggestions regarding ways that MMHPs can be structured and operated to maximize compliance with State laws.

Keywords: ethics, liability

185. Blum, S. R. (1992). Ethical issues in managed mental health. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 245–266). Springfield, IL: Charles C. Thomas.

The author argues that the crux of the ethical debate in managed mental health care is the perceived trade-off between the goals of cost containment through management versus quality of care. This chapter uses the discipline of applied health care ethics to examine the implications of managed care for both provider as well as consumer on issues such as patient and provider autonomy, informed consent, and the “double agent” problem (the divided loyalty clinicians feel to both patient and care manager/payor). He concludes that the success of

managed mental health must be judged both on its quality and cost-effectiveness as well as on the extent to which the ethical issues are addressed and resolved satisfactorily.

Keyword: ethics

186. Boyle, P. J., & Callahan, D. (1995). Managed care in mental health: The ethical issues. *Health Affairs*, 14(3), 7–22.

This article examines the ethical issues involved with managed care penetration in the mental health care market. The authors discuss the ethical arguments behind six of the major criticisms of managed care. These criticisms concern managed care's supposed adverse effects on quality, limitations on access, a loss of the provider/patient relationship, insufficient promotion of informed patient choice, heightened secrecy of policy and benefit design, and the transfer of decision-making responsibility from physicians to managers under utilization review processes. The report concludes that, from an ethical viewpoint, the problems that confront managed mental health care diverge very little from those of managed care. The authors contend that ultimately the managed mental health care system, if it continues to attempt to curb abuses and rectify ethical problems, should prove superior on the whole to fee-for-service medicine.

Keyword: ethics

187. Dörken, H., & Pallak, M. S. (1994). Using law, research, professional training, and multi-disciplinary collaboration to optimize managed care. *Managed Care Quarterly*, 2(2), 53–59.

Poor collaboration among health professionals leads to negative outcomes for patients. In this article, the authors outline the potential for revisions of law, application of research, professional collaboration, and focused training to maximize collaboration between mental health care professionals and the effectiveness of managed care. They argue that when a multidisciplinary perspective is brought to bear on a situation requiring mental health care, the strengths of these resources far outweigh those of any single professional approach to the same situation.

Keyword: providers

188. Elpers, J. R., & Abbott, B. K. (1992). Public policy, ethical issues, and mental health administration. *Administration and Policy in Mental Health*, 19, 437–447.

Today's mental health clinician-administrators in both the public and private sector face a number of ethical dilemmas. The authors describe a variety of conflicts and issues, such as patient rights, resource allocation, and problems posed by privatization and managed care. They suggest that a professional organization develop ethical guidelines to assist administrators in monitoring and making difficult choices.

Keyword: ethics

189. Geraty, R. D., Hendren, R. L., & Flaa, C. J. (1992). Ethical perspectives on managed care as it relates to child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 398–401.

The increased influence of managed care on the way child and adolescent psychiatry is practiced has created new ethical and legal dilemmas for the clinician and administrator. This article reviews the history of managed care and medical ethics and discusses the role of social values in medical decision making. Salient ethical issues are discussed, as are current legal decisions addressing clinician responsibility within a managed care system. The authors recommend that child and adolescent psychiatrists anticipate ethical dilemmas before they occur and work with hospital administrators to develop guidelines that address contradictory fiscal and clinical decisions.

Keywords: children, ethics, overviews

190. Hall, R. C. W. (1994). Legal precedents affecting managed care: The physician's responsibilities to patients. *Psychosomatics, 35*, 105–117.

This article reviews some of the most significant legal cases related to managed care and physician responsibility for patient care. The author focuses on the implications of these cases for how psychiatrists should practice in a managed care environment. Suggestions are made for how physicians might manage care when they feel they are caught in an ethical dilemma by managed care companies or their third-party reviewers.

Keywords: ethics, liability

191. Higuchi, S. A. (1994). Recent managed-care legislative and legal issues. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 83–118). Washington, DC: American Psychological Association.

This article is an extension of Newman and Bricklin's review (Chapter 4; reference numbers 193 and 194) of legal issues relevant to managed mental health care. The author describes in detail the content of State statutes regarding utilization review, preferred provider organizations, and HMOs. Recent court cases are discussed in light of expanding liability for managed care systems and providers. The author discusses typical legal dilemmas faced by psychologists, particularly those involving utilization review and access to mental health care services. The chapter concludes with a number of legal strategies that can be used by practitioners who are experiencing problems in managed care systems.

Keywords: liability, overviews

192. Lazarus, J., & Pollack, D. (1997). Ethical aspects of public sector managed care. In K. Minkoff & D. Pollack (Eds.), *Managed mental health care in the public sector: A survival manual*. Amsterdam: Harwood Academic Publishers.

When the public sector enters into managed care arrangements for the provision of services, certain ethical dilemmas can arise. This article discusses the roles of the following ethical concerns in public sector managed care (PSMC) systems: confidentiality, informed consent, full disclosure, double-agentry and conflicts of interest, honesty, financial incentives and disincentives, outcomes, interference in the clinical relationship, relationships among mental health professionals, consumers as providers, telemedicine, formulary restrictions, leverage, inadequate experience of PSMC systems, and organizational issues. In addition to discussing ethical concerns that may arise, this article also suggests ways to maintain ethically sound practices.

Keywords: ethics, public sector

193. Newman, R., & Bricklin, P. M. (1991). Parameters of managed mental health care: Legal, ethical, and professional guidelines. *Professional Psychology Research and Practice*, 22, 26–35.

The authors express concern about the potentially adverse consequences of cost containment on quality of care in managed care settings. They argue that managed care legislation has failed to establish parameters for ensuring the quality of mental health services. More effective laws and regulations are needed to ensure that cost-containment efforts do not compromise quality mental health care. State statutes and regulations to ensure quality are outlined, such as those aimed at licensing and prohibiting false advertising. Also described are recent lawsuits to hold managed care companies accountable for the care they provide. The authors discuss the major legal, ethical, and professional parameters available to guide clinicians and managed care companies. Finally, they propose methods of ensuring that a focus on providing quality care is not compromised by strategies for cost containment.

Keywords: liability, overviews

194. Newman, R., & Bricklin, P. M. (1994). Parameters of managed mental health care: Legal, ethical, and professional guidelines. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 63–82). Washington, DC: American Psychological Association.

See Newman and Bricklin, 1991 (reference number 193) for annotation.

195. Olsen, D. P. (1994). The ethical considerations of managed care in mental health treatment. *Journal of Psychosocial Nursing*, 32(3), 25–28.

This article, written from a nursing perspective, addresses ethical issues in managed mental health care. The author suggests that the three areas most significantly impacted by managed care are restrictions on patient autonomy of choice of treatment and treatment site; relationship between the nurse as a managed care agent and the patient; and patient responsibility in

treatment decisions made through managed care with concomitant denial or alteration of access to treatment based on compliance. The author argues that while managed care is neither inherently good nor bad, the medical profession must examine managed care in light of these potential ethical dilemmas.

Keyword: ethics

196. Olsen, D. P. (1995). Ethical cautions in the use of outcomes for resource allocation in the managed care environment of mental health. *Archives of Psychiatric Nursing*, 9(4), 173–178.

With the rise in competitive contracting for health care resources, outcome data is becoming a common deciding factor in the allocation of contracts and financial rewards. In this article, the author discusses the ethical concern about using outcome data in the field of mental health. In particular, the paper focuses on the ethical concerns with six specific types of outcome measurements: utilization data, patient reports, clinician reports, objective measures of diagnostic entities, objective measures of functioning, and multifactor research. The author suggests guidelines for addressing ethical concerns and presents the difficulty in defining good outcomes.

Keywords: ethics, outcomes, performance measurement

197. Packer, I. K. (1998). Privatized managed care and forensic mental health services. *Journal of the American Academy of Psychiatry and the Law*, 26(1), 123–129.

This article describes the introduction of managed care for mental health services into the public sector, and the special challenges unique to serving the forensic population, such as pretrial evaluation services, pretrial treatment services, and post-adjudication services. Throughout the report, the author describes examples where States have been managing forensic services and highlights the successes and challenges they have faced in serving this population. According to the author, five primary elements are required for any State to properly monitor the delivery of forensic services by the private sector: a specialized utilization review process, a quality assurance tool, a standard to properly train and assess the performance of professionals, the release of a risk assessment concurrent with the release of forensic patients, and a tool to monitor the prevalence of severely mentally ill forensic patients.

Keywords: public sector

198. Patterson, R. F. (1998). Managed behavioral healthcare in correctional settings. *Journal of American Academic Psychiatry Law*, 26(3), 467–473.

This article focuses on issues of concern in negotiating managed care contracts for the provision of behavioral health care services in correctional settings. The author summarizes the factors that contribute to the complexity of providing services in correctional settings. He discusses key decision points in negotiating behavioral health care services with managed care organizations and argues for the involvement of mental health professionals in these areas.

These key considerations include staffing levels, drug formulary, level of service requirements, and other costs related to health care which, although typically borne by the State, influence the provision of care and should be taken into account during contract negotiations.

Keywords: contracting, public sector

199. Petrila, J. (1995). Who will pay for involuntary civil commitment under capitated managed care? An emerging dilemma. *Psychiatric Services*, 46(10), 1045–1048.

With mental health reimbursement increasingly relying on capitation and managed care principles, there are incentives to limit hospital bed use for the civilly committed. Yet these individuals must often remain hospitalized for even longer periods because of their civil profile and the perceived risk involved in releasing them into general society. In this paper, the author explores this conflict as well as the relationship between civil commitment and cost-shifting in a capitated payment system. The author suggests six strategies for providers dealing with these issues: avoiding negotiations concerning payment questions after evaluation and treatment have begun by including conditions for civil commitment in their contracts; creating services and social supports to reduce the need for commitment; implementing consistent risk assessment standards for all patients; conducting research on the use of civil commitment in managed care settings; ensuring that States with managed Medicaid programs do not create incentives to shift costs through commitment; and engaging in discussions with treatment staff about the dilemma.

Keywords: capitation, involuntary commitment

200. Petrila, J. (1998). Courts as gatekeepers in managed care settings. *Health Affairs*, 17(2), 109–117.

This article describes instances where the judicial system orders behavioral health treatment for offenders and questions the responsibility of managed care providers to pay for services that might not be “medically necessary.” The author examines the often conflicting goals of the courts and the managed care organization (MCO), the plan structure of the MCO, and the enforcement and liability of the MCO that chooses to limit reimbursement of services for court-ordered behavioral health treatment. The author provides solutions reached by different States through legislative means that help to designate financial responsibility, risk, and provision of services between judges acting as “gatekeepers” and the MCO as the payer or provider of services.

Keywords: involuntary commitment

201. Rich, J. P. (1992). Managed mental health: Key legal issues. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 267–290). Springfield, IL: Charles C. Thomas.

This chapter provides an overview of the trends in the managed health care field, concentrating on legal issues affecting managed mental health care. These include significant court cases and

federal and state regulatory actions. The federal and state regulatory environment in which the managed care industry and mental health professionals work is described, as are current legal issues confronting provider-controlled managed care entities. Several managed mental health liability issues are discussed. These include provider credentialing and peer review liability, utilization review decisions, risk sharing and restrictive referrals, refusal to consent to psychotropic drugs, and liability for failing to protect mental health patients or their victims from harm.

Keywords: liability, overviews, trends

202. Simon, N. P. (1994). Practitioner ethics and managed care. *Managed Care Quarterly*, 2(2), 43–45.

Providers of managed mental health services often argue that the profit motive base of managed care companies generates dilemmas for providers that may have serious legal and ethical implications for them. These dilemmas are briefly discussed. The author argues that in the best interests of patients, both managed care companies and care providers should strive for a more cooperative working relationship, open discussion, and resolution of the ethical issues at stake.

Keyword: ethics

203. Stone, A. A. (1999). Managed care, liability, and ERISA. *Forensic Psychiatry*, 22(1), 17–29.

In 1974, Congress passed the federal Employee Retirement Income Security Act (ERISA) to secure health benefits negotiated between management and labor without providing either side an edge over the other. This article provides an overview of the crucial issues that have had an impact on the nature and quality of care that patients receive from physicians, psychiatrists, and other mental health practitioners. These include ERISA's restrictions on health care, identified by examples from specific court cases; liability for suicide; and ERISA restrictions that cause harm to patients in the era of managed care. With ERISA's effects of lowering professional standards of care and protecting insurance carriers from liability, perhaps malpractice liability will become the primary vehicle for mitigating the injustices sparked by this regulation.

Keywords: legislation, liability

204. Substance Abuse and Mental Health Services Administration. (1998). *Ethical issues for behavioral health care practitioners and organizations in a managed care environment: Vol. 5. Managed care technical assistance series*. Rockville, MD: Author.

This monograph of five sections presents discussions and case studies to illustrate a number of core ethical issues in managed behavioral health care. The first section discusses the ethical principles relevant to overall allocation of behavioral health care resources, the second discusses those ethical principles informing the treatment relationship, and the third and fourth sections discuss the impact of managed behavioral health care on these ethical principles. The monograph concludes with a discussion of how behavioral health care individual

providers and organizations might respond to these ethical dilemmas. According to the monograph, ethical issues are especially relevant to the managed care system because it poses particularly difficult ethical issues due to the tension between cost containment and obtaining services for people with mental disorders.

Keywords: ethics, technical assistance

205. Wineburgh, M. (1998). Ethics, managed care, and outpatient psychotherapy. *Clinical Social Work Journal*, 26(4), 433–443.

The author discusses ethical issues that managed care organizations and mental health care providers should consider in the environment of managed mental health care. These include respect for the patient and patient autonomy, informed consent regarding procedures and treatment, confidentiality, issues of divided loyalty among practitioners who also work for managed care organizations, placing a priority on the promise to do no harm to the patient, resisting the impulse to treat all patients with short spans of care, and taking on the duty to appeal the patient's case to the managed care organization where applicable.

Keywords: ethics, providers

X. Provider Issues

206. Armenti, N. P. (1991). The provider network in managed care. *The Behavior Therapist*, 123–128.

This article describes the characteristics of providers who might be most successful in a managed care system. These include having substance abuse training and experience; the ability to provide emergency and crisis intervention; behavioral training; a demonstrated ability to use community resources; and a community mental health or agency background. The author describes some of the varying styles of managed care for providers and suggests that providers also need to be selective when choosing a managed care arrangement to join.

Keyword: providers

207. Austad, C. S., & Berman, W. S. (1991). Managed health care and the evolution of psychotherapy. In C. S. Austad & W. H. Berman (Eds.), *Psychotherapy in managed health care: The optimal use of time and resources* (1st ed., pp. 3–18). Washington, DC: American Psychological Association.

This chapter, written by the book's editors, describes how the changing health care system has impacted the field of psychotherapy. They examine the evolution of short-term therapy, and describe the commonalities in all of the therapies practiced in managed care settings. Psychotherapy as it is practiced in the HMO setting is discussed, as are controversies in and about managed health care.

Keywords: providers, psychotherapy

208. Austad, C. S., Sherman, W. O., Morgan, T., & Holstein, L. (1992). The psychotherapist and the managed care setting. *Professional Psychology Research and Practice*, 23, 329–332.

This study explores the practice patterns and attitudes of 43 mental health professionals working in staff-model HMOs in the Northeast. Participants were asked to respond to semi-structured and open-ended questions about their work setting, burnout, graduate training, and the evolution of their practice style. Therapists were found to “happen” into the HMO setting and to possess little information about HMOs prior to their employment. Participants reported that their work involves a high level of direct client contact, that they use mostly brief therapy methods, and that they use a variety of strategies to prevent burnout. The study also discusses the ways in which psychologists differ from other mental health professionals in their practice styles.

Keywords: providers

209. Backlar, P. (1996). Managed mental health care: Conflicts of interest in the provider/client relationship. *Community Mental Health Journal, 32*(2), 101–106.

This article is a theoretical analysis of the conflicts of interest confronting health care providers with special attention paid to mental health providers and the implicit economic conflicts of interest brought about by managed care. According to the author, there are three primary positions where conflicts of interest arise in health care: when providers promote their clients' interests over all other interests; when providers promote the general social good by acting as rational resource allocators; and when providers promote their own financial well-being at the expense of all other interests. The author argues that conflicts of interest in managed mental health care are distinct from those that arise in traditional health care services because the mentally ill population oftentimes has a limited ability to care for itself or to make informed choices. Therefore, the author sees a potential loss of confidentiality in patient care for people with mentally illness, as well as a potential conflict between the provider's personal financial loyalties and the patient's interests.

Keywords: ethics, providers

210. Baker, N. J., & Giese, A. A. (1992). Reorganization of a private psychiatric unit to promote collaboration with managed care. *Hospital and Community Psychiatry, 43*, 1126–1129.

Over the past five years, an increased number of managed care organizations in the Denver, Colorado, area have challenged psychiatric hospitals to reduce costs and length of stay. This article describes the experience of one private psychiatric hospital unit that reorganized a locked unit into three progressively less restrictive ones through which patients could progress at their own rate. In the first year after reorganization, length of stay and staffing costs were significantly reduced. This article describes these and other impacts of this hospital-based alternative model.

Keywords: models, providers

211. Barnes, P. D. (1991). Managed mental health care: A balancing act. *Administration and Policy in Mental Health, 19*, 51–55.

Managed mental health care is characterized by tensions between countervailing interests, goals, and approaches. In this opinion piece, the author identifies some of the areas in which mental health professionals are working to strike a balance, and the implications of the choices that they make. Managed care companies' desire to use a selected panel of providers must be balanced against consumer freedom of choice; quality control must be balanced against the need to control costs; utilization review must serve providers, consumers, and payors alike; and mental health goals must be balanced with health care goals. After describing these tensions, the author outlines methods to reduce adversarial relationships, arguing that the behavior of managed health care and practitioners will eventually become more similar and collaborative.

Keyword: providers

212. Bennett, M. J. (1992). The managed care setting as a framework for clinical practice. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 203–217). Washington, DC: American Psychiatric Press.

The author describes a treatment model for psychotherapy in a managed setting that was developed with over 20 years of experience in an HMO environment. The treatment model, referred to as focal psychotherapy, consists of five phases that can be characterized along six axes. This treatment model is described, as are the implications of this model for assessment and monitoring client progress. The author argues that this model is responsive to patient needs as well as cost-effective. He asserts that although the focal psychotherapy originated in a closed setting, the model is compatible with a wide variety of clinical settings with similar missions.

Keywords: models, providers, psychotherapy

213. Berkman, A. S., Bassos, C. A., & Post, L. (1988). Managed mental health care and independent practice: A challenge to psychology. *Psychotherapy, 25*, 434–440.

This article addresses ways in which high quality of care can be delivered within a framework that emphasizes cost-containment. The authors outline the key strategies of the Synton Group, a mental health management firm. These strategies include diagnostic consultation; utilization management committee; and use of patient satisfaction surveys. The article describes critical issues that managed care systems should consider: using experienced providers; meeting both clinical and financial goals; establishing effective mechanisms to ensure access to care; and matching patients with providers and treatment. The authors also discuss the various arrangements between managed care firms and providers, and their advantages and disadvantages. Finally, the article reviews questions regarding what constitutes effective mental health treatment, and the role of diagnosis in such treatment.

Keywords: managed behavioral health care organizations, providers

214. Berman, W. H., & Austad, C. S. (1991). Managed mental health care: Current status and future directions. In C. S. Austad & W. H. Berman (Eds.), *Psychotherapy in managed health care: The optimal use of time and resources* (1st ed., pp. 264–278). Washington, DC: American Psychological Association.

This chapter, written by the book's editors, provides an overview of the book. The authors write that the purpose of the book has been to "describe optimal mental health care as it is practiced by clinicians in managed health care systems." The collection of chapters demonstrates the various ways that psychotherapists have adjusted their practices to accommodate changes in financing and organization of the mental health care system. This chapter summarizes some of the innovations in theory, assessment, and treatment and explores current developments in program development, treatment of chronic patients, and training and staff development.

Keyword: providers

215. Bittker, T. E. (1992). The emergence of prepaid psychiatry. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 3–10). Washington, DC: American Psychiatric Press.

This chapter briefly describes the emergence of prepaid psychiatry over the past 25 years, from its beginnings in the HMO movement of the 1960's to its recent forms of managed care. The author argues that physician surpluses and escalating medical care costs have promoted an alliance between government, corporate America, and health insurers that has led to an industrialization of medicine. He describes the impact of this industrialization on mental health professionals and discusses the ways in which changes in the financing and organization of psychiatric services will continue to impact psychiatry in the next century.

Keywords: overviews, providers, trends

216. Carson, D. (1993). Managed care: A provider perspective. *New Directions for Mental Health Services*, 59, 81–87.

This chapter uses the experience of a private psychiatric hospital to describe the impact on both the hospital and its staff of moving towards a managed care model. As in other psychiatric hospitals, managed care led to a shift in focus from inpatient to outpatient care. In addition to the impact on locus of care, there was a concomitant impact on length of treatment, type of treatment, and range of services offered to clients by the hospital. Moreover, managed care had a profound impact on clinicians. A detailed case example describes the initial problems experienced by the hospital and staff, changes in staff attitudes, administrative issues, financial issues, and the vision for the future.

Keyword: providers

217. Dewan, M. (1999). Are psychiatrists cost-effective? An analysis of integrated versus split treatment. *American Journal of Psychiatry*, 156, 324–326.

Recent models of health care have emphasized the need to treat the patient holistically, integrating behavioral health services and physical health services under one managed care organization. Yet within the realm of mental health, many health maintenance organizations (HMOs) favor split treatment between psychiatrists and psychotherapists over integrated care by a single provider because they assume split treatment will be less costly. In this study using 1998 fee schedules from seven large managed care organizations and Medicare, the author models clinical scenarios of psychotherapy alone, medication alone, and the combined treatment provided by a psychiatrist or split with a psychologist or social worker. From the results, short-term psychotherapy alone by a social worker is the least expensive modality. For patients who require more intensive treatment, integrated care is less expensive than split treatment for almost all treatment length scenarios. The author argues for further research to differentiate patients who will respond better to brief psychotherapy alone compared with combined treatment.

Keywords: costs, integration, models, providers, psychotherapy

218. Dial, T. H., Bergsten, C., Haviland, M. G., & Pincus, H. A. (1998). Psychiatrist and nonphysician mental health provider staffing levels in health maintenance organizations. *American Journal of Psychiatry*, *155*, 405–408.

Based on research from the Group Health Association of America (now the American Association of Health Plans) concerning clinical staffing patterns in a sample of staff and group model health maintenance organizations (HMOs), this study examines the ratios of full-time psychiatrists to members and nonphysician mental health professionals to psychiatrists. From the results, the overall mean number of psychiatrists per 100,000 HMO members is 6.8, and there are 4.5 nonphysician mental health professionals on average for every licensed psychiatrist in the plan. Compared to previous estimates of the required psychiatrist-to-population ratios in fee-for-service and managed care environments, the overall number of psychiatrists per 100,000 members is less than half the requirement for a fee-for-service environment estimated in 1980 and about 40–80 percent greater than that for a managed care environment estimated by later studies. The authors argue for the need of adequate projections of the future demand for psychiatrists and suggest potential mechanisms to aid in this analysis.

Keyword: HMOs, providers, staffing

219. Dörken, H. (1994). Managed care intervenes where state regulation fails. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 113–126). Springfield, IL: Charles C. Thomas.

In this chapter the author argues that managed care has brought the issue of clinical standards, quality of care, and accountability to the fore. He discusses the inadequacies of regulatory entities to ensure competency among mental health providers and to maintain reasonable practice standards through peer review. He reviews licensing and other legislation in the state of California to demonstrate the inability of such legislation to regulate professional behavior.

Keywords: California, legislation, providers

220. Dorwart, R. A. (1990). Managed mental health care: Myths and realities in the 1990s. *Hospital and Community Psychiatry*, *41*, 1087–1091.

As managed mental health care is becoming the norm for people who are insured, concerns about the effects of managed care are increasingly being raised by both clients and providers. These concerns have focused around whether managed care really reduces costs, whether it adversely affects the quality of care, and the ways in which it affects access to care. The author calls for more and better research to answer some of these questions and debunk some of the myths about managed health care. This research would ideally lead to better communication between mental health professionals and managed care organizations.

Keyword: providers

221. Feldman, J. L. (1992). The managed care setting and the patient-therapist relationship. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 219–229). Washington, DC: American Psychiatric Press.

This chapter delineates five major aspects of managed care practice that influence the patient-therapist relationship. These are payment, systems issues, regulatory issues, internal management issues, and organizational values. The author discusses each of these issues in a managed care setting. She argues that the overall values and philosophy of an organization will significantly impact the therapeutic relationship. She presents a model of the therapeutic relationship as a “family triad” of patient, therapist, and organization, and asserts that alliances between any two of the parties will impact the quality of the relationship between the patient and the clinician and inevitably affect the outcome of therapy.

Keywords: overviews, providers

222. Feldman, J. L., & Fitzpatrick, R. (Eds.), (1992). *Managed mental health care: Administrative and clinical issues* (1st ed.). Washington, DC: American Psychiatric Press.

This book includes articles about managed mental health care from administrative as well as clinical points of view. The book is divided into three sections: administrative issues (covering the historical, economic, and managerial approaches to managed care); clinical issues (often using a case study approach to discuss treatment approaches developed by the authors); and a special issues section. Two chapters in the clinical issues section focus specifically on managed care services for drug and alcohol abuse. In the final section on “special topics” are articles discussing new delivery system approaches, including one that describes a computer-assisted therapy method for short-term therapy.

Keyword: providers

223. Fowls, D. J. (1994). From managed care to cooperative care. *Managed Care Quarterly*, 2(2), 46–50.

The tensions between managed care companies and providers of care have led to what this author calls “organizational schizophrenia.” This article addresses some of the reasons for the lack of communication and cooperation between many providers of mental health care and the managed care companies they work for. Two case studies are presented in which providers and managed care companies have moved beyond a conflictual relationship to form a collaborative one. The author argues that this can only happen with leadership from both camps and a shared vision of quality and cost-effective care that puts the consumer and provider first.

Keyword: providers

224. Goldstein, L. S. (1989). Genuine managed care in psychiatry. *General Hospital Psychiatry, 11*, 271–277.

In this article, the author describes a genuine managed mental health care system and the role of psychiatrists in such a system. Genuine managed care is defined as a practice pattern that mental health practitioners can use to deliver quality care cost-effectively. Practice pattern is a structure for care, and includes provision of multiple services by a multidisciplinary staff. It is also a process characterized by collaboration, utilization review, and quality assurance. The author concludes by presenting an evaluation study analyzing the use of such a practice pattern by a group practice.

Keyword: providers

225. Goodman, M., Brown, J., & Deitz, P. (1992). *Managing managed care: A mental health practitioner's survival guide*. Washington, DC: American Psychiatric Press.

This book is written specifically for mental health practitioners who may need help understanding their evolving role in a managed mental health care system. It is intended to guide the clinician through the review processes inherent in managed care services and to help them develop appropriate treatment plans. The authors use clinical vignettes to illustrate how to write patient impairment profiles and outcome objectives. In lengthy appendices, they provide specific psychotherapeutic interventions for many common mental disorders.

Keywords: providers, technical assistance

226. Gould, R. L. (1992). Adult development and brief computer-assisted therapy in mental health and managed care. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 347–358). Washington, DC: American Psychiatric Press.

This chapter presents a model of adult development based on Erickson's theory that development, developmental blocks, and repair of previous developmental blocks occur at all ages. This paradigm of adult development lends itself well to short-term therapy, i.e., the goal being to find and resolve the current developmental block that is interfering with healthy functioning. The author proposes the therapeutic learning program, which is a computer-assisted brief therapy program written for patients to work through themselves. The program consists of 10 interactive, sequential computer sessions. The patient also works with a therapist at the end of each session. This chapter describes each of the goals and objectives of the 10 steps, describes the advantages of such a program, and reviews an outcome study of the first 2,000 patients using this method.

Keywords: models, providers, psychotherapy

227. Hoyt, M. F., & Austad, C. S. (1992). Psychotherapy in a staff model health maintenance organization: Providing and assuring quality care in the future. *Psychotherapy, 29*, 119–129.

This article describes “good” therapy in an HMO setting. The essential characteristics of such therapy include crisis intervention; clear definition of patient and therapist roles; flexible and creative use of time; interdisciplinary collaboration; use of multiple treatment models; intermittent rather than long-term care; and utilization review. The authors recommend the use of groups and family systems approaches, as well as growth-oriented rather than cure-oriented approaches. They also review research evidence demonstrating the effectiveness of short-term therapy and outline strategies to ensure that quality of care and accountability are maintained.

Keywords: HMOs, providers, psychotherapy

228. Jellinek, M. S., & Nurcombe, B. (1993). Two wrongs don’t make a right: Managed care, mental health, and the marketplace. *Journal of the American Medical Association, 270*, 1737–1739.

In this commentary, the authors describe the evolution of the mental health delivery system from primarily “unleashed market forces” to “unopposed incentives to cut services.” The authors argue that just as there were few countervailing forces against overutilization and misuse of mental health services in the 1980’s, there is currently little to check systematic profiteering from underutilization of services. They discuss the implications of the decreasing professional autonomy for psychiatrists and suggest what individuals and organizations can do to pursue specific political objectives. The article describes implications for primary care clinicians and why managed care represents both a threat and an opportunity.

Keyword: providers

229. Lane, N. E. (1994). Managed care and providers: You’re in business! In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 65–75). Springfield, IL: Charles C. Thomas.

This chapter explores issues in managed behavioral health care from the perspective of the providers. The author directs her discussion to the mental health provider who may be feeling disillusioned with the changes in the field during the past decade. She describes concrete ways that providers can cope with these changes, such as how to view behavioral health services as a commodity to be bought, sold, marketed, and negotiated. Finally, she suggests ways that providers can approach managed care organizations about participation in their programs, and how to negotiate with these companies.

Keyword: providers

230. Olsen, D. P., Rickles, J., & Travlik, K. (1995). A treatment-team model of managed mental health care. *Psychiatric Services, 46*(3), 252–256.

This article examines the treatment-team model of managed care for mental health patients. This model includes an in-person assessment by a clinician who acts as the managed care agent, immediate accessibility of this clinician, referral services with a broad range of intensity, and participation of the managed care clinician on the treatment team. The advantages of this approach include an increased ability to provide patients with individualized services, and a more organized system of care management. Limitations of the model include difficulty in decision-making due to the presence of team decisions, and the potential for overuse of emergency care by primary care physicians.

Keywords: models, providers

231. Patterson, D. Y., & Sharfstein, S. S. (1992). The future of mental health care. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 335–346). Washington, DC: American Psychiatric Press.

In this chapter, the authors speculate on what the future of mental health care will hold as we move towards the 21st century. They review some of the critical historical turning points in mental health policy and briefly discuss current trends. These include the growing role of employers, perceived inadequacy of HMOs, widespread concern with the rapid rise of mental health and substance abuse costs, and concurrent decline in Federal and State direct oversight for public mental health care. They speculate that managed care will continue to grow in importance, that there will be a clearer definition of private versus public responsibility for health care, a clearer delineation of responsibilities between medical and nonmedical mental health care professionals, growing involvement of employers in health care, and increasing number of training programs to prepare clinicians for the 21st century.

Keywords: providers, trends

232. Resnick, R. J., Bottinelli, R. W., Puder-York, M., Harris, B., & O'Keefe, B. E. (1994). Basic issues in managed mental health services. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 41–62). Washington, DC: American Psychological Association.

The chapter compares and contrasts the four most prevalent managed care systems: health maintenance organizations, preferred provider organizations, employee assistance programs, and competitive medical plans. The authors delineate the ways in which psychologists participate in these systems—as owners, shareholders, independent providers, and employees. Finally, the article examines the various professional relationship and practice issues that affect providers who work in managed care settings. The authors conclude that mental health professionals in today's practice environment need to be aware of the clinical and financial implications of managed care systems so that they participate effectively and influence their design.

Keywords: overviews, providers

233. Richardson, L. M., & Austad, C. S. (1991). Realities of mental health practice in managed-care settings. *Professional Psychology Research and Practice, 22*, 52–59.

This article describes aspects of the managed care system that are of concern to psychologists. Topics discussed include mental health benefits under HMOs, the advantages and disadvantages of employment as staff or contractors, financial considerations in providing services in fee-for-service arenas, prospective payment and capitation plans, and potential barriers to treatment. The authors also review practice issues. Psychologists working in HMOs continue to prefer long-term psychodynamic approaches; however, efforts are underway to help these practitioners develop skills in providing short-term therapy. The authors argue that psychologists in HMOs must address challenges such as reducing inpatient use, providing care for chronically ill and noncompliant clients, and interacting effectively in an interdisciplinary team. The pros and cons of providing service in a managed care system are outlined, as well as criteria clinicians can use in working in such systems.

Keywords: overviews, providers

234. Richardson, L. M., & Austad, C. S. (1994). Realities of mental health practice in managed-care settings. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 151–168). Washington, DC: American Psychological Association.

See Richardson and Austad, 1991 (reference number 233) for annotation.

235. Root, L. S. (1991). Cost controls on mental health services: Context and the role of the professional. *Employee Assistance Quarterly, 7*(2), 1–13.

Cost control is a key concern for employers; employee benefits represent 37.6 percent of U.S. payroll costs. To address rising costs, employers offer health insurance through HMOs and preferred provider organizations that is less expensive than fee-for-service plans. The author describes three cost-containment strategies: exclusions and limits on coverage, managed care carve-outs, and employee assistance programs as case managers, and explains how these strategies are aimed at controlling behavior, use, and price. The author examines the context of cost-control efforts in both mental health and substance abuse services. He argues that mental health practitioners must be proactive and take initiative in creating an approach that manages the care of clients, not simply limits the cost of the care.

Keywords: costs, providers

236. Sabin, J. E. (1991). Clinical skills for the 1990s: Six lessons from HMO practice. *Hospital and Community Psychiatry, 42*, 605–608.

HMO clinical practice currently embodies many of the features that are being required of managed mental health care providers. These include attention to cost containment, identification of outcomes, practice audits and treatment guidelines. This author argues that identifying the skills required for clinical effectiveness and professional satisfaction in the HMO can

be extremely valuable for all clinicians working in a managed care environment. He identifies six crucial skills that can help clinicians become more effective, and uses brief case examples to illustrate how these skills may be useful in managed-care settings.

Keywords: HMOs, providers

237. Sabin, J. E., & Borus, J. F. (1992). Mental health teaching and research in managed care. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 185–199). Washington, DC: American Psychiatric Press.

In this chapter, the authors argue that the accelerating shift from fee-for-service to managed care has created a need for a new set of training skills for clinicians to practice effectively. This chapter delineates six new skills that managed care clinicians should possess. Several examples of teaching programs designed to train mental health practitioners in skills appropriate for practicing in a managed care environment are presented. In a separate section, the benefits and problems of conducting research in HMOs are discussed. The authors conclude that both academic medical centers and HMOs will gain substantially by fostering meaningful collaboration in training and research.

Keywords: providers, training

238. Sargent, S. C. (1992). Contracting and managed care payment options. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 53–67). Washington, DC: American Psychiatric Press.

The author of this chapter argues that mental health providers in the 1990's must be able to design payment options that will work for them rather than respond to potentially inappropriate managed care offers. This chapter offers a template for mental health providers to use when approaching and evaluating managed care opportunities. Six steps for managed care contracting are discussed in detail: preparation, proposal, negotiation, contract, implementation, and evaluation/renewal. The author recommends that a provider have a template such as this one to help assess whether any given managed care plan will meet the needs of patients and their families.

Keywords: contracting, providers, technical assistance

239. Scheffler, R., & Ivey, S. L. (1998). Mental health staffing in managed care organizations: A case study. *Psychiatric Services, 49*, 1303–1308.

Temporal changes in staffing numbers and ratios within health maintenance organizations (HMOs) offer us a valuable tool for estimating the future composition of the health care workforce as the trend toward managed care organizations continues. This article examines such staffing configurations of mental health providers through case studies of two staff-model HMOs. In an effort to address the move of many HMOs to contracting out mental health services to specialized behavioral health organizations, the authors compare staffing ratios of these HMOs with a 1-year average from a managed behavioral health carve-out organization

in the same State. Results indicate a decline in total number of patient care physicians regardless of enrollment changes, similar ratios of general psychiatrists per 100,000 members between the two HMOs that were about half the State's average, and a higher percentage of doctoral-level psychologists in the carve-out plan. The results highlight a need for future research focused on outcome measurement, the possibility of improvements in service delivery and quality through collaboration among provider types, and the effects of substituting non-specialist physicians for behavioral health services.

Keywords: carve-outs, HMOs, managed behavioral health care organizations, providers, staffing

240. Schreter, R. K. (1993). Ten trends in managed care and their impact on the biopsychosocial model. *Hospital and Community Psychiatry, 44*, 325–327.

In this article, the author expresses concerns about the impact of managed care on the biopsychosocial model of diagnosis and treatment. He identifies 10 trends in managed care and examines their impact on clinicians and their clients. He argues that managed care in its present form is being transformed as mental health services are increasingly being carved out, and provider networks are becoming the norm.

Keywords: providers, trends

241. Schreter, R. K., Sharfstein, S. S., & Schreter, C. A. (Eds.). (1994). *Allies and adversaries: The impact of managed care on mental health services* (1st ed.). Washington, DC: American Psychiatric Press.

This edited volume is a collection of essays written by clinicians and mental health executives. The book revolves around paired essays (one representing the managed care view, the other the clinical view). In a section on clinical services, inpatient services, intermediate level of care, outpatient care, child and adolescent services, and drugs and alcohol are addressed. The same format is used to show the two perspectives regarding the role of providers, including the psychiatrist, psychologist, and social worker. Ethical issues under managed care, quality-of-care guidelines, and practice guidelines are also addressed. Essayists were asked to respond to two questions: What do you believe are the major problems with managed mental health care? What would you do to improve the situation? Many of the chapters are written in an informal, personal style with liberal use of anecdotes and case studies. The editors wrote the final chapter, entitled "How Adversaries Can Become Allies," in which they outline the areas of both conflict and agreement between managed care executives and clinicians and reiterate the need for dialogue between the two groups.

Keyword: providers

242. Schuster, J. (1991). Ensuring highest-quality care for the cost: Coping strategies for mental health providers. *Hospital and Community Psychiatry, 42*, 774–776.

Frustrated with mixed reviews regarding the ability of methods such as utilization review, diagnosis-related groups (DRGs), and HMOs to control health care costs, the Federal Government is now exploring other avenues to achieve cost control. These include increased attention to outcome studies, renewed interest in a national health care system, and the enactment of the Medicare Volume Performance Standard. Psychiatry has followed a different path with regard to cost control; for example, most psychiatric services have not been subject to DRG limitations. This author describes current cost-containment methods in mental health care and concludes that mental health providers be proactive in exploring cost-containment methods that provide the highest quality for the cost.

Keywords: costs, providers

243. Sederer, L. I., & St. Clair, R. L. (1989). Managed health care and the Massachusetts experience. *American Journal of Psychiatry, 146*, 1142–1148.

Managed behavioral health care represents both danger and opportunity for psychiatry. The authors describe some of the reasons for the rapid growth of managed care and the clinical, economic, ethical, and practical implications. They then discuss the ways in which psychiatrists have organized to counterbalance the trend. The authors describe the efforts of the Task Force on Managed Care of the Massachusetts Psychiatric Society to ensure that psychiatrists continue to play a major role in determining the destiny of psychiatric care. The task force chose to focus on three areas: developing criteria for minimal standards of care; certification and monitoring of utilization review organizations; and maintaining a second opinion service as a back-up for when a psychiatrist or patient disagrees with a managed care organization.

Keywords: providers, standards of care, utilization management

244. Sederer, L. I. (1994). Managed mental health care and professional compensation. *Behavioral Sciences and the Law, 12*, 367–378.

In this article, the author examines physicians' organizational relationship to new managed systems of care as well as physician compensation within these systems. The paper presents three models of professional compensation: profit maximization, target income, and patient agency. The author then describes five different types of physician organizations, entities integrating physicians with health care systems. From these foundations, the author discusses the impact of managed mental health care on physician compensation and incentives, concluding that fully integrated, physician-hospital organizations with target income compensation arrangements are the most successful for both physicians and organized systems of care. The paper includes a discussion of the dilemmas and challenges in bringing together managed care, organized networks of care, and professional compensation.

Keywords: economics, models, providers

245. Snibbe, J. R., Radcliffe, T., Weisberger, C., Richards, M, & Kelly, J. (1989). Burnout among primary care physicians and mental health professionals in a managed health care setting. *Psychological Reports, 65*, 775–780.

The authors administered the Maslach Burnout Inventory to primary care physicians and psychiatric staff (psychiatrists, psychologists and social workers) of a large health maintenance organization (HMO). They found that for all providers except psychologists, their HMO sample scored significantly higher on all subscales than the Maslach normative population of physicians and mental health professionals. Several interprofessional differences also emerged. For example, internists scored significantly lower on emotional exhaustion than did psychiatrists; however, psychiatrists scored higher on depersonalization than either family practitioners or internists. The authors discuss implications of these findings for HMOs that include job rotation, mentoring systems, and workshops to help health care professionals recognize and cope with burnout.

Keywords: HMOs, providers

246. Sturm, R., Meredith, L. S., & Wells, K. B. (1996). Provider choice and continuity for the treatment of depression. *Medical Care, 34*(7), 723–734.

This article examines the effects that the changing payment system in mental health care has had on characteristics of the patient-provider relationship such as a choice of specialist versus generalist, and the duration of the relationship. The authors compare provider selection among depressed patients in prepaid and traditional fee-for-service (FFS) plans. Data from the Medical Outcomes Study are analyzed among three competing systems of care in urban areas across the country. The results of the patient survey administered by the authors finds that FFS patients were more likely than those in prepaid health plans to consider a psychiatrist to be their main source of care. FFS individuals were also found to have a higher probability of provider continuity over time than those in prepaid health plans. This study may be useful in future policy analysis on issues of patient-provider relationships as well as the quality of care being offered in the managed behavioral health care market.

Keywords: depression, evaluation, providers

247. Thompson, J. W., Smith, J., Burns, B. J., & Berg, R. (1991). How mental health providers see managed care. *Journal of Mental Health Administration, 18*, 284–291.

This paper reports the findings from a 1989 study using focus groups to explore mental health practitioners' attitudes regarding managed care. The 23 participants (psychologists and psychiatrists) were either contractors with managed care firms or on an "approved" list of providers. Although there were differences of opinion on a number of points, the general consensus of the groups was that managed care has adversely affected quality of care as well as their own practice. Participants believed that limits on the number of sessions and inpatient stays interfered with effective treatment. They identified barriers to engaging clients such as inappropriate intake assessments by untrained case managers and the subjective use of "standardized"

criteria. The participants called for peer review, greater collaboration between providers and managed care firms, more stability in benefits and standards, and more autonomy in decision-making.

Keyword: providers

248. Van Gelder, D. W. (1992). Surviving in an era of managed care: Lessons from Colorado. *Hospital and Community Psychiatry, 43*, 1145–1147.

This paper discusses how managed care has affected nonprofit psychiatric facilities in Colorado, where more than half of the State's population is covered by managed care plans. The author describes the strategies one facility has used to function effectively in an era of cost containment. Because of a decrease in length of stay, the facility needs more patients to maintain a full census. To achieve this, the facility has trained staff in brief treatment and implemented a marketing campaign to generate referrals. The author suggests a number of approaches to prevent declines in employee morale should layoffs become necessary. These include making the facility mission clear to employees and giving them a say in decisions about cutbacks.

Keyword: providers

249. Wagman, J. B., & Schiff, J. (1990). Managed mental health care for employees: Roles for social workers. *Occupational Social Work Today, 53–65*.

Case management is a major strategy for controlling skyrocketing mental health costs. The authors identify the causes of the problem of high costs, how case management is being used to address this problem, and the role of social workers in case management and employee assistance programs. Social workers possess skills that are useful in assessment and referral, as well as in review and monitoring of treatment. Managed mental health care has provided many opportunities for clinicians who are competent in both direct practice and administrative skills. The authors argue that as the field of managed mental health care grows, social work education will need to address the emerging roles that it presents for social workers.

Keywords: case management, providers

250. Whittington, H. G. (1992). Managed mental health: Clinical myths and imperatives. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 223–244). Springfield, IL: Charles C. Thomas.

This chapter argues that the clinical, social, and economic imperatives in favor of a managed mental health approach are compelling. The author identifies and refutes a number of myths about managed mental health care. These include beliefs such as that controlling physician behavior is amenable to simple economic incentives; that mental health care is unmanageable; that adverse selection will occur if good mental health benefits are offered; that patients as a rule overutilize psychotherapy, and that managed care results in poorer service outcomes.

The author argues that the skepticism with which managed mental health and substance abuse services are viewed by the general public and payors is largely due to ignorance about the clinical and economic realities of such services; and that managed mental health represents an opportunity to improve both clinical outcomes and economic efficiency.

Keywords: economics, providers

251. Zakheim, M. H., Leifer, J. C., & Schwartz, R. A. (1998). *A guide for providers of mental health and addictive disorder services in managed care contracting: Vol. 9. Managed care technical assistance series*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

As more and more health care providers are contracting with managed care organizations, it has become increasingly important for providers to understand the structure and organization of these contracts before they begin to negotiate. The purpose of this guide is to assist providers of publicly funded substance abuse and mental health services as they enter into contracts with managed care organizations. In particular, the discussion centers around the wording of these contracts, with a focus on identifying commonly found weaknesses in the provisions and recommending alternatives. The guide is composed of five sections: Fundamentals of Managed Care Contracting, Scope of Services, Financial Issues, Eligibility and Enrollment, and Dispute Resolution and Conditions of Termination. Each chapter presents a discussion of a specific type of contract provision as exemplified by relevant excerpts from actual contracts followed by critiques and recommendations.

Keywords: contracting, providers, public sector, substance abuse, technical assistance

252. Zimet, C. N. (1989). The mental health care revolution: Will psychology survive? *American Psychologist*, 44, 703–708.

The author argues that psychologists should help shape the managed care system. The key tasks for psychologists are to provide high-quality care and to assert their role in providing that care. The article provides an overview of managed care as a cost-containment approach. Although psychiatric hospitals have been exempted from cost containment, it is only a matter of time before these facilities are reimbursed prospectively and treatments are paid at a fixed rate. Reimbursement limits will have important implications for psychologists. The article also describes the ways in which psychologists can play a role in assuring quality assurance, developing reimbursement guidelines, and in advocating for the use of mental health services as a way of reducing medical costs.

Keyword: providers

XI. Public Sector

253. Austin, M. J., Blum, S. R., & Murtaza, N. (1995). Local-state government relations and the development of public sector managed mental health care systems. *Administration and Policy in Mental Health* 22(3), 203–215.

This article begins by establishing the existence of a trend over the past three decades of devolution of authority for the raising of funds and provision of services in the mental health arena from the Federal government to States and from States to county and city governments. Resources are extremely scarce in the realm of mental health services, and therefore policy makers have adopted the theory that they can best be managed and fairly distributed by local authorities. This article describes how county governments handle the burden of responsibility for mental health services and problems that emerge. Some of the problems raised are the difficulties in raising adequate funds, the failure to move dollars from inpatient to community care, the burden of costly reporting and accountability requirements, and the expanding of responsibility without simultaneous increase in funding or autonomy. The advent of managed mental health care is beginning to once again alter the dynamic of responsibility between State and county governments. The authors identify potential implications for county mental health services.

Keywords: local governments, public sector

254. Beinecke, R. H., & Lockhart, A. (1998). A provider assessment of the Massachusetts Medicaid managed behavioral health program: Year four. *Administration and Policy in Mental Health* 25(4), 411–426.

This article reports the results of the third annual assessment of the Massachusetts Medicaid Managed Mental Health/Substance Abuse Program. A random sample of 80 providers, stratified by service type and region, were interviewed by phone for their views on the program in year four as compared with year three. Providers were questioned about access, utilization, and quality of care; severity of the clients seen by providers; length of stay; readmission; emergency room admissions aftercare; effect on clients in the program; integration of care in the program; clinical review process; medication use; hospital discharge; and administration of the program. The results indicated that access and quality of care were better or the same; client severity continued to increase; length of stay decreased; and readmission, aftercare, and emergency room admissions were the same. The providers reported difficulties with integration of services, linkages with support services, and the administration of the program.

Keywords: carve-outs, evaluation, Massachusetts, Medicaid, public sector

255. Beinecke, R. H., & Perlman, S. B. (1997). The impact of the Massachusetts managed mental health/substance abuse program on outpatient mental health clinics. *Community Mental Health Journal* 33 (5), 377–385.

This article discusses how mental health clinics in Massachusetts have responded to the Medicaid Mental Health/Substance Abuse Program (MH/SAP). Data were used from a telephone survey of a random sample of providers in the Mental Health Management of America (MHMA) network, and from MHMA claims payment data for fiscal years 1993 and 1994. The authors found that total expenditures decreased while utilization increased over the previous year, and that service indicators such as access, utilization, and quality of care were similar or better. The article also discussed providers' problems with program management, and changes outpatient providers have made in their services and their organization in response to the MH/SAP.

Keywords: carve-outs, community providers, evaluation, Massachusetts, Medicaid, public sector

256. Beinecke, R. H., Shepard, D. S., Goodman, M., & Rivera, M. (1997). Assessment of the Massachusetts Medicaid managed behavioral health program: Year three. *Administration and Policy in Mental Health* 24(3), 205–220.

This article reports the results of the second annual assessment of the Massachusetts Medicaid Managed Mental Health/Substance Abuse Program. Information was collected from claims data in fiscal years 1993 and 1994 and a random sample of 88 providers, stratified by service type and region, who were interviewed by phone for their views on the program in year two. The authors interviewed providers, professionals, consumer organizations, and public officials from the Division of Medical Assistance and Mental Health Management of America. Providers were questioned about access, utilization, quality of care, severity of the clients seen by providers, length of stay, readmission, aftercare, integration of care in the program, and the clinical review process. The results indicated that access and quality of care were the same or better in year three, client severity was higher, and aftercare planning and integration of care had improved. However, providers reported continuing problems with program administration.

Keywords: carve-outs, evaluation, Massachusetts, Medicaid, public sector

257. Callahan, J. J., & Merrick, E. L. (1997). Designing public sector managed care systems. In K. Minkoff and D. Pollack (Eds.), *Managed mental health care in the public sector: A survival manual* (pp. 45–58). Amsterdam: Harwood Academic Publishers.

This chapter discusses system-level considerations and decisions involved in the design of public sector managed care arrangements. The authors address the implications of a variety of decisions for the organization of health care delivery and for consumers, mental health practitioners, third-party payers, and managed care companies. The following issues are

discussed: the “make” versus “buy” decision, for-profit managed care organizations (MCOs) versus nonprofit agencies, total population versus subpopulation coverage, statewide versus sub-State coverage, carve-out versus integration with general health care services, selection of strategies for limiting utilization (demand- versus supply-side controls, capitation versus non-capitated payment mechanisms, managed care networks versus HMOs, and the selection of methodologies for accountability and quality control.

Keywords: overviews, public sector

258. Callahan, J. J., Shepard, D. S., Beinecke, R. H., Larson, M. J., & Cavanaugh, D. (1995). Mental health/substance abuse treatment in managed care: The Massachusetts Medicaid experience. *Health Affairs*, 14(3), 173–184.

This study assesses the impact of Massachusetts Medicaid’s specialty mental health managed care carve-out on expenditures, access, and quality of care in the first year of operation. The report is based on information from the program’s “independent review” submitted to the Health Care Financing Administration. Access was evaluated based on the percentage of enrollees who used services. Quality was based on the percentage of discharges followed by readmissions. The findings show that a 22 percent reduction in expenditures below levels predicted without managed care was accomplished; that access and quality were not diminished on the whole; and that cost savings resulted from reduced numbers of admissions, shorter lengths of stay, use of alternative nonhospital 24-hour care facilities, and lower prices. One possible area of concern within the findings is in the treatment of children and adolescents, whose readmission rates increased slightly and whose providers reported lower levels of satisfaction. On the whole, the authors find results that confirm the potential benefits of managed mental health and substance abuse treatment.

Keywords: carve-outs, children, costs, evaluation, Massachusetts, Medicaid, outcomes, public sector, substance abuse, utilization

259. Chalk, M. (1997). Privatizing public mental health and substance abuse services: Issues, opportunities, and challenges. *Quality Management in Health Care*, 5(2), 55–64.

This article provides a discussion of the concerns faced by States as they move into contracting with private companies for the provision of public mental health and substance abuse treatment services. The author notes that States are making a large number of critical decisions, such as whether to “carve out” certain services or populations, and complicated calculations, such as determining reasonable capitation rates for vulnerable groups, without adequate information or experience in the practice of health care management. States may not recognize the particular complexities and challenges of managing substance abuse and mental health services. The management of these services is a newer field in which there is less experience on which to base policies. The author discusses the chronicity, stigmatization, and social costs of mental illness and substance abuse problems as examples of the unique complexities of mental health and substance abuse treatment. The author addresses resulting implications for policy making

in the course of privatization initiatives. Topics discussed include organizational structure, coordination and integration of agencies and private companies, organizational mission and values, establishing methods of performance assessment, and ensuring consumer participation and control.

Keywords: contracting, public sector, substance abuse

260. Cuffel, B. J., Snowden, L., Masland, M., & Piccagli, G. (1996). Managed care in the public mental health system. *Community Mental Health Journal, 32*(2), 109–124.

This article describes managed care's organizational arrangements using "principal-agent theory," wherein the managed care organization (MCO) has as its primary functions the role of agent for the payer and the responsibility of managing the relationships between payers, providers, and consumers. These players enter into contractual relationships with one another, thereby creating an "agency relationship." In this relationship, however, there is the potential for the provider party to act in its own interest, rather than that of the other parties, because of the fact that the other parties have imperfect knowledge of provider behaviors and consumer outcomes. According to this theory, the MCO presents a potential solution to this problem in that it is able to oversee these behaviors and outcomes. This role becomes more complex in the public mental health system when MCOs are responsible for managing the relationships between citizen/taxpayer and government, consumer and provider, and government and mental health authority. In addition, there may be multiple agency or program payers at multiple levels of government. These authors argue that MCOs must recognize the intricacies of their responsibility to each of these parties, and that public agencies must recognize the value of oversight and information-gathering made possible by MCOs in order for this partnership to be successful.

Keywords: contracting, managed behavioral health care organizations, public sector

261. Dangerfield, D., & Betit, R. L. (1993). Managed mental health care in the public sector. *New Directions for Mental Health Services, 59*, 67–80.

In 1991, the Utah Medicaid Prepaid Mental Health Plan was implemented in three regions of the State. This chapter describes the implementation of this plan at one site, Valley Mental Health (VMH), a private, not-for-profit corporation that provides mental health services under contract with the State. Prominent features of the Medicaid demonstration project include capitation, placing the provider at financial risk, providing incentives for providers to manage care wisely, and tying payments to a specific risk pool. VMH developed a number of principles to ensure that clients receive appropriate and timely services. These principles include enhanced services to severely and persistently mentally ill persons, individualized treatment planning, broad array of services, attention to location of services, and single clinical authority. A case example illustrates the VMH approach.

Keywords: capitation, public sector, Utah

262. Egnew, R. C., & Baler, S. G. (1998). Developing principles, goals, and models for public/private partnerships. *Administration and Policy in Mental Health, 25*(6), 571–579.

At a time when behavioral health authorities are becoming the major administrative entity responsible for the provision of behavioral health care services, many have begun to explore the option of developing a public/private partnership with a for-profit managed care organization for specific administrative or technologically based services. This article examines the necessary philosophy, common set of principles, and objectives for this type of partnership to be successful. The authors identify principles on governance, administration, participation, and services and demonstrate four potential models for collaboration. Finally, they consider potential benefits as well as obstacles to collaboration and present suggestions for public sector behavioral health authorities considering such a partnership.

Keywords: models, public sector

263. Essock, S. M., & Goldman, H. H. (1995). States' embrace of managed mental health care. *Health Affairs, 14*(3), 34–44.

It is important for State Mental Health Authorities (SMHAs) to take advantage of specialized health care management expertise that has been developed in the private sector. At the same time, the authors are concerned with the need for SMHAs to continue to make use of their own expertise in serving vulnerable populations. This article discusses present issues and trends in the development of public sector managed behavioral health care: how States can fit together their own management goals with those of managed care contractors; how managed care techniques such as contracting, utilization review, and monitoring can be put to use in public sector programs; how States can navigate the transition from delivering services to monitoring their delivery; and how they can effectively write incentives into contracts to promote better management of care.

Keywords: contracting, public sector

264. Feldman, S., Baler, S., & Penner, S. (1997). The role of private-for-profit managed behavioral health in the public sector. *Administration and Policy in Mental Health, 24*(5), 379–389.

This article discusses the rapid growth of public sector investment in the provision of behavioral health services through contracts with private managed care companies, the reasons for this growth (political climate, need to contain costs and prove effectiveness), and its outcomes—both benefits and drawbacks. Among the topics discussed are the observation that merging public and private sectors can lead to a clash of cultures with different sets of values, priorities, and practice patterns; and concerns that the public sector has traditionally served a very different population from those traditionally treated in the private sector. The article also presents divergent models that are emerging, using Solano County, CA, and Kings County, WA, as examples.

Keywords: California, local governments, models, public sector, Washington

265. Fisher, W. H., Lindrooth, R. C., Norton, E. C., & Dickey, B. (1999). How managed care organizations develop selective contracting networks for psychiatric inpatient care: A Massachusetts case study. *Inquiry, 35*(4), 417–431.

This case study describes the formation of a public managed care network to service Medicaid beneficiaries in Massachusetts. The study draws on the Massachusetts example to answer questions applicable to the Medicaid managed mental health care market around the Nation. It models how hospitals' experience with Medicaid psychiatric patients, prior reimbursement rates, and geographic location each affected the decision of a Massachusetts hospital to bid for membership in a managed care organization (MCO). Also, the study models which factors determined the MCO's choice of hospitals with which to contract. The data analysis shows that hospitals are more likely to bid if they have treated more psychiatric inpatients and more Medicaid Supplemental Security Income individuals, and MCOs are more likely to choose hospitals for their network based on experience with Medicaid patients and geographic dispersion rather than reimbursement rates.

Keywords: contracting, Massachusetts, Medicaid, public sector

266. Frank, R. G., & McGuire, T. G. (1997). Savings from a Medicaid carve-out for mental health and substance abuse services in Massachusetts. *Psychiatric Services, 48*(9), 1147–1152.

This article describes cost savings accomplished by the Massachusetts behavioral managed care carve-out, as the first and one of the few such behavioral carve-outs to have employed a for-profit company to deliver services of this kind to this population. Using data from publicly available documents, mainly those used in the contract rebidding process, these authors compare expenditures for the delivery of services by the managed care vendor to projected expenditures based on the year before the carve-out adjusted for inflation. Findings show savings of 25 percent below projected expenditures, and show that these savings were maintained in later years. Furthermore, an examination of incentives built into the contract with the State indicates that the vendor had relatively weak incentives to reduce costs below target for the direct services component of its budget, while having greater opportunity for profit through savings in the contract's budget for administrative functions. These authors conclude that other motivations existed for the vendor to practice "managing to the contract," such as the interests of recontracting and of pursuing other clients by pleasing Massachusetts Medicaid.

Keywords: carve-outs, contracting, costs, evaluation, Massachusetts, Medicaid, public sector

267. Geller, J. L., Fisher, W. H., McDermeit, M., & Brown, J. M. (1998). The effects of public managed care on patterns of intensive use of inpatient psychiatric services. *Psychiatric Services, 49*(3), 327–332.

Public sector managed behavioral health care is intended to change utilization in ways that lead to more cost-effective uses of mental health services. Some changes, however, may actually affect certain populations of patients adversely, making their care less cost-effective. This article

presents a study of patterns of inpatient mental health services utilization by frequent users, in order to recommend ways for public sector managed care systems to serve these patients more effectively. The authors draw their sample of patients from users of the Massachusetts public sector managed care program who were identified by the Massachusetts Department of Mental Health client tracking system as having five or more admissions in any year from 1992 to 1995. They compare such factors as patients' demographics, levels of function and personal distress, repeated use of the same facilities vs. new ones, frequency of admissions, and length of inpatient stays. The authors conclude that some of the practices of managed mental health care in Massachusetts have an adverse impact on patients in this particular special needs population. For example, their results indicate that patients who made use of multiple different facilities rather than the same one consistently tended to have longer stays. They point out that constraints of managed care networks can lead to this kind of discontinuity, which ultimately results in less rather than more cost-effective care. On the basis of these results, the authors make policy recommendations.

Keywords: Massachusetts, outcomes, public sector, serious mental illness, utilization

268. Hadley, T. R., Schinnar, A. P., & Rothbard, A. B. (1992). Managed mental health in the public sector. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 45–60). Springfield, IL: Charles C. Thomas.

Policymakers have introduced a number of proposals to apply capitation and managed care to public sector mental health programs serving chronic mentally ill persons. These proposals are based in part on cost containment models developed over the past 30 years. This chapter describes capitation demonstration projects in five States. In general, these experiments are designed to improve coordination of services and discourage inpatient care. This is achieved through the use of incentives to provide more individualized treatment, and by centralized management. The provision of mental health care through capitated financing requires the development of a single funding stream administered by a central authority, such as a county office. Resources and responsibilities are transferred either “downstream,” from Federal to State to local authorities, or “upstream,” from local to higher level authorities. The authors discuss the savings as well as the costs of downstream financing, and conclude that capitation models should be adapted to meet the unique needs of their communities.

Keywords: capitation, public sector, serious mental illness

269. Hogan, M. F. (1996). Managing the whole system of care. *New Directions for Mental Health Services*, 72, 13–24.

As managed care increases its penetration into the public mental health system, responsibility for mental health care shifts from the public sector to the private sector, bringing about tensions over which populations should receive priority for care, along with the concurrent changes in the financing and organization of services. This article analyzes the match between managed care methods and public mental health services. The author examines several factors in assessing the congruence between the two, including the ability of managed care to meet the needs of the diverse and needy population served by the public system; the fit between public

and private system management strategies; the applicability of managed care to other aspects of the public mental health system such as housing and rehabilitation; and the implications of managed care for public mental health programs involving social or legal control. The article also discusses the social and political implications of allying the private and public sectors to manage public care.

Keywords: overviews, public sector

270. Hoge, M. A., Davidson, L., Griffith, E. E. H., & Jacobs, S. (1998). The crisis of managed care in the public sector. *International Journal of Mental Health, 27*(2), 52–71.

This article discusses the current trends in public sector managed behavioral health care and defines the potential opportunities and dangers of using managed care. The authors begin with a brief overview of past public sector efforts in managed care and set forth an ideal approach. They then discuss recent trends in public sector managed care, classifying public sector managed care initiatives into three general categories (managed Medicaid, initiatives focused on populations with severe and prolonged mental illness, and programs that mainstream the severely ill into health maintenance organizations [HMOs]), and summarize findings about the outcome of managed behavioral health care in the public sector. The authors discuss the potential opportunities created by public sector managed care (greater accountability, access, and coordination of care for specific individuals and for the system of services as a whole; less restrictive treatments of care; greater cost control and flexibility in spending; enhanced quality control; and expanding coverage for the uninsured), and the potential dangers (using managed care as a ploy for decreased funding; fragmentation of funding and services with little pooling of funds; cost-shifting; erosion of local systems of care; and an erosion of a skilled workforce). They offer several conclusions on the current state of public sector managed behavioral health care.

Keywords: Medicaid, public sector, serious mental illness, trends

271. Hoge, M. A., Davidson, L., Griffith, E. E. H., Sledge, W. H., & Howenstine, R. A. (1994). Defining managed care in public-sector psychiatry. *Hospital and Community Psychiatry, 45*, 1085–1089.

This paper attempts to draw a connection from managed care in the private sector to the adoption of managed care policies by the public sector. The authors offer a conceptual framework and a working definition of public sector managed care. The argument first analyzes the four major service delivery strategies used by the public sector: case management, assertive community treatment, local mental health authorities, and financing strategies. On the basis of these core functions, the authors posit a definition of managed care in the public sector, and use this definition to evaluate the existing public-sector managed care delivery system as well as the Clinton administration's proposed changes to the health care system.

Keywords: overviews, public sector

272. Hoge, M. A., Jacobs, S., Thakur, N. M., & Griffith, E. E. H. (1999). Ten dimensions of public-sector managed care. *Psychiatric Services*, *50*, 51–55.

Recent literature on managed care organizations in the public sector has demonstrated that each managed care initiative is shaped by local structures, history, geography, and politics. In this paper, the authors examine existing initiatives in the public sector to extend the knowledge from earlier reviews. They identify 10 dimensions on which a managed care initiative should be assessed in order to understand its likely effect on existing systems of care. The dimensions are objectives, scope, organizational structures and authority, enrollment, benefit package, strategies for managing utilization, best practices, financing, quality management and outcomes measurement, and the impact of the initiative on the public mental health system. From their review of existing initiatives, the authors conclude that most focus on one principal dimension, giving less attention to other important dimensions. They argue for a set of common assessment criteria to enable a comprehensive approach to planning and implementing managed care projects.

Keywords: overviews, public sector

273. Katz, S. E., & Trainor, P. E. (1988). Impact of cost containment strategies on the state mental health delivery system. In D. J. Scherl, J. T. English, and S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (1st ed., p. 172). Washington, DC: American Psychiatric Association.

This chapter discusses the role of State government in mental health, and mental health officials' concerns about the impact of Medicare's prospective payment system (PPS) and capitation on quality of care. The authors argue that PPS will have three major effects: increase the inpatient caseload, shift costs from general to State psychiatric hospitals, and lead to the loss of Federal funds to support inpatient care in psychiatric hospitals. Prompted by these concerns, the National Association of State Mental Health Program Directors conducted a study of the impact of PPS on the State mental health system in five States. The authors discuss concerns about the DRG (diagnosis-related group)-based and capitation approaches to containing Medicaid costs, and call for evaluation of these efforts. They raise questions about the standards used by professional review organizations to monitor hospital admissions. Finally, they express concern that the private sector will forget its duty to share the responsibility to care for mentally ill persons and inappropriately shift the burden to the State system.

Keywords: capitation, DRGs

274. Leadholm, B., & Kerzner, J. (1994). Public managed care: Developing comprehensive community support systems in Massachusetts. *Managed Care Quarterly*, *2*, 25–30.

In 1991, the Massachusetts commissioner of mental health proposed to restructure the service system through implementing public managed care. The reorganization has led to a shifting of resources from inpatient hospital use to managed community-based services. This article

describes the organization of the program within the Massachusetts Department of Mental Health and the ways that the new program's concern with consumer choice and psychosocial rehabilitation are promoted. Accountability and quality management are ensured through the development of quality councils, a utilization management system, practice guidelines, and performance standards. These features are discussed, as are methods of managed care financing and barriers to implementation.

Keywords: Massachusetts, public sector

275. McFarland, B. H., George, R. A., Pollack, D. A., & Angell, R. H. (1993). Managed mental health in the Oregon health plan. *New Directions for Mental Health Services, 59*, 41–54.

This article outlines the development of the Oregon Health Plan, which is intended to provide health coverage for uninsured Oregonians. In particular, it describes the efforts to demonstrate the rationality of including mental health coverage in a comprehensive plan. The authors describe the issues and challenges raised in determining which services would be provided and in integrating the Oregon Health Plan with the ongoing public mental health system. The delivery and financing systems are also described.

Keywords: Oregon, public sector

276. Mechanic, D. (1991). Strategies for integrating public mental health services. *Hospital and Community Psychiatry, 42*, 797–801.

There are significant deficiencies in the delivery and financing of the public mental health sector, particularly for chronically mentally ill persons. A major problem is not just the lack of funds, but the lack of integrated and coherent efforts to provide services. The author presents four generic approaches to building a viable public mental health system: developing assertive community treatment systems, capitating mental health care, building strong local mental health authorities, and developing supportive reimbursement structures. The author discusses the advantages and disadvantages of each model, and recommends that they be implemented conjointly to reduce costs and improve quality of care.

Keywords: models, public sector, serious mental illness

277. Minkoff, K. (1994). Community mental health in the nineties: Public sector managed care. *Community Mental Health Journal, 30*, 317–321.

The author discusses the recent shift toward managed care in public sector mental health programs. Implications for community mental health professionals are reviewed, and principles for evaluating public sector managed care programs are presented.

Keywords: community providers, public sector

278. Moscovice, I. S., Finch, M., & Lurie, N. (1989). Minnesota: Plan choice by the mentally ill in Medicaid prepaid health plans. *Advances in Health Economics and Health Services Research, 10*, 265–278.

This study reports on a federally funded demonstration project to test the efficacy of providing prepaid health care services to a Medicaid population. Minnesota was one of six States to receive a Federal waiver for this project, and the only State with a true experimental design in which enrollees are randomly assigned to either a prepaid health plan or fee-for-service system. Thirty-five percent of all Medicaid beneficiaries in Hennepin County were randomly assigned to prepaid plans. The State provided a broker to contact clients and educate them about their choices of health care plans. Those who did not choose a health care plan within 90 days were assigned to a plan. The study examined predictors of voluntarily choosing a plan rather than being assigned to one. Eighty-two percent of clients chose a plan. The two main factors responsible for likelihood of choosing a plan were presence of a usual source of care and education.

Keywords: capitation, Medicaid, Minnesota, public sector

279. Norton, E. C., Lindrooth, R. C., & Dickey, B. (1997). Cost shifting in a mental health carve-out for the AFDC population. *Health Care Financing Review, 18*(3), 95–108.

Many States have opted to “carve out” mental health and/or substance abuse services from their regular Medicaid programs and contract them to managed care vendors. This article explores the potential that managed care vendors who administer a behavioral health carve-out may have an incentive to promote services in the mainstream health care system to their clientele so as to shift costs to the regular Medicaid program and reap the financial reward. Certain medical and pharmaceutical services (all covered by regular Medicaid) can be substituted for some behavioral health services. These authors examine data for the Massachusetts mental health carve-out serving the Aid to Families with Dependent Children (AFDC) population. Their analysis shows overall change in expenditures after implementation of the carve-out, examines expenditures for two services covered by the Medicaid program and two covered by the behavioral managed care vendor as a test for cost-shifting, and inquires into whether cost-shifting was more pronounced for patients with severe mental illness. This last inquiry is significant because patients who are more severely ill represent a greater financial risk. Results indicate that total expenditures were reduced after implementation of the carve-out, and that this reduction occurred most dramatically among those with more serious mental illness. However, the authors find little or no evidence for cost-shifting among the AFDC population, in contrast to previous indication of such an effect among the disability population.

Keywords: carve-outs, costs, economics, evaluation, Massachusetts, Medicaid, public sector, serious mental illness

280. Rohland, B. M. (1998). Implementation of Medicaid managed mental health care in Iowa: Problems and solutions. *The Journal of Behavioral Health Services & Research*, 25(3), 293–299.

Geared toward stakeholders who are developing Medicaid managed mental health care programs, this commentary examines the issues that Iowa encountered in developing such a program in 1995. The article summarizes Iowa's strategy for developing the Medicaid managed mental health contract, as well as the resulting problems and regulatory attempts to address these problems. Concerns at the time included denial of hospitalization, premature discharge from the hospital, qualifications of utilization managers, inconsistency among case reviewers, slow payment of claims, and excessive paperwork requirements. The author addresses these problems as well as the success of the regulatory attempts, and provides suggestions for other States on the development, implementation, and oversight of managed care contracts to avoid such issues. Suggestions include developing appropriate contract specifications, providing mechanisms for oversight, and enforcing standards of care in Medicaid managed care contracts.

Keywords: contracting, Iowa, Medicaid, public sector

281. Semke, J., Brown, L., Sutphen-Mroz, J., Cox, G. B., et al. (1994). Impact of mental health reform on service use. *Evaluation and Program Planning*, 17, 73–79.

This article is one of several in this journal issue discussing the recent reforms and reorganization of public sector mental health services in the State of Washington. The authors evaluate the impact of the early stages of implementation of mental health system reform on client utilization of community mental health services.

Keywords: public sector, utilization, Washington

282. Stein, L. I. (1989). Wisconsin's system of mental health financing. *New Directions for Mental Health Services*, 43, 29–42.

In 1971, Wisconsin passed legislation requiring its counties to plan for and provide (or purchase) services for mentally ill persons. Funding was provided on a formula basis, with each county contributing at least 9 percent in matching funds. This chapter discusses this process of mental health service decentralization and funding integration. The State provided counties with "special needs" funds to facilitate the transition from hospital- to community-based care. This chapter describes the results in the 15 years that Wisconsin has funded its public mental health system via a consolidated mental health budget. A case example of Dane County is used to illustrate how one community successfully implemented this law, which posed a significant challenge to the traditional service delivery model.

Keywords: local governments, public sector, Wisconsin

283. Stoner, T., Manning, W., Christianson, J., Gray, D., & Marriott, S. (1997). Expenditures for mental health services in the Utah prepaid mental health plan. *Health Care Financing Review, 18*(3), 73–93.

This article reports on an analysis of the effect of the Utah Prepaid Mental Health Plan (UPMHP), a mental health carve-out, on utilization and expenditures for populations in the catchment area of three community mental health centers (CMHCs). The study compares these data for the periods before and after the implementation of the carve-out, and also compares those enrolled in UPMHP to a control group in the same catchment area who were not enrolled in the plan. Both Medicaid and UPMHP claims/encounter forms data were used. Stated goals of the program included reducing expenditures and increasing use of the outpatient facilities while reducing inpatient care. The results indicate that the goal of reducing expenditures on inpatient care was achieved, and that this was accomplished by reducing the number of admissions. For outpatient care, however, there was no difference in utilization between the capitated and noncapitated (enrolled and nonenrolled) populations. Thus, this study does not provide evidence that outpatient care replaced inpatient care. The authors also conclude that the carve-out made no overall impact on mental health expenditures.

Keywords: capitation, carve-outs, costs, evaluation, Medicaid, public sector, Utah, utilization

284. Stroup, T. S., & Dorwart, R. A. (1995). Impact of a managed mental health program on Medicaid recipients with severe mental illness. *Psychiatric Services, 46* (9), 885–889.

This article reports on research into the impact of the Massachusetts Medicaid managed behavioral health care program on Medicaid clients with severe mental illness. For the purposes of this study, clients defined as severely mentally ill were those with psychotic disorders, certain mood and anxiety disorders, and borderline personality disorder. Using retrospective data about client demographics, diagnosis, and service utilization from the Department of Mental Health's client tracking system, the authors examined patterns of emergency room referrals and length of stay for patients admitted to the hospital. They compare data on recipients of services through the State's managed behavioral health program with data on a comparison group of severely mentally ill patients who are demographically and diagnostically similar, but who have another payer. The study covers the 18-month period before, during, and after implementation. The results indicated significant changes in care patterns for both groups, including a 16 percent drop in the number of visits to the emergency room that led to admission, concurrent with an increase in referral to alternative 24-hour care settings. There was also a 27 percent decline in mean length of stay for acute hospitalizations. The authors find that the likelihood of referral or transfer to lower intensity care settings is more common in the managed behavioral health program population, but they do not find higher rates of denial of care, nor do they find evidence of cost-shifting on the part of the State's behavioral health contractor. The impact of the program as well as the larger context of mental health systems change is discussed.

Keywords: carve-outs, evaluation, Massachusetts, Medicaid, public sector, serious mental illness

285. Yank, G. R., Hargrove, D. S., & Davis, K. E. (1992). Toward the financial integration of public mental health services. *Community Mental Health Journal, 28*, 97–109.

Because of a lack of fiscal and administrative integration of State and community services, the public mental health care system is not meeting the needs of seriously mentally ill persons. Public mental health agencies are accountable to a plethora of funders, policies, and regulations. Further, public financing encourages the use of expensive hospitalization by not providing adequate incentives to develop alternative forms of treatment such as crisis intervention. The author argues that capitation, performance contracts, utilization review, and regional mental health authorities can stimulate integration by encouraging providers to create coordinated and cost-effective services. The article describes how a number of States have integrated services using these strategies, and how these have led to the expansion of alternative services.

Keywords: public sector, serious mental illness

XII. Quality Assurance and Outcomes

286. Bartlett, J., & Cohen, J. (1993). Building an accountable, improvable delivery system. *Administration and Policy in Mental Health, 21*, 51–58.

The authors describe the efforts of their organization, MCC Behavioral Care, Inc., to collect outcome data for the purpose of improving managed mental health and substance abuse treatment. They say three conditions are necessary to drive improvement in overall system function: that the process be ongoing, that data generated be sound and relevant, and that the process become an integral part of an organization's regular operations. MCC contracted with the Institute for Health Services Research at the University of Minnesota to provide the scientific rigor needed for providing an accountable, improvable delivery system. MCC hopes that this investment in continuous data collection will drive forward the state of the art, both within MCC and in the field in general, and that it holds great promise for the continual improvement in quality and cost-effectiveness of managed approaches in mental health and substance abuse care.

Keywords: performance measurement, quality assurance

287. Berlant, J. L. (1992). Quality assurance in managed mental health. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 201–222). Springfield, IL: Charles C. Thomas.

This chapter discusses the wide range in the definition of quality assurance systems, from “standard practice” to the “avoidance of adverse outcomes” to “optimal care.” The author discusses constraints on developing and maintaining a good quality assurance system. A 10-step monitoring and evaluation plan is outlined, as well as guidelines that many hospitals have found useful in implementing internal evaluation. The author argues that despite claims to the contrary, mental health services are amenable to quality assurance. Tools for quality assurance are described. The author concludes with several directions for quality assurance in managed mental health that appear promising, and suggests that a national data bank should be established for the collection, analysis, and dissemination of quality assessment findings in mental health.

Keywords: quality assurance, technical assistance

288. Borenstein, D. B. (1990). Managed care: A means of rationing psychiatric treatment. *Hospital and Community Psychiatry, 41*, 1095–1098.

Employers are looking increasingly to managed care and utilization review to reduce their medical expenses. This paper describes some of the problems experienced by patients and

psychiatrists as a result of these review processes. These problems include unqualified reviewers, lack of avenues for appeal of reviewers' decisions, disruptions in the therapeutic relationship because of the frequency and intensity of reviews, and fears about loss of confidentiality. The author emphasizes the need for setting standards for review organizations that will help overcome these and other problems.

Keywords: utilization management

289. Breslow, R. E., Klinger, B. I., & Erickson, B. J. (1996). Characteristics of managed care patients in psychiatric emergency service. *Psychiatric Services, 47*, 1259–1261.

Because managed care organizations (MCOs) function as gatekeepers, they should reduce patient reliance on psychiatric emergency services. Among individuals receiving emergency services, those patients in MCOs should be more likely than patients who are not enrolled in managed care to require hospitalization, should require a shorter contact time with the service as a result of preauthorization of hospital care, and should be a more functional group. To test these hypotheses, researchers examined records for 293 patients who visited a psychiatric emergency service, 69 of whom were enrolled in managed care. Contrary to their hypotheses, they found that almost half of the managed care patients visiting the emergency service were not hospitalized, but were referred for outpatient behavioral health services after receiving crisis services. Managed care patients also required more contact time with the service. Finally, the results showed significant differences between the two groups, with the non-managed-care group having more psychotic and substance abuse disorders, requiring more emergency community interventions, and having more previous psychiatric hospitalizations.

Keywords: outcomes, utilization

290. Burlingame, G. M., Lambert, M. J., Reisinger, C. W., Neff, W. M., & Moiser, J. (1995). Pragmatics of tracking mental health outcomes in a managed care setting. *The Journal of Mental Health Administration, 22*(3), 226–236.

The authors of this article are a mixture of academic researchers and health program administrators. They discuss logistical and methodological considerations involved in applying outcome monitoring techniques to managed mental health programs for the purposes of accountability and of verifying cost-effectiveness and Continuous Quality Improvement. Topics addressed include selection of representative and meaningful outcome measures, selection of instruments, obstacles to ongoing monitoring systems, the challenges of changing provider behavior toward incorporating outcomes assessment, and the implications for delivery of mental health services.

Keywords: outcomes, performance measurement, quality assurance

291. Burton, W. N., Hoy, D. A., Bonin, R. L., & Gladstone, L. (1989). Quality and cost-effective management of mental health care. *Journal of Occupational Medicine, 31*, 363–367.

This article describes a corporation-based comprehensive mental health plan that combines expanded outpatient mental health benefits, an emphasis on prevention and early detection, and psychiatric hospital utilization review. Analysis found that the number of hospitalizations, average length of stay, and costs have decreased significantly compared with figures 12 months before the program was implemented. The authors argue that a managed mental health care plan can simultaneously improve quality of services and be cost-effective.

Keywords: costs, quality assurance

292. Carpinello, S., Felton, C. J., Pease, E. A., DeMasi, M., & Donahue, S. (1998). Designing a system for managing the performance of mental health managed care: An example from New York State's prepaid mental health plan. *The Journal of Behavioral Health Services & Research, 25*(3), 269–278.

Across the United States, several States are implementing managed care principles as a way both to contain costs and to improve service effectiveness within the publicly funded mental health system. Research on the outcomes of individuals receiving these services and the impact of managed care on the overall system has been sparse, because most mental health care information systems have been transaction- and not outcome-oriented. In this paper, the authors provide an in-depth analysis of one example of a managed mental health plan with an outcome-oriented information system—the Prepaid Mental Health Program in New York State. The paper examines the development, implementation, and early experiences with the plan's performance management system for public sector managed behavioral health. The authors highlight policy, administrative, and financial implications of this basis for quality improvement activities and information-reporting products.

Keywords: capitation, information systems, New York, performance measurement, public sector, quality assurance

293. Center for Health Policy Studies (1996). *Policy assessment study of managed care and mental health/substance abuse services under health care reform*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).

This report, written for SAMHSA, is the synthesis of two expert advisory panels representing the mental health/substance abuse (MH/SA) community, raw data collected from managed care organizations, and a review of the available literature. The findings are presented in a question-and-answer format with substantial utilization and cost data analyzed by different patient categories. The report finds that substantial premium savings are brought about by managed care, but that the effects of managed care on MH/SA services are inconsistent as a result of poor data collection and methodological problems. The authors ultimately recommend that SAMHSA continue its role in promoting standardization of performance measures for MH/SA

delivery systems (Appendix E is a catalog of potential performance measures deemed suitable by the authors) to better monitor the effects of managed care penetration on the quality of MH/SA services.

Keywords: costs, outcomes, performance measurement, substance abuse, utilization

294. Dickey, B. (1997). Assessing cost and utilization in managed mental health care in the United States. *Health Policy, 41* (Suppl.), S163–S174.

This article examines the preliminary results of experiments with Medicaid managed care. The author presents a brief background of the managed care system and describes some of the early failures of Medicaid waivers and managed care at the State level. Preliminary data on mental health and substance abuse expenditures and patterns of use from the successful Medicaid managed care experience in Massachusetts show cost savings without a significant reduction in quality. The author suggests that future experiments with managed care invest in information systems to better track data, pay more attention to quality-of-care issues, move away from externally imposed utilization review processes, and carve out mental health management.

Keywords: carve-outs, costs, evaluation, Massachusetts, Medicaid, public sector, utilization

295. Essock, S., & Goldman, H. (1997). Outcomes and evaluation: System, program, and clinician level measures. In K. Minkoff & D. Pollack (Eds.), *Managed mental health care in the public sector: A survival manual*. Amsterdam: Harwood Academic Publishers.

Because managed care systems are concerned with the cost-effectiveness of care, this chapter seeks to address how to evaluate and monitor the “effectiveness” component of the equation, with particular attention to the special obligations involved in services provided through the public sector. The authors address relevant outcome measures at the individual client level, treatment program level, and systems level. They discuss the need for outcome measures to be based directly on changes in patients’ disabilities and areas of functional impairment rather than on indirect measures of structures, processes, or indirect outcomes. Outcome measures are hailed as an essential counterbalance to economic incentives to undertreat and as necessary information for determining fair and reasonable distribution of resources. Methods for data collection and factors involved in deciding which outcome measures to use are discussed as well.

Keywords: performance measurement, public sector

296. Feldman, J. (1999). How will mental health outcomes data be used in private systems? *New Directions for Mental Health Services, 71*, 103–109.

This article discusses how varied mental health outcomes data are used depending on the parties involved and their needs. Different stakeholders favor different variables and attempt to influence payers and provider to produce data useful to them. Stakeholders include employers and other payers, managed care organizations, mental health managers and provider groups,

patients and families, and researchers and academics. The author summarizes the data needs of each stakeholder and the ideal variables that each stakeholder desires. The author also contrasts the ideal data needs with data that are currently being used, addresses conflicts between stakeholder needs, and offers an opinion on the types of studies and measures that would affect quality of care.

Keywords: performance measurement

297. Feldman, S. (1992). *Managed mental health services: Ideas and issues*. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 3–26). Springfield, IL: Charles C. Thomas.

This chapter discusses several controversial and unresolved issues in the managed mental health care debate. The author describes the rhetoric of the debate and some of the underlying concerns of critics of managed mental health care. For example, he discusses ways in which concerns about loss of money and autonomy tend to be framed in terms that are more professionally and socially acceptable—such as on “quality of life,” “professional standards,” and “patient needs.” The author identifies common misunderstandings about managed care and argues that done well, managed mental health should be a method to better match the treatment to the problem. An effective managed care system should integrate managers, providers, and payers into a system of care that can flexibly respond to the needs of the mental health field. The author believes that a constructive tension between providers and case managers should have a positive impact on the quality of care in the managed system. A case study of U.S. Behavioral Health is used to illustrate his points.

Keywords: quality assurance

298. Garnick, D. W., Hendricks, A. M., & Comstock, C. (1996). Using health insurance claims data to analyze substance abuse charges and utilization. *Medical Care Research and Review*, 53(3), 350–368.

Over the past decade, many researchers have studied health insurance claims data in an effort to answer questions ranging from the effects of managed care on substance abuse cost to the effectiveness of programs to prevent readmissions. Health insurance claims data sets have several advantages, including multiple years of data, very large databases, and information on a variety of treatment settings. In this article, the authors present several challenges to utilizing insurance claims data by using illustrations from three large employers to answer questions about costs to employers, utilization of services to treat abuse of specific drugs, and the effects of managed care strategies. They conclude that insurance claims data sets are more suitable for researching some questions (such as tracking changes in employers' charges) than others (such as studying the use of treatment for specific drugs). They suggest three potential improvements to broaden the application of these data sets to substance abuse research.

Keywords: performance measurement, substance abuse, utilization

299. Giles, T. R. (1991). Managed mental health care and effective psychotherapy: A step in the right direction? *Journal of Behavior Therapy and Experimental Psychiatry*, 22, 83–86.

The author argues that alternatives to fee-for-service models of care delivery, such as HMOs, not only contain costs but better serve the mental health needs of consumers. Because of capitation, practitioners must demonstrate that their methods result in successful outcomes. The paper presents a brief history of managed mental health care and describes how managed care companies are carefully reviewing the outcome literature to identify effective behavioral and short-term treatment approaches.

Keyword: outcomes

300. Ginsberg, S. (1991). Managed care's paradoxical effect. *International Journal of Partial Hospitalization*, 7, 171–177.

The author cautions that managed care companies are paying disproportionate attention to the dollar at the expense of appropriate patient care and argues that these companies should be held accountable for decisions to deny payment for treatment. A particularly effective and cost-efficient form of psychiatric care, the day hospital, is discussed at length. The author concludes that utilization review should be undertaken by appropriately trained mental health professionals and that payers must bear responsibility for the impact of the care that patients receive.

Keywords: utilization management

301. Goldman, W., McCulloch, J., Cuffel, B., Zarin, D. A., Suarez, A., & Burns, B. J. (1998). Outpatient utilization patterns of integrated and split psychotherapy and pharmacotherapy for depression. *Psychiatric Services*, 49, 477–482.

In the era of HMOs, mental health service models that manage costs as well as services have gained increasing popularity. One such model, hypothesized to reduce costs, is “split treatment,” where psychiatrists provide pharmacotherapy and less costly mental health specialists provide psychotherapy. In order to study the benefits of split therapy over the model of integrated therapy, where a psychiatrist provides both pharmacotherapy and psychotherapy, the researchers examined differences in the utilization patterns of depressed patients from a national managed mental HMO in the two treatment models. The results show that patients receiving integrated treatment not only used significantly fewer outpatient sessions, but also had lower treatment costs than those patients in split treatment. The researchers conclude that integrated treatment is not more costly than split treatment in a managed care network.

Keywords: costs, depression, HMOs, models, outcomes, psychotherapy, utilization

302. Goldman, W., McCulloch, J., & Sturm, R. (1998). Costs and use of mental health services before and after managed care. *Health Affairs*, 17(2), 40–52.

This paper highlights the successful implementation of a West Coast-based employer's mental health carve-out that achieved parity for mental health services without increasing costs. The authors track the costs of mental health care for a private employer during a period in which mental health benefits were carved out of the medical plan and managed care was introduced. Before the change, mental health costs had been increasing 30 percent annually; in the first year after the change, costs dropped by more than 40 percent while utilization of mental health services actually increased. The authors attribute the successful mental health carve-out experiment to increased efficiency resulting in reduced probability of an inpatient admission, reduced inpatient length-of-stay, and substantially lower costs per unit of service.

Keywords: carve-outs, costs, performance measurement, utilization

303. Hamilton, J. M. (1988). The role of peer review and quality assurance in changing reimbursement schemes. In D. J. Scherl, J. T. English, & S. S. Sharfstein (Eds.), *Prospective payment and psychiatric care* (pp. 129–138). Washington, DC: American Psychiatric Association.

This chapter describes the activities of the American Psychiatric Association (APA) in quality assurance, utilization review, and peer review. Medical review has progressed from retrospective to concurrent review. Together with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the APA developed a national peer review system for inpatient and outpatient psychiatric treatment. APA has also published several editions of its manual providing models for standards and criteria in peer review. The author provides an overview of the APA's joint venture with the insurance company Intracorp to provide quality assurance, utilization review, case management, and discharging.

Keywords: quality assurance, utilization management

304. Huskamp, H. A. (1998). How a managed behavioral health care carve-out plan affected spending for episodes of treatment. *Psychiatric Services*, 49(12), 1559–1562.

Many employers and States are carving out behavioral health services from their health plans in an effort to manage behavioral health costs. But are these efforts successful? This paper provides an in-depth exploration of the impact of carving out behavioral health care on spending for episodes of treatment. The researcher compared spending per episode before and after implementation of the carve-out for episodes of care provided in an inpatient facility, episodes involving both inpatient and outpatient care, and episodes involving only outpatient care. From the results, the implementation of the carve-out resulted in a large decrease in spending per episode across all three episode types, with inpatient care showing the greatest

reduction. Those episodes involving a diagnosis of either unipolar depression or substance dependence resulted in particularly large reductions, regardless of treatment type.

Keywords: carve-outs, costs, depression, substance abuse

305. Ingram, B. L., & Chung, R. S. (1997). Client satisfaction data and quality improvement planning in managed mental health care organizations, *Health Care Management Review, 22*(3), 40–52.

This article examines the principles of total quality management (TQM) used by health care administrators to increase the quality of care. The authors perform a Chi Square Automatic Interaction Detection (CHAID) statistical analysis of client satisfaction survey data from a large, national managed care organization to separate clients into two categories, the “maximally” and the “moderately” satisfied, and develop a predictive model of maximum satisfaction. The authors present a methodology for the analysis of client satisfaction surveys, and ultimately, suggest ways in which such surveys can be constructed to improve future analyses.

Keywords: client satisfaction, quality assurance

306. Kane, R. L., Bartlett, J., & Potthoff, S. (1995). Building on empirically based outcomes information system for managed mental health care. *Psychiatric Services, 46*(5), 459–461.

This article describes how one national managed mental health care corporation, in cooperation with the University of Minnesota, has begun to create a clinical management information system. The underlying principles of this system involved data collection at admission to create a baseline, and outcome data collection by telephone after departure. The authors view this system as reliable because it had continuous input from clinicians through its development. The key to the success of the system is its use in clinical practice for the analysis of sound data to support better and more effective clinical decision making.

Keywords: information systems

307. Lazarus, A. (1994). Dumping psychiatric patients in the managed care sector. *Hospital and Community Psychiatry, 45*, 529–530.

This article provides three examples of what the author describes as patient dumping from the medical sector into the managed psychiatric sector. In each of the cases, the patient was transferred to psychiatric facilities while he or she was still medically unstable; in two of the three cases, the transfer had not been authorized by the managed care company. The author cautions that such inappropriate transfers from medical to psychiatric settings may be a result of fragmented treatment brought on by lack of coordination between medical and psychiatric care, and that efforts to control costs through selective contracting, prospective payment, and carve-outs may exacerbate this trend.

Keywords: quality assurance

308. Leff, H. S., & Woocher, L. S. (1998). Trends in the evaluation of managed mental health care. *Harvard Review of Psychiatry*, 5(6), 344–347.

This article describes work currently under way to develop a tracking system for evaluation studies of public managed behavioral health care. The evaluation studies cited within the article fall into three broad categories: State-funded and initiated, federally funded and initiated, and investigator-initiated studies funded by foundations or Federal agencies. The authors analyze five studies, the majority of which compare managed care with fee-for-service systems in terms of service use and cost and consumer outcomes such as health status, symptoms, quality of life, and patient satisfaction.

Keywords: client satisfaction, costs, evaluation, outcomes, public sector, utilization

309. Leon, S. C., Lyons, J. S., Christopher, N. J., & Miller, S. I. (1998). Psychiatric hospital outcomes of dual diagnosis patients under managed care. *The American Journal on Addictions*, 7(1), 81–86.

Many studies have found that utilization patterns of patients with both mental illness and substance abuse diagnoses (the dually diagnosed) differ from non-substance-abusing patients. This study examines the impact of managed care on the inpatient psychiatric utilization of persons with dual diagnosis. Patients with coexisting substance abuse disorders spent fewer days in the hospital, but experienced higher rates of recidivism, than patients with psychiatric disorders only. Such results suggest that managed care has not had an impact on patterns of psychiatric hospital use by patients with coexisting substance abuse disorders. The authors discuss potential incentives for such utilization patterns for the dually diagnosed and stress the importance of focusing solutions on preventative programs.

Keywords: outcomes, utilization

310. McCarthy, P. R., Gelber, S., & Dugger, D. E. (1993). Outcome measurement to outcome management: The critical step. *Administration and Policy in Mental Health*, 21, 59–68.

Several strategies for measuring mental health outcomes have been developed, but few mechanisms have been designed to assess the quality of care for use in case management. The author describes a conceptual model to measure quality based on a model developed by Donabedian (1980) that evaluates structure, process, and outcome. A quality/improvement algorithm is described that can be used to assess quality in a single system or to compare systems. These data aid in management functions, such as establishing network standards against which individual providers can be compared in terms of both cost-effectiveness and quality. The authors argue that while implementing a quality-focused outcome is clearly more costly in the short term, it will lead to substantial benefits in the long run for the patient, the managed health provider, and the payer.

Keywords: case management, outcomes, performance measurement

311. Milstein, A., Henderson, M., Berlant, J. L., & Anderson, D. (1994). Evaluating psychiatric and substance abuse case management organizations. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 222–240). Springfield, IL: Charles C. Thomas.

In this chapter, the authors discuss two methods of evaluating mental health and chemical dependency case management organizations: (1) direct evaluation of case management operations, including interviews, observations, and examination of staff work sheets; and (2) evaluation of claims data. The authors offer specific steps that can be used to conduct the evaluations and discuss the rationale for using external evaluators.

Keywords: case management, performance measurement

312. Pallak, M. S., & Cummings, N. A. (1994). Outcomes research in managed behavioral health care: Issues, strategies, and trends. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 205–221). Springfield, IL: Charles C. Thomas.

The authors argue that three factors have led to the interest in clinical outcome research in the behavioral sciences. These are (1) the continuing rise in costs for alcohol/drug abuse and mental health services; (2) the perception within the managed care industry that knowledge about outcomes is valuable marketing information; and (3) the increasing availability of research tools and strategies regarding outcomes. In this chapter, they examine the implications of these factors. They explore the problems that managed care companies face when trying to develop procedures to address effectiveness and discuss new trends in treatment outcome measures.

Keywords: outcomes, trends

313. Pandiani, J. A., Banks, S., & Gauvin, L. (1997). A global measure of access to mental health services for a managed care environment. *The Journal of Mental Health Administration*, 24(3), 268–277.

This article proposes a quantitative measure of access to mental health services in a managed care environment. The measure, referred to as the access ratio, compares the number of people receiving mental health services to the number of people in need of mental health services in a population. The authors describe the methodology for deriving the measures of need and utilization, and then illustrate its use by measuring access to inpatient mental health care in the State of Vermont. The results of this study produced objective quantitative measures of access and identified pattern variations in access that can be used as comparative benchmarks for future work in this area. The authors conclude with a discussion of the role of the appropriate use of the access ratio, and other quantitative measures of system performance, in improving systems of care.

Keywords: performance measurement, public sector, Vermont

314. Pickett, S. A., Lyons, J. S., Polonus, T., Seymour, T., & Miller, S. I. (1995). Factors predicting patients' satisfaction with managed mental health care. *Psychiatric Services, 46*(7), 722–723.

In response to concerns about quality of care in managed mental health plans, this study examined patients' satisfaction with a managed mental health care program using a mail survey. The survey included questions measuring two types of variables: patients' perception of each element in a service delivery model and patients functioning after treatment. From the results, patients who reported better psychological functioning and who found the managed care staff to be helpful and their therapist skillful and conveniently located were more likely to be satisfied with their services. The authors conclude that managed mental health plans should train mental health professionals in effective service delivery, select providers that are convenient for the patient, and monitor the helpfulness of their staff.

Keywords: client satisfaction, performance measurement

315. Roberts, B. (1996). Quality as the driving force for cost-effective psychiatric managed care. *Journal for Healthcare Quality, 18*(1), 4–8.

This paper outlines the author's view of the "megatrends" of economics, politics, and technology influencing contemporary psychiatric treatment. The author compares psychiatric treatment between the conventional fee-for-service paradigm and the "new" managed care paradigm. According to the author, the "new" paradigm emphasizes identification and treatment of symptoms rather than the diagnosis of disease according to standard therapy. This article compares the two treatment paradigms through a hypothetical clinical case summary of a depressed individual. The author relates an account of the treatment schedule under both the fee-for-service paradigm and the "new" managed care paradigm in an attempt to show that the managed care paradigm provides more focused, cost-effective treatment for psychiatric services.

Keywords: outcomes

316. Roberts, B. (1998). An evolving continuous quality improvement role for managed care: A behavioral healthcare perspective. *Journal for Healthcare Quality, 20*(5), 20–23.

The author describes the evolution of continuous quality improvement (CQI) in managed behavioral health care. The author posits that the initial impact of managed care on health care was a result of the sentinel, or Hawthorne, effect. The sentinel effect refers to the impact on quality of knowing that outcomes will be monitored. The author proposes that the positive impact of the sentinel effect has ebbed and suggests new ways to continue the evolution. The author suggests the Clinical Navigator Model, in which the clinician is the "navigator" of each patient's treatment and this navigation can be improved if the clinician follows a few tasks: (1) Define the clinical destination via a clinical assessment with the patient, based on the desired end-result. (2) Develop the best clinical approach to get the desired end-result. (3) Decide on the most effective mode to get to the end result (i.e., the least restrictive, least

intrusive site of care). This model can be used to positively reinforce good outcomes and help continue the evolution of managed behavioral health care.

Keywords: models, outcomes, providers, quality assurance

317. Rodriguez, A. R. (1989). Evolutions in utilization and quality management: A crisis for psychiatric services? *General Hospital Psychiatry, 11*, 256–263.

Science, social policies, and government funding brought about high-quality mental health services from 1948 to the early 1980s, when payers began implementing strategies to reduce and control the costs of health care. These strategies include benefit redesign and structuring, alternative reimbursement methods, utilization review, and alternative delivery systems. The author contends that managed care programs must ensure quality as well as affordability. He argues that this combination will be difficult to achieve because there is little consensus as to what constitutes effective treatment.

Keywords: quality assurance

318. Rodriguez, A. R. (1992). Management of quality, utilization, and risk. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 83–97). Washington, DC: American Psychiatric Press.

In this chapter, the author discusses critical issues in medical quality management. He describes some of the epidemiological trends in the utilization of mental health services, and the mechanisms that have been instituted to control utilization. The mechanisms discussed include benefit redesign and structuring to provide economic disincentives to seek care, alternative reimbursement approaches such as prospective payment, alternative delivery systems, and utilization review and management. Finally, the author describes some of the major components of an effective risk management system. He concludes that more effective management information systems for health services are needed to avoid arbitrary and/or discriminatory apportionment systems.

Keywords: overviews, quality assurance

319. Rohrer, J. E., & Rohland, B. M. (1998). Oversight of managed care for behavioral health services. *Journal of Public Health Management Practice, 4*(1), 96–100.

This article is concerned with the need for payers to be able to set contract specifications for behavioral health services to help ensure that services are delivered in a way that is accessible, efficient, and effective. To that end, these authors propose staff-per-population ratios, service utilization rates, and outcome data as useful performance measures for monitoring the performance of managed care providers and for selecting vendors when new contracts are being planned. The authors review previous literature on quality and access indicators and then put

forth their own measures as a more practical set of tools. Finally, they emphasize the importance of consistent monitoring and further comparative research to refine indicators.

Keywords: contracting, performance measurement

320. Savitz, S. A. (1992). Measuring quality of care and quality maintenance. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 143–158). Washington, DC: American Psychiatric Press.

This chapter explores ways of defining, measuring, and improving the quality of care in a managed mental health care environment. The author describes the issues of cost versus quality; discusses methods of assessing quality of medical care, including standards for treatment, tracers, patient satisfaction, and claims review; and describes some problems associated with each. He addresses ways in which organizations can improve quality through problem identification, establishing standards, collecting data, remedial action, and monitoring and follow-up. The author concludes that managed care organizations have structural advantages for providing quality care compared with the independent nature of fee-for-service practice.

Keywords: overviews, quality assurance

321. Schoenbaum, M., Zhang, W., & Sturm, R. (1998). Costs and utilization of substance abuse care in a privately insured population under managed care. *Psychiatric Services, 49*(12), 1573–1578.

Even with the increasing trend toward carving out behavioral health services, there has been little research on the actual cost and utilization of substance abuse and mental health services. This paper examines 1995 cost and utilization patterns for substance abuse treatment for members of private managed care carve-out behavioral health plans. From their review of claims made in 1995 in 93 behavioral health care plans, the researchers found that approximately 5.2 percent of members used mental health services and 0.3 percent used substance abuse services. Average costs for substance abuse patients were more than twice as high as average costs for mental health patients. This disparity in costs reflected greater rates of use of inpatient and intensive outpatient services for substance abuse treatment. The authors conclude that substance abuse coverage accounts for a small portion of behavioral health coverage payments and an even smaller fraction of insurance payments for overall health care.

Keywords: carve-outs, costs, substance abuse, utilization

322. Scholle, S. H., Peele, P. B., Kelleher, K. J., Frank, E., & Kupfer, D. (1999). Satisfaction with managed care among persons with bipolar disorder. *Psychiatric Services, 50*(6), 751.

In this study, researchers surveyed members of a national voluntary case register of persons with bipolar disorder. To examine the impact of restrictions on care on patient satisfaction with care, they categorized respondents into four groups: self-referral to any mental health provider; self-referral to a restricted provider network; referral through another gatekeeper; and referral through a toll-free number. From the results, those respondents with restricted access

to provider networks (85 percent of respondents) were less satisfied with their health plans than those respondents with no restrictions (the first category). The authors conclude that systems of care need to track satisfaction over time, because dissatisfaction influences insurance disenrollment, adherence, fragmentation in care, and treatment rates.

Keywords: client satisfaction, depression

323. Sederer, L. I., & St. Clair, R. L. (1990). Quality assurance and managed mental health care. *Psychiatric Clinics of North America*, 13, 89–97.

This article discusses the ways in which quality of care for mental health services has traditionally been defined and is currently being modified. The authors describe a new direction in quality assurance, called continuous improvement in care, that moves away from quality “control,” with its reliance on surveillance, toward a vision of seeking defects as “treasures.” The authors describe many of the forms of managed care and some of the potential problems in reconciling quality, cost, access, and efficiency, and offer suggestions for what can be done.

Keywords: overviews, quality assurance

324. Shueman, S. A., & Troy, W. G. (1994). Quality assurance in managed systems. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 131–148). Springfield, IL: Charles C. Thomas.

The main focus of this chapter is on the design of quality assurance (QA) strategies for managed behavioral health care systems. The authors describe the characteristics that an adequate QA program should have. These include a system that reflects the perspectives of key stakeholders; that focuses on multiple aspects of clinical services, case management, and administration; and that uses subjective and objective data and multiple data sources to assess quality. The authors profess to take a relatively traditional QA approach, but one that examines the ways in which the applications of QA have been influenced by more recent approaches to quality, such as total quality management and continuous quality improvement.

Keywords: overviews, quality assurance

325. Shueman, S. A., Troy, W. G., & Mayhugh, S. L. (1994). In Mayhugh, S. L. (Ed.), *Managed behavioral health care: An industry perspective*. Springfield, IL: Charles C. Thomas.

This book is about, for, and by those in the forefront of the managed behavioral health care movement. Part I lays the groundwork by describing how the economic structure of health care in the 1970s and early 1980s was fertile ground on which to sow a managed care approach. Part II focuses on the roles and responsibilities of the provider in a managed care program. In one particularly useful chapter, the essentials of case management are presented as conducted by one specialized case management organization. Part III describes the history of Federal and State initiatives in managed health care, and part IV concentrates on the important topics of quality assurance and practice guidelines. Part V deals with educational issues. The

remainder of the book focuses on issues of interest to researchers and program evaluators in managed behavioral health with interesting chapters on the state of outcomes research, and a basic “how to” on evaluating behavioral case management organizations.

Keyword: overviews

326. Shusterman, A. (1994). Expanding the “Q” word. *Managed Care Quarterly*, 2, 19–21.

This article presents a broad, multidisciplinary definition of quality that moves beyond the therapeutic relationship between a clinician and a provider. In this article, quality includes accessibility, affordability, positive clinical outcomes, and patient satisfaction. The author argues that only through such a systemic approach to quality can mental health care take its rightful place in the sphere of necessary, affordable, universal health care.

Keywords: quality assurance

327. Smith, G. R. (1996). State of the science of mental health and substance abuse patient outcomes assessment. *New Directions for Mental Health Services*, 71, 59–67.

This article discusses three areas that summarize the current status of patient outcomes assessment. The first area concerns achievements in patient outcomes assessment. Providers, payers, and mental health clinicians are becoming proficient in the science of outcomes assessment. Recent advances in outcomes research have been concentrated in two areas: development of a consensus on outcome domains and development of patient-based assessment scales and indexes. The second area concerns issues of scientific debate. The author discusses five such issues that have implications for the design of outcomes assessment: disorder-specific assessment versus generic assessment; sampling versus assessment of an entire population; assessment of a tracer condition versus assessment of all disorders; brief assessments versus precise, multidimensional assessments; and assessment logistics: Which method is best? Finally, the author discusses the challenges that must be addressed in order to advance the science of outcomes assessment: understanding consumer preferences for a particular outcomes domain, interpretation and management of assessment results, and development of new assessment technology to enhance the feasibility of implementing outcomes assessment systems.

Keywords: outcomes, performance measurement

328. Smith, J., & Gaumer, G. L. (1992). Evaluation of managed mental health programs. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 165–200). Springfield, IL: Charles C. Thomas.

Evaluation can provide information that can ensure that managed care programs are effective and are not driven purely by untested assumptions held by providers, consumers, and employers. Assessing what happened, why, and the implications of these changes is difficult. The authors discuss some of the important issues in the evaluation of managed mental health programs and provide guidelines for evaluating programs' effects. To ensure that the

evaluation correctly attributes changes to the intervention, evaluators use methods such as randomization, comparison, and control groups. The authors emphasize the importance of descriptive and baseline data.

Keyword: evaluation

329. Stelovich, S. (1992). Managed care and major mental illness: An overview. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 249–260). Washington, DC: American Psychiatric Press.

A brief historical overview of mental health service delivery is used to illustrate the challenges in finding new ways to provide appropriate care. The author argues that the locus and potential treatment options for mental illness are extremely limited, and that to improve upon historical failures to provide quality mental health care, we need to reassess both the focus (biological, psychological, and social) and setting (spectrum of services) for mentally ill persons. He argues that alliances between managed care systems and private mental health care organizations may significantly increase the quality, number, and spectrum of services as alternatives to the hospital.

Keywords: overviews, quality assurance

330. Sturm, R., Jackson, C. A., Meredith, L. S., Yip, W., Manning, W. G., Rogers, W. H., & Wells, K. B. (1995). Mental health care utilization in prepaid and fee-for-service plans among depressed patients in medical outcomes study. *Health Services Research, 30*(2), 320–340.

This study examines the difference in utilization patterns among depressed patients between prepaid and fee-for-service health plans. In particular, the authors explore whether there is adverse selection among patients switching between the two types of insurance plans, what effect switching plans has on utilization of services, and whether utilization differences, switching, and provider specialty are related. From their longitudinal data on depressed patients participating in the Medical Outcomes Study, the researchers found that depressed patients in the prepaid system exhibited 35 to 40 percent fewer mental health visits than similar patients in the fee-for-service system. There was some evidence of adverse selection, with patients switching out of prepaid plans showing higher baseline utilization and patients switching out of fee-for-service plans showing lower utilization. While all patients who switched plans demonstrated a decline in utilization, there was no increase in utilization after the switch. The authors conclude that there is an interruption in care for patients switching between plans.

Keywords: depression, outcomes, utilization

331. Thompson, J. W., Burns, B. J., Goldman, H. H., & Smith, J. (1992). Initial level of care and clinical status in a managed mental health program. *Hospital and Community Psychiatry, 43*, 599–603.

This study uses indirect measures to examine the quality of care of a managed mental health care demonstration project, using data from 9,055 adult psychiatric intakes. The relationship

between clinical status and level of care was the indirect measure used to assess quality. The study found a 50 percent decrease in the use of inpatient care in all clinical conditions (mild to severe) under the managed care system. The study also found that the use of detoxification and outpatient services doubled. The diversion of patients to outpatient care was not related to condition but to a policy decision. The authors conclude that data must be case-oriented, rating scales must be systematized, and measures of treatment outcome are needed in order to better assess the quality of these programs.

Keywords: performance measurement, quality assurance, utilization

332. Wells, K. B., Astrachan, B. M., Tischler, G. L., & Unutzer, J. (1995). Issues and approaches in evaluating managed mental health care. *The Milbank Quarterly*, 73(1), 57–75.

The purpose of this article is to discuss methodological considerations involved in conducting research into the performance of managed care organizations (MCOs) with respect to access, quality, and outcomes. The article begins by defining and describing different types of MCOs and explaining some of their methods for achieving cost savings. These methods include pre-certification, the use of gatekeepers and case management strategies, provider selection, and clinical guidelines and protocols. With regard to the evaluation of mental health services delivered by MCOs, these authors discuss challenges and obstacles to research, such as issues of confidentiality, problems with data sources, and feasibility of developing and implementing more complex research protocols in the fast-paced and profit-driven environment of private MCOs. In describing approaches to managed care research, these authors address differences in priorities and obstacles for internal and external evaluation studies, and for studies that facilitate industry purposes versus studies that are of interest from a societal perspective. Sample data from a variety of evaluation studies are presented to illustrate the discussion.

Keywords: evaluation, performance measurement

333. Westermeyer, J. (1991). Problems with managed psychiatric care without a psychiatrist-manager. *Hospital and Community Psychiatry*, 42, 1221–1224.

The author uses seven case studies to illustrate that managed psychiatric care in which a nonpsychiatrist directs care can harm patients with severe psychiatric illness. In a review of these cases, the author found indication of the following problems: infrequent and inconsistent psychotherapy, failure to recommend standard therapies, poor recordkeeping, and inappropriate use and monitoring of hospitalization and medications. He suggests ways in which higher quality mental health care can be administered within a managed context. These include more consistent monitoring of quality of outpatient care, use of fourth-party audit organizations, and increased use of peer review.

Keywords: quality assurance

XIII. Special Populations

A. CHILDREN

334. Eisen, S., Griffin, M., Sederer, L., Dickey, B., & Mirin, S. M. (1995). The impact of preadmission approval and continued stay review on hospital stay and outcome among children and adolescents. *The Journal of Mental Health Administration* 22(3), 270–277.

This article reports on results of a study that used a multiple regression model to predict the impact of utilization review on length of inpatient stay and clinical outcomes for children and adolescents under 18 years of age. The independent variables used in the model included demographic and clinical characteristics, hospital ownership type, and pre-admission approval or continued stay review. Results of the study indicated that only two of the 10 predictor variables included in the model were statistically significant in predicting length of stay: previous psychiatric hospitalization and for-profit hospital status. The model was unsuccessful in accounting for a significant amount of the variance in hospital outcome. The authors conclude with a discussion of limitations of the study, and the implications of the findings for health care reform.

Keywords: children, outcomes, utilization management

335. Gresenz, C. R., Liu, X., & Sturm, R. (1998). Managed behavioral health services for children under carve-out contracts. *Psychiatric Services*, 49(8), 1054–1058.

Amidst the recent growth in managed care organizations that specialize in administering behavioral health care benefits apart from general health services, few studies have focused on the effects of these new carve-out plans on children. In this study, researchers investigated children's cost and utilization patterns in carve-out plans and compared them with the patterns of adults in these plans. From the results, adolescents in this plan were twice as likely as adults and about seven times as likely as children ages 6 to 12 to use inpatient services. Adolescents were also more likely than adults or other children to have higher inpatient costs, while adults were the most likely to have higher outpatient costs. The authors conclude that adolescents may benefit most from the elimination of caps on mental health care costs covered by insurance.

Keywords: carve-outs, children, costs, utilization

336. Kaplan, D. W., Calonge, B. N., Guernsey, B. P., & Hanrahan, M. B. (1998). Managed care and school-based health centers. *Archives of Pediatric and Adolescent Medicine* 145, 25–33.

This article examines the use of physical and mental health services for adolescents who participate in managed care organizations, comparing those who have access to school-based health centers (SBHCs) to those who do not. The study specifically looked at the use of primary and specialty medical, mental health, substance abuse, preventative health, and urgent care services. Results showed that adolescents with access to SBHCs were 10 times more likely to make a mental health or substance abuse visit than non-SBHC students. Students with access to SBHCs made one more medical visit per year, had decreased rates of use of emergency or urgent care, were more likely to have one comprehensive health supervision visit, and were more likely to be screened for high-risk behaviors than students without access to SBHCs. SBHCs were shown to be very successful in improving access to treatment for mental health and substance abuse problems and to comprehensive health supervision.

Keywords: children, school-based health, substance abuse, utilization

337. Jellinek, M., & Little, M. (1998). Supporting child psychiatric services using current managed care approaches. *Archives of Pediatric and Adolescent Medicine*, 152(4), 321–326.

This report details specific business approaches used by for-profit behavioral health care companies that have carved out mental health services for children. First, the authors discuss the evolution of managed mental health services and the negative implications of managing the care of children by limiting access and shifting costs to the public sector and pediatricians. These factors are not sufficiently counterbalanced by some of the positive changes, such as lower costs from the decreased utilization of inpatient services within managed care, and political pressure by legislative means. Ultimately, the commentary recommends that child and adolescent psychiatric services should be reintegrated into the overall medical care of children and families, and that market-driven managed care allocations are not the optimal path to achieve high-quality mental health services for the Nation's most vulnerable children.

Keywords: carve-outs, children

338. Lourie, I. S., Howe, S. W., & Roebuck, L. L. (1996). *Systematic approaches to mental health care in the private sector for children, adolescents, and their families: Managed care organizations and service providers*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Child Mental Health.

In this study of private sector models for delivering mental health services to children, adolescents, and their families, researchers examined five provider sites—two managed care organizations and three service provider agencies—all of which offer their own managed care products. Among the findings are the lack of a true system of care in the private sector including mechanisms for access to services, case management/coordination at the client level, coordination across agencies, and mechanisms for financing services; the positive potential for managed

care; and the growing private sector continuum of care. The book provides in-depth analysis of managed care organizations, service providers, and public/private integration issues. Appendices include site visit reports, values and principles for the System of Care outlined by the Federal Child and Adolescent Service System Program, a list of advisers, a list of qualified nominated organizations, and the private system of care questionnaire.

Keywords: children, evaluation, integration, models

339. Mason, M. J. (1998). School-based health clinics and the role of mental health services: A review of the literature. *Journal of Health and Social Policy, 10(2)*, 1–13.

This article begins by establishing the heightening national concern about targeting mental health and substance abuse problems in children, and points to goals cited in the Healthy People 2000 initiative. It describes the origins and growth of the school-based health center (SBHC) as a model of service delivery that effectively broadens access to health services in general for children and adolescents. According to the author, SBHCs play an important role in delivering counseling, assessment, and referral services for mental health and substance abuse problems. A variety of issues affecting the proliferation of SBHCs are discussed, including the need to build in systematic research protocols that would aid in accounting for the cost-effectiveness of services delivered in these facilities. Some other issues addressed are current and potential future sources of funding for SBHCs, the need for attention to public relations concerns, and the impact of managed care on SBHCs. Managed care organizations (MCOs) have traditionally been reluctant to contract with SBHCs because of the difficulty they have in meeting practice guidelines of the MCOs. The article calls for research initiatives to prove the importance and effectiveness of SBHCs in delivering mental health services to youth.

Keywords: children, overviews, school-based health, substance abuse

340. Nicholson, J., Young, S. D., Simon, L., Bateman, A., & Fisher, W. H. (1996). Impact of Medicaid managed care on child and adolescent emergency mental health screening in Massachusetts. *Psychiatric Services, 47(12)*, 1344–1350.

This article reports on an initial evaluation of the impact of the Massachusetts Medicaid managed mental health reform on service use and dispositions for children and youth through an examination of the emergency mental health screening process. The study compared client attributes and system characteristics (payer, referral source, and disposition) for emergency mental health screenings for the year before and the first year after implementation of Medicaid managed care. The study found that after the implementation of managed Medicaid mental health and substance abuse benefits, the volume of emergency mental health screening for children and adolescence significantly increased, while the percentage of inpatient admissions decreased. The authors further discuss these findings and the necessity to address issues of quality of care and longer term savings.

Keywords: carve-outs, children, evaluation, Massachusetts, Medicaid, public sector

341. Nicholson, J., Young, S. D., Simon, L. J., Fisher, W. H., & Bateman, A. (1998). Privatized Medicaid managed care in Massachusetts: Disposition in child and adolescent mental health emergencies. *The Journal of Behavioral Health Services and Research, 25*(3), 279–292.

Against the backdrop of Massachusetts's transition to Medicaid managed care, this study investigates two questions: the impact of privatized Medicaid managed care on the level of care provided to children and adolescents with the greatest clinical need, and the relationship between payer source and disposition. To answer these questions, the researchers examined data from child and adolescent emergency mental health screening episodes before and after privatized Medicaid managed care. They found that the transition to Medicaid managed care decreases the likelihood of hospitalization by more than 60 percent for individuals covered by Medicaid compared with those covered by HMOs. Additionally, privatized Medicaid managed care does not seem to compromise quality of care, as measured by matching clinical need with level of care. The authors describe the multiple forces shaping professional standards, decision making, and quality of care as well as implications for behavioral health policymakers.

Keywords: carve-outs, children, evaluation, Massachusetts, Medicaid, utilization

342. Pumariega, A. J., Nace, D., England, M. J., Diamond, J., Fallong, T., Hanson, G., Lourie, I., Marx, L., Solnit, A., Grimes, C., Thurber, D., & Graham, M. (1997). Community-based systems approach to children's managed mental health services. *Journal of Child and Family Studies, 6*(2), 149–164.

As managed care principles infiltrate into the children's mental health service delivery system, there is concern that they could deprive children of necessary intervention and prevention services. In this paper, the authors review guidelines developed by the American Academy of Child and Adolescent Psychiatry for the implementation of managed Medicaid contracts through community-based systems of care principles. The authors describe the development and principles of the community-based systems approach as a means to ensure that the needs of seriously emotionally disturbed children are met within the health system. The key principles of the system of care approach include access to a comprehensive array of services, individualized treatment, treatment in the least restrictive environment possible, full participation of families, interagency coordination, early identification and intervention, care management, advocacy efforts, effective transition into the adult system, and culturally sensitive services. The authors also examine the community-based systems approach to managed care, including guidelines on governance, benefit design, access to care, assessment, care plan development, treatment services, care management, quality, provider supports, and information management.

Keywords: children, contracting, Medicaid, overviews

343. Scholle, S. H., Kelleher, K. J., Childs, G., Mendeloff, J., & Gardner, W. P. (1997). Changes in Medicaid managed care enrollment among children. *Health Affairs, 16*(2), 164–170.

This study looks at voluntary enrollment and disenrollment data for Medicaid managed care in Allegheny County, PA, paying particular attention to patterns among children with mental illness. Self-selection patterns for managed care versus fee-for-service are significant because patients who voluntarily choose managed care are generally in better health and have lower utilization of health care services. This phenomenon can distort data about managed care performance, consumer satisfaction, cost savings, and other factors, and may benefit plans financially if capitation payments are not risk-adjusted. These authors are particularly concerned with patients with mental illness, because managed care plans have traditionally provided a low level of mental health services. Results of this study indicate that markers for more severe mental illness were associated with lower levels of enrollment in managed care. In addition, disabled children and those receiving cash assistance were less likely to enroll. Disenrollments were higher for children with psychiatric conditions than for children with other conditions. The authors discuss causes of these trends and make policy recommendations.

Keywords: children, Medicaid, Pennsylvania, public sector

344. Semlitz, L. (1996). Adolescent substance abuse treatment and managed care. *Child and Adolescent Psychiatric Clinics of North America, 5*(1), 221–241.

This paper examines the impact of managed care on adolescent substance abuse treatment planning and care delivery. The author describes the emergence of the managed care era from the traditional fee-for-service system, including the types of managed care plans; the impact on the doctor-patient relationship; responses of insurance companies/HMOs, hospitals, and physicians to managed care; the idea of managed competition; and the trend toward capitation. Other components of managed care reviewed include patient placement criteria, patient treatment matching, outcome as a factor in treatment planning, treatment plan documentation, successful treatment plans, and utilization review. The author examines the impact of managed care on substance abuse services and discusses ethical issues of managed care on the doctor-patient relationship, such as the importance of patient confidentiality, standards of review, and the prohibition of incentives to withhold care.

Keywords: children, substance abuse

345. Stroul, B. A., Pires, S. A., & Armstrong, M. I. (1998). *Health care reform tracking project: Tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families*. Tampa, FL: University of South Florida Research and Training Center for Children's Mental Health.

This is a report on calendar year 1997 of a 5-year project designed to track and analyze public sector managed care reform targeting children and adolescents with emotional and substance abuse problems and their families. The authors outline the specific goals of this report as

describing the managed care reforms that affect behavioral health care for children and adolescents, analyzing the effects of these changes, and identifying both problem areas and effective strategies to help refine managed care systems for this vulnerable population. This report surveys all of the States on a broad range of managed care topics, and then analyzes the impact through examples from in-depth site visits to a select sample of States. The tracking project finds that there is a wide variation in the extent to which States assume an active role in designing and overseeing managed care systems for this population.

Keywords: children, overviews, public sector, substance abuse

B. ELDERLY

346. Colenda, C. C., Banazak, D., & Mickus, M. (1998). Mental health services in managed care: Quality questions remain. *Geriatrics*, *53*(8), 49–63.

This article is intended to be useful to primary care health professionals who may be called upon to counsel their patients about decisions on whether to enroll in a Medicare managed care plan. The authors are particularly concerned that patients be well informed about the nature of mental health services delivered by these plans. In this article the authors profile Medicare risk contract plans, identify pros and cons, define and explain the difference between “carve-outs” and “carve-ins,” and explain what patients should expect from a plan’s staffing model with regard to adequate numbers of mental health providers. Finally, the article discusses potential advantages and disadvantages of managed care plans specific to the prevention and treatment of Alzheimer’s disease.

Keywords: elderly, HMOs, overviews

347. Robinson, G. K., Crow, S. E., & Scallet, L. J. (1998). Managed care policy: Meeting the mental health needs of the aged? *Generations*, *22*(2), 58–62.

With many States moving to managed care in an effort to control public health care costs, the question arises of how managed care will affect mental health care for the elderly. This paper explores the approaches States are taking to manage public mental health services. In particular, the researchers focus on the advantages and disadvantages of integrated and carved-out mental health services as well as the different types of reimbursement. They describe one example of a program enrolling people eligible for both Medicaid and Medicare as a potential model for other programs for mental health care for the elderly. Finally, the authors present some policy questions concerning the methods and feasibility of managed mental health plans for the elderly.

Keywords: elderly, overviews, public sector

C. ETHNIC GROUPS

348. Dana, R. H. (1998). Problems with managed mental health care for multicultural populations, *Psychological Reports*, 83, 283–294.

This article suggests that current psychological treatment is inadequate in its consideration and treatment of multicultural populations. It explains that historically, interventions in the United States were designed primarily for Americans of European descent, and thus were oriented toward Caucasian patients. The author argues that managed care has reduced the availability and quality of these interventions for all patients and further limited the evolution and diversification of treatment toward nonwhite patients. Culturally competent mental health services are described and related to the quality of care. An agenda for the implementation of culturally sensitive services is suggested.

Keywords: ethnic groups

349. Snowden, L. R. (1998). Managed care and ethnic minority populations. *Administration and Policy in Mental Health*, 25(6), 581–592.

This article addresses the impact on minority populations of changes in mental health practice patterns and utilization resulting from managed care. Differences in utilization of the mental health system across racial/ethnic groups and problems with the cultural appropriateness or accessibility of mental health services preceded the advent of managed care growth. Nonetheless, these problems take a new form within the context of managed care. While oversight, coordination, and accountability may be beneficial aspects of managed care for minorities, other aspects can be detrimental. The inflexibility of when and where services can be accessed and the potentially intimidating and confusing nature of the bureaucracy are potential problem areas. Additionally, the average cost of care per patient differs across ethnic groups, meaning that a reimbursement strategy based on capitation may create incentives to under-treat these clients or avoid covering them altogether. Further areas of concern are addressed, and some policy solutions are proposed.

Keywords: capitation, ethnic groups, overviews

D. WOMEN

350. Glied, S. (1997). The treatment of women with mental health disorders under HMO and fee-for-service insurance. *Women & Health*, 26(2), 1–16.

This report analyzes data on office visits by women with mental health problems from 1990 to 1994 to examine characteristics of office visits by payment type. The study finds that the expansion of managed care practices may harm the treatment of women with mental health problems. Specifically, women enrolled in HMOs are more likely to see a primary care physician rather than a specialist, and of the women in specialty care, those in HMOs are more

likely to have medications substituted for psychotherapy than are those with fee-for-service payments. The author suggests that a possible solution might be to allow self-referral for women to lower cost specialty care.

Keywords: HMOs, women

351. Huskamp, H. A., Azzone, V., & Frank, R. G. (1998). Carve-outs, women, and the treatment of depression. *Women's Health Issues, 8*(5), 267–282.

This article examines the impact of “carving out” mental health services on the treatment of depression in women. The first part of the article provides background information on behavioral health care carve-outs, describing the market functions of the two general forms of carve-outs, the health plan subcontract, and the payer carve-out. The authors provide an overview of women and depression and suggest some possible effects of carve-outs on the treatment of depression in women. The authors then report on their analyses of three separate employer-based data sets, which allowed them to examine the impact of behavioral health carve-outs on service utilization and spending for women with a diagnosis of depression. The first data set was used to examine a cross section of health plans. The other data sets were used to look at pre-/post-comparison of a health plan subcontract model and an employer carve-out model.

Keywords: carve-outs, costs, depression, utilization, women

352. Newell, A. R., & Saltzman, G. M. (1997). The impact of managed mental health care on women. *Journal of the American Medical Women's Association, 52*(2), 69–74.

Based upon differences in epidemiological patterns of mental illness in men and women, aspects of psychodynamic theory, and evidence from outcome and cost studies, these authors suggest that managed behavioral health care will have a differential impact on the receipt of mental health care by women. Women are more likely to seek mental health services, to be diagnosed with conditions that require care exclusively through the health care system, and to have conditions such as eating disorders or trauma from abuse that require long-term treatment. Various restrictions and cost-saving strategies involved in managed care strategies will therefore disproportionately affect women. This article argues that certain managed care cost-saving strategies do not make sense in light of evidence from cost-benefit studies of mental health services. Instead, the authors argue for more focused and appropriate managed care interventions, innovation in treatment methods, and legislation for minimum standards.

Keywords: overviews, women

XIV. Substance Abuse

353. Alexander, J. A., & Lemak, C. H. (1997). The effects of managed care on administrative burden in outpatient substance abuse treatment facilities. *Medical Care, 35*(10), 1060–1068.

This article describes a study of the burden (in hours per week and per client) of administrative functions related to managed care on outpatient substance abuse treatment facilities. The authors focus in particular on the effects of four dimensions: managed care oversight procedures, organizational experience with managed care (length of time), managed care penetration, and complexity of managed care arrangements. The sample was drawn from the 1994 to 1995 National Frame of Substance Abuse Treatment Programs and prior waves of the National Drug Abuse Treatment System Survey. A telephone survey was conducted of the facilities' administrative and clinical directors. The authors' findings support their hypothesis that administrative requirements imposed by managed care create a significantly increased burden on these facilities. They find that managed care penetration and managed care oversight procedures are most strongly associated with this increased burden.

Keywords: community providers, substance abuse

354. Alexander, J. A., & Lemak, C. H. (1997). Managed care penetration in outpatient substance abuse treatment units. *Medical Care Research and Review, 54*(4), 490–507.

This article reports the first national data on the impact of managed care at the provider level. The study used data from a 1995 national survey of 618 outpatient substance abuse treatment (OSAT) units. The sample was categorized by treatment modality, ownership status, and organizational affiliation. The study investigated the level of managed care penetration into OSAT units and found that they were not affected by managed care. However, for-profit OSAT units were more involved in managed care than public and private not-for-profit units. OSAT units involved with managed care utilized multiple arrangements and on average are involved with eight separate managed care arrangements that conform to a series of different and even competing requirements. Hospital-affiliated OSAT units are more likely to have multiple managed care arrangements. The study indicates that OSAT units are participating in very few public managed care arrangements, whereas private managed care arrangements occur at a greater frequency and with a constant distribution across types of arrangements.

Keywords: community providers, substance abuse

355. Caplan, R. (1992). Treatment of drug abuse in the managed care setting. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 305–320). Washington, DC: American Psychiatric Press.

In this chapter, the author demonstrates how the philosophy of managed care can be well integrated with a clinically sound approach to drug treatment. He outlines the specific elements that make managed care different from other settings, and describes a treatment model developed for a staff model HMO. In this model, major clinical decisions are made using a clinical algorithm. He explains how a managed care system can handle the four major phases of drug treatment—evaluation, stabilization, relapse prevention, and maintenance—and addresses additional issues of contracting for services, staffing, the role of the case manager, and employer groups. Alternative approaches to dealing with the small but difficult group who experience chronic relapse are presented.

Keywords: models, substance abuse

356. French, M. T., Dunlap, L. J., Galinis, D. N., Rachai, J. V., & Zarkin, G. A. (1996) Health care reforms and managed care for substance abuse services: Findings from eleven case studies. *Journal of Public Health Policy, 17*(2), 181–203.

This paper presents data from case studies of 11 drug treatment programs, on their current funding and level of cost, as well as their perceptions about the current or forthcoming impact of behavioral managed care on their delivery of services. The programs included in the study cover a broad geographic, programmatic, and organizational range. They include public and private facilities, inpatient and outpatient models, and a variety of modalities of care. The authors used two instruments developed by the Research Triangle Institute—the Drug Abuse Treatment Cost Analysis Program (DATCAP) and the Drug Abuse Treatment Financing Analysis Program (DATFin)—to gather data on cost and financing of the facilities. Perceptions of the impact of managed care varied among the programs depending on the type of site. For example, many of the residential treatment facilities expressed concern that case management strategies would result in more patients being referred to outpatient modalities, even though they may not be the ideal treatment type for some patients, simply because they offer lower intensity and lower cost care.

Keywords: costs, evaluation, substance abuse

357. Gondolf, E., Coleman, K., & Roman, S. (1996). Clinical-based vs. insurance-based recommendations for substance abuse treatment level. *Substance Use & Misuse, 31*(9), 1101–1116.

This article reports on an exploratory study created to determine the extent of the disagreement between clinical-based and insurance-based recommendations for level of care in substance abuse treatment. The study included 250 patients from three treatment facilities in the Western Pennsylvania region, and compared treatment recommendations based on criteria developed by the American Society of Addiction Medicine (ASAM) to those based on criteria

developed by managed care organizations. The study showed that 85 percent of the insurance-based and clinical-based recommendations for treatment level were in agreement and that 93 percent of the cases coincided with ASAM recommendations for care. These findings suggested that even when there was disagreement in treatment, clinical-based recommendations were most likely to be followed.

Keywords: standards of care, substance abuse

358. Gragg, D. M. (1991). Managed health care systems: Chemical dependency treatment. In C. S. Austad & W. H. Berman (Eds.), *Psychotherapy in managed health care: The optimal use of time and resources* (1st ed., pp. 202–219). Washington, DC: American Psychological Association.

This chapter describes the Chemical Dependency Recovery program at Kaiser Permanente Medical Center in Los Angeles. The author discusses treatment philosophy, guidelines, program design and development, general principles of addictions treatment, psychotherapeutic goals and issues, and specific influences of managed health care on treatment programs such as this one. He describes key elements in an evaluation of this and similar programs to ensure quality of care, and a philosophy of critical “self-study” among staff of an addictions treatment program.

Keywords: substance abuse

359. Kushner, J. N., & Moss, S. (1995). *Purchasing managed care services for alcohol and other drug treatment: Essential elements and policy issues: Vol. 16. Technical assistance publication series*. Rockville, MD: Center for Substance Abuse Treatment.

As States consider or move forward with the decision to redirect public funds for the treatment of substance abuse to private managed care organizations (MCOs), they face certain opportunities and challenges. This document serves as a brief technical assistance manual for State AOD (alcohol and other drug) agencies. Chapter 1 provides an overview of current State managed care arrangements and urges States to use their contracts with MCOs as a means of enforcing standards of treatment. Chapter 2 discusses access issues that emerge under managed care, ranging from geographic accessibility of services to the cultural, ethnic, and gender sensitivities of providers. Chapter 3 discusses the importance of ensuring the provision of wrap-around services, targeted outreach to special populations, and inclusion of publicly funded programs/essential community providers, especially because private managed care companies may be inexperienced in the treatment of populations receiving publicly funded AOD treatment services. Chapter 4 discusses financial considerations that should be taken into account—risk management strategies, potential benefits restrictions, the elimination of opportunities for cost-shifting the burden of uncompensated care, and the importance of understanding and being able to challenge actuarial analysis. Chapter 5 addresses key consumer protections such as out-of-plan services, disenrollment processes, “consumer-friendly” materials, and appeals. This document also provides examples of model contract language for the establishment of stan-

dards, as well as a Managed Healthcare Organizational Readiness Checklist—a resource designed to help States take into account the broad spectrum of policy issues that enter into effectively contracting for services through the private managed care market.

Keywords: contracting, public sector, substance abuse, technical assistance

360. McNeese-Smith, D. K. (1998). Program directors' views of the effect of managed care on substance abuse programs in Los Angeles County. *Psychiatric Services, 49*(10), 1323–1329.

Fifty program directors, representing 134 substance abuse treatment centers in Los Angeles County, responded to a survey in early 1997 soliciting their views about the impact of managed care on their facilities. The primary topics of the survey were changes in the programs since 1994 resulting from managed care, major concerns about the influence of managed care on substance abuse programs, advantages and disadvantages of managed care, and anticipated future changes to promote success in the managed care environment. Responses indicated that outreach and marketing had increased while length of treatment and staffing levels had decreased. There were concerns that incentives to provide the least costly service posed a threat to quality. Advantages described were an increasing focus on outcomes, the opportunity to contract with managed care providers, and the establishment of consistent program standards. Disadvantages named were contractual restrictions on services, increasing paperwork, restrictions on length of treatment, and decreasing quality. Directors described a wide array of anticipated future changes including changes in structure, type of program, sources of referral, staff composition, revenue generation, and increased focus on prevention.

Keywords: community providers, substance abuse

361. Rawson, R. A., Obert, J. L., McCann, M. J., Marinelli-Casey, P., & Suti, E. (1991). Outpatient chemical dependency treatment and the managed care system: An unrealized symbiosis. *Journal of Ambulatory Care Management, 14*, 48–59.

This paper traces the rise of outpatient treatment models for chemical dependency as it relates to the managed care movement. The authors draw on their own clinical experience to argue that there are serious problems in the coordination of outpatient drug and alcohol abuse programs by the managed care industry. They point to poor communication with providers, technical “sloppiness,” and idiosyncratic, unscientific treatment programs as just some of the pitfalls of managed chemical dependency services. Suggestions are offered for how managed care organizations and chemical dependency treatment providers can work together.

Keywords: models, substance abuse

362. Renz, E. A., Chung, R., Fillman, O., Mee-Lee, D., & Sayama, M. (1995). The effect of managed care on the treatment outcome of substance use disorders. *General Hospital Psychiatry, 17*, 287–292.

This article examines the effect of managed care and other reimbursement mechanisms on the outcome of substance abuse treatment at a single treatment facility. Data were collected from

1,594 patient records at the Castle Medical Center of Hawaii. Patients in the study were adults admitted for treatment of substance use disorders. The study looked at the incidence of recidivism in each patient over a 2-year period. The sample was divided into four groups: intensive managed care, traditional managed care, private pay, and State-funded. The study concluded that managed care patients are not more likely to return to treatment because of truncated treatment episodes. Also, no difference was found between managed and nonmanaged patient populations on relapse rates. The authors discuss the need for future research to include other outcome measures besides recidivism rate.

Keywords: outcomes, performance measurement, substance abuse

363. Schneider, R. J., & Herbert, M. (1992). Substance abuse day treatment and managed health care. *Journal of Mental Health Administration, 19*, 119–124.

For a variety of reasons, not the least being availability of reimbursement, inpatient care has been viewed as the treatment of choice for substance abuse over the past three decades. However, with the rise of managed health care, prospects for greater acceptance of day treatment programs have improved. This article describes the day treatment program at the Harvard Community Health Plan, a 2-week program that uses a variety of approaches including group work, family meetings, and individual treatment sessions. The authors discuss ways of marketing day treatment and overcoming patient resistance to day treatment.

Keywords: substance abuse

364. Shwartz, M., Mulvey, K. P., Woods, D., Brannigan, P., & Plough, A. (1997). Length of stay as an outcome in an era of managed care. *Journal of Substance Abuse Treatment, 14*(1), 11–18.

With their emphasis on cost reduction, managed care systems reimburse only for “appropriate” lengths of stay. Yet there is no research base for determining what is an appropriate length of stay for a client in substance abuse treatment, and previous studies have found lengths of stay to be important predictors of client outcomes. In this paper, the authors identify length of stay categories within four treatment modalities such that program completion rates are consistent within category and differ among categories. The four treatment modalities are short-term residential, long-term residential, outpatient, and detox. The authors demonstrate that future utilization over a 2-year period differs between categories, with those clients in short-length-of-stay categories being admitted more frequently and spending more days in treatment over the followup period than the long-length-of-stay clients. The researchers conclude that length of stay is an easily measured proxy for treatment success and should be considered by managed care companies in constructing length-of-stay cutoffs.

Keywords: outcomes, performance measurement, substance abuse

365. Sturm, R., Zhang, W., & Schoenbaum, M. (1999). How expensive are unlimited substance abuse benefits under managed care? *The Journal of Behavioral Health Services and Research*, 26(2), 203–210.

With the Federal Mental Health Parity of 1996, legislators prohibited dollar limits on mental health benefits, but not on substance abuse benefits because of the high cost associated with substance abuse treatment. In response, many employers have begun to decouple the two types of services in their behavioral health contracts, which could lead to less efficient care and difficulties in coordinating treatment. In this paper, the researchers examine how many patients are affected by substance abuse coverage limits and the implications of limits on insurance payments. They find that removing an annual limit of \$10,000 per year on substance abuse treatment would increase insurance payments by only 6 cents per member per year while affecting a large percentage of patients needing the care. The authors conclude that “parity” for substance abuse in employer-sponsored health plans is not very costly.

Keywords: parity, substance abuse

366. Wilson, C. V. (1993). Substance abuse and managed care. *New Directions for Mental Health Services*, 59, 99–105.

This chapter discusses the problems that exist in the coverage of substance abuse. Dissatisfied with high costs and ineffective treatment for substance abuse, employers are turning to managed care. A case example illustrates the benefits of this approach. The author suggests that case managers and payers use a standardized intake, assessment, and outcome method developed by the American Society of Addiction Management in order to address concerns about cost and quality.

Keywords: substance abuse

367. Woodward, A. (1992). Managed care and case management of substance abuse treatment. In R. S. Ashery (Ed.), *Progress and issues in case management* (DHHS Publication number ADM 92-1946). Rockville, MD: National Institute on Drug Abuse.

This monograph discusses the relevance of managed care to case management of substance abuse programs. The author argues that the goals of the two are contradictory; whereas the focus of case management is on providing comprehensive, coordinated care, managed care is concerned primarily with cost-effectiveness. Yet despite the differences in their goals, both case management and managed care have similar shortcomings. Among these are lack of criteria in assessment, referral, intervention activities, and followup as well as lack of documented cost-effectiveness.

Keywords: case management, substance abuse

368. Zwick, W. R., & Bermon, M. (1992). Spectrum of services for the alcohol abusing patient. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (1st ed., pp. 273–304). Washington, DC: American Psychiatric Press.

This chapter discusses the elements of a successful program for alcohol-abusing patients in a managed care environment. The authors outline four assumptions that they believe should guide the design of a cost-effective managed program for the treatment of alcohol abuse and dependence. They discuss cost, staffing issues (type of staff and staffing ratios), and marketing of alcohol treatment services (to primary care providers, mental health providers, and the corporate community). They also describe integration of substance abuse in general mental health through education and suggest ways of overcoming some of the traditional conflicts between alcohol specialists and other mental health providers. Finally, they outline priorities and program qualities of an exemplary alcohol abuse program and describe the ideal spectrum of services that should be offered. Issues regarding referral to appropriate level of care are also described in detail.

Keywords: models, staffing, substance abuse

XV. Training and Education

369. Austad, C. S., & Berman, W. H. (Eds.). (1991). *Psychotherapy in managed health care: The optimal use of time and resources* (1st ed.). Washington, DC: American Psychological Association.

This edited text brings together many prominent contributors who attempt to outline specific models for the provision of mental health services in a managed care setting. Both practitioners and administrators should find this book useful. Part I reviews the evolution of psychotherapy in managed health care and gives the reader a broad overview of the historical and economic context of managed mental health. Part II presents several theoretical models for the practice of mental health in the managed care setting. Part III provides guidelines for working with specific populations and disorders, with an emphasis on how a managed care approach can enhance care for many patients. The final section addresses future trends in practice, training, and research in managed mental health.

Keywords: models, psychotherapy, training, trends

370. Austad, C. S., & Hoyt, M. F. (1992). The managed care movement and the future of psychotherapy. *Psychotherapy, 29*, 109–118.

This article describes the ways that the practice of psychotherapy is being changed by the economic climate of managed health care. The authors describe several models of psychotherapy that have emerged from a managed care approach that require providers to be clinically effective as well as cost-effective. These include a goal-directed, problem-solving orientation, with a focus on efficient use of time, and crisis-oriented intermittent psychotherapy through the life cycle and single-session approaches. The authors argue that while the trend toward requiring accountability in the provision of mental health care is understandably controversial, placing the burden of proof on providers will potentially lead to higher quality mental health care.

Keyword: models, psychotherapy

371. Blackwell, B., & Schmidt, G. L. (1992). The educational implications of managed mental health care. *Hospital and Community Psychiatry, 43*, 962–964.

This article discusses the clinical, professional, ethical, and organizational aspects of training mental health practitioners in an HMO setting. The authors also describe the educational opportunities unique to such a setting. They argue that mental health trainees should develop

skills such as providing short-term treatment, collaborating with other professionals, and ensuring that treatment is “medically necessary” and ethical. To support such learning, HMOs are urged to develop curricula and provide financial support for educational activities for faculty and trainees. Such support can result in increased recruitment and retention of qualified mental health staff.

Keywords: HMOs, training

372. Browning, C. H., & Browning, B. J. (1993). *How to partner with managed care: A “do-it-yourself-kit” for building working relationships and getting steady referrals*. (1st ed.). Los Alamitos: Duncliff’s International.

This book is directed toward clinicians who need assistance in overcoming the frustration and confusion commonly associated with managed care systems. Writing from the perspective that many mental health practitioners perceive managed care as a “nightmare,” the authors offer detailed, practical advice on how to use managed care to build practices and provide solution-oriented, cost-effective services. The book covers four basic areas: (1) a comprehensive definition of managed care, including managed care trends and current perspectives; (2) how to market one’s practice in a competitive, managed care environment; (3) how to increase referrals through managed care systems, particularly preferred provider networks and case managers; and (4) how to provide effective brief therapy within a managed care context. The book’s detailed table of contents reflects the user-friendly approach employed by the authors. The final chapter covers questions commonly asked by therapists as they consider the impact of managed care on their practices. Additionally, the appendix includes advice for clinicians from managed care insiders, assistance for office support staff in managing administrative details, and a list of definitions of key terms.

Keywords: providers, technical assistance

373. Budman, S. H. (1992). Models of brief individual and group psychotherapy. In J. Feldman & R. J. Fitzpatrick (Eds.), *Managed mental health care: Administrative and clinical issues* (pp. 231–248). Washington, DC: American Psychiatric Press.

The author of this chapter discusses definitional confusion over what constitutes brief therapy and distinguishes between the therapeutic assumptions, perspectives, and expectations of the long- and short-term therapists. He discusses several basic principles of brief individual and group therapy and describes models of brief individual and group psychotherapy that take into account the realities of working in a prepaid health care environment. He concludes that in order for brief therapy in managed settings to be provided in a high-quality, competent manner, therapists need special training programs in HMOs.

Keywords: models, psychotherapy

374. Budman, S. H., & Armstrong, E. (1994). Brief therapy for managed mental health companies: Becoming a learning organization. *Managed Care Quarterly*, 2, 31–35.

The authors argue that neither contracted mental health providers nor case managers at managed mental health companies are sufficiently trained in time-efficient therapy. A successful provider is often defined by managed care companies by the brevity of treatment and the lack of recidivism of clients. The authors put forward a model that focuses not so much on the brevity of treatment as on the time-effectiveness of treatment. This article describes some of the ways that providers can learn to use this mode of treatment effectively, but focuses on the challenges to managed care companies to provide training programs for their network providers. The authors contend that the survivors in this competitive industry will be those companies that are able to learn about the services they are offering, which in essence become “learning organizations.”

Keyword: training

375. Goldman, W., & Feldman, S. (Eds.). (1993). *New Directions for Mental Health Services*, 59.

In this special volume of *New Directions for Mental Health Services* on managed mental health care, the editors bring together a wide range of expertise on the subject. Authors present alternative models of managed mental health care. Among the nine chapters are ones describing models of managed mental health care from various perspectives, including providers and employers. Other chapters discuss how managed care can focus on special client groups such as children and adolescents or persons with substance abuse problems. Two model programs for managed services in the public sector are described; other chapters explore the impact of managed care, and historical and policy links with the community mental health movement.

Keywords: children, models, substance abuse

376. Haas, L. J., & Cummings, N. A. (1991). Managed outpatient mental health plans: Clinical, ethical, and practical guidelines for participation. *Professional Psychology: Research and Practice*, 22, 45–51.

This article addresses the ways psychologists can make informed decisions about whether to participate in managed mental health care plans. It describes some of the options and relevant ethical concerns and common features of plans that psychologists should be aware of before signing up with a particular plan. The article also addresses the question of whether there are certain prospective patients for whom time-limited treatment would be contraindicated and certain clinicians who are not capable of conducting such therapy. The authors note that time-limited treatment is not simply the abbreviated form of long-term therapy and argue that this type of therapy requires its own set of skills. They advocate that only by carefully selecting their training, the plans they associate with, and the interventions they attempt will psychologists be prepared for a satisfactory professional life under managed care.

Keywords: ethics, psychotherapy

377. Haas, L. J., & Cummings, N. A. (1994). Managed outpatient mental health plans: Clinical, ethical, and practical guidelines for participation. In R. L. Lowman & R. J. Resnick (Eds.), *The mental health professional's guide to managed care* (pp. 137–150). Washington, DC: American Psychological Association.

See Haas and Cummings, 1991 (reference number 376) for annotation.

378. Lowman, R. L., & Resnick, R. J. (Eds.). (1994). *The mental health professional's guide to managed care*. Washington, DC: American Psychological Association.

This book is directed toward mental health practitioners and researchers who are looking for a general overview of what managed care is and how to operate effectively within it. For example, chapter 1 reviews the economic shifts that underpin the rise of managed health care. Chapter 3 outlines the basic issues in managed mental health services, especially how mental health professionals must adapt to a changing environment. Chapter 4 summarizes some of the legal and ethical issues inherent in practicing in a managed care setting, and chapter 6 reviews mental health benefit claims analysis and its implications. The final chapter discusses future directions in managed mental health care.

Keywords: ethics, overviews

379. Meyer, R. E., & Sotsky, S. M. (1995). Managed care and the role and training of psychiatrists. *Health Affairs*, 14(3), 65–77.

This article discusses the future challenges that psychiatry faces as a result of the changing economic environment produced by managed care. The new managed care environment must define the psychiatrist's role and determine new training strategies. The authors discuss the challenges and opportunities psychiatrists will encounter in managed care, such as a surplus of psychiatrists; academic training to fit the needs of a managed care system; structural problems created by the new roles of academic psychiatry departments; getting funding for clinical training in hospitals; and adapting clinical training to fit the changing environment. The authors conclude with a discussion on funding challenges faced by academic psychiatry departments.

Keywords: providers, training

380. Moffic, H. S., Krieg, K., & Prosen, H. (1993). Managed care and academic psychiatry. *Journal of Mental Health Administration*, 20, 172–177.

This article discusses the impact of managed care on the training of psychiatric residents. Surveys of chairs of psychiatry in 125 medical schools were conducted in 1989–1990 and again in 1991–1992. In 1989, only about one-third of respondents reported that their departments were involved in some aspect of managed care. By 1991, more than half were involved. In 1989, 19 percent of psychiatric residency programs had provided training in some aspect of clinical managed care to their residents; by 1991, the figure had doubled to 38 percent of programs. Despite academic psychiatry's growing involvement in managed care, academic leaders

in the field continue to view managed care with skepticism, and feel that the main beneficiaries may not be the patients.

Keyword: training

381. Pomerantz, J. M., Liptzin, B., Carter, A. H., & Perlman, M. S. (1994). The professional affiliation group: A new model for managed mental health care. *Hospital and Community Psychiatry, 45*, 308–310.

This article suggests that a professional affiliation group might be an ideal model for the delivery and financing of mental health services. The 30 Independent Physicians Association psychiatrists associated with an HMO in Massachusetts chose to design their own model rather than use a national managed mental health care company to carve out their mental health benefits. The model that they selected included a 1-year fee freeze, risk-sharing, and other controls. The article describes the process, outcomes, limitations, and benefits of developing a professional affiliation group.

Keywords: models, providers

382. Quaytman, M., & Sharfstein, S. S. (1990). Managed patient care. *Hospital and Community Psychiatry, 41*, 1296–1298.

Managed care in a psychiatric setting may intensify conflicts between members of the treatment team as to how to best address patients' defenses to treatment. This dynamic is explored in three case examples, which illustrate how managed care can arouse patients' ambivalence about treatment. The authors argue that inadequate treatment can result unless clinicians work collaboratively. They base their assessments on reliable outcome data as well as on the views of the patients and their families.

Keyword: providers

383. Shueman, S. A., Troy, W. G., & Mayhugh, S. L. (1994). The way ahead: The promise and challenges of managed behavioral health care. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 243–256). Springfield, IL: Charles C. Thomas.

In this final chapter of the book, the authors discuss their vision of the promises and challenges that lie ahead for managed behavioral health care. The two major types of challenges are (1) "developmental" ones, such as quality of care issues, that arise from rapidly developing programs; and (2) structural ones, like those between two or more agencies, such as managed care companies and governments or providers. They describe some specific promises and challenges. They conclude with a discussion of the ways in which financing and service delivery systems are substantially changing the evolution and identity of mental health professionals.

Keyword: trends

384. Staton, D. (1991). Psychiatry's future: Facing reality. *Psychiatric Quarterly*, 62, 165–176.

Public and private mental health care costs have risen markedly in recent years. To address this problem, public programs such as Medicaid will soon severely limit or cut psychiatric coverage. Proposals to contain mental health care costs in Oregon and California have established reimbursement priority. In several States, priority is given to seriously psychiatrically ill children and employable individuals with substance abuse disorders. The author argues that psychiatric treatment must now be short-term, be crisis-oriented, and permit transfer of patients to alternative settings such as in-home crisis management. Further, psychiatrists must develop cost-effective, high-quality performance indicators and an ethic in which they see themselves as responsible for meeting society's mental health priorities. The author believes that psychiatrists should be trained to make rapid assessments and to provide short-term treatment in non-hospital settings.

Keyword: providers

385. Troy, W. G. (1994). Developing and improving professional competencies. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 168–188). Springfield, IL: Charles C. Thomas.

A major thesis of this chapter is that most training programs do not have among their faculties the expertise needed to treat the critical issues of managed care. Moreover, the author argues that their allegiance to a core set of knowledge and skills curtails their interest in expanding the curriculum to include issues of managed care. He asserts that managed care companies need to take a proactive, leadership role with regard to post-graduate training and describes some approaches to curricular reform.

Keyword: training

386. Winegar, N. (1992). *The clinician's guide to managed mental health care* (1st ed.). New York: Haworth Press.

This book provides mental health clinicians with a thorough overview of the essential components of the emerging managed care system. Chapters cover topics such as the role of preferred provider organizations and employee assistance programs, and how to manage the utilization review process. Several chapters offer concrete suggestions for clinicians on how to survive in the era of managed care, including lengthy appendices with sample contracts, and examples of how to maintain treatment records. Overall, this book gives clinicians the basic knowledge they need to respond effectively to the rise of managed mental health care.

Keywords: overviews, technical assistance

XVI. Utilization Management

387. Baker, F., & Vischi, T. (1989). Continuity of care and the control of costs: Can case management assure both? *Journal of Public Health Policy, 10*, 204–213.

Traditionally, case-managed services have focused on individual needs through providing comprehensive, flexible, and continuous services to mentally ill persons. The more recent emphasis on managed care belies an increasing concern with cost control. This article explores the potential conflict between the goals of continuity of care and of cost control, and describes a number of steps to reduce the potentially negative effects of these competing policies.

Keywords: utilization management

388. Belcher, J. R. (1993). The trade-offs of developing a case management model for chronically mentally ill people. *Health and Social Work, 18*, 20–31.

This article describes the role of case management in caring for chronic mentally ill people. While case management appears to be an ideal method to improve the quality of care and control mental health costs, the author cautions about the difficulty of accomplishing both goals simultaneously. The article reviews different case management and brokering models and argues that social work professionals need to play a key role in proposing and implementing case management models that match client needs with appropriate services and that accurately reflect the costs of providing these services.

Keywords: case management, models, serious mental illness, utilization management

389. Clark, R. E., & Fox, T. S. (1993). A framework for evaluating the economic impact of case management. *Hospital and Community Psychiatry, 44*, 469–73.

Confusion about the efficacy and cost-effectiveness of alternative models of case management for mental health care stems in part from poorly defined assumptions about outcomes and unclear theories of the effect of case management on costs. This article identifies and discusses some of the determinants of cost-effective case management such as characteristics of the case management model, characteristics of clients served, and the administrative and financial context in which a program is implemented. Several models of case management are described, focusing on the ways in which these models differ with regard to resource management. A critical distinction between models with implications for both costs and outcome is the extent to which each is client-directed or case-manager-directed. The authors conclude that case management has the potential to reduce costs, and to improve the lives of people with mental illness,

but that it is not likely to do so unless unambiguous goals are set and the mechanisms for achieving them are clearly defined.

Keywords: case management, models, utilization management

390. Frank, R. G., & Brookmeyer, R. (1995). Managed mental health care and patterns of inpatient utilization for treatment of affective disorders. *Social Psychiatry and Psychiatric Epidemiology*, 30(5), 220–223.

This analysis estimates the impact of managed care on the provision of hospital care for depression, using a database of individuals insured by large American corporations. The authors assessed the effects of managed care on the cost per episode and the likelihood of re-hospitalization. Results of the analysis suggest that the managed care strategies of utilization review and case management have clear short-run impacts. Pre-admission certification programs also resulted in both long- and short-term savings through a reduction of both episode duration and re-hospitalization.

Keywords: costs, depression, utilization management

391. Gabbard, G. O., Takahashi, T., Davidson, J., Bauman-Bork, M., & Ensroth, K. (1991). A psychodynamic perspective on the clinical impact of insurance review. *American Journal of Psychiatry*, 148, 318–323.

This article explores the impact of managed care and utilization review on clinicians, their clients, and families. According to the authors, utilization review creates uncertainty about the length of stay for psychiatric inpatient care, and chaotic treatment planning. The authors argue that managed psychiatric care has led to adverse outcomes for many patients through premature discharge and a reluctance to hospitalize. Five case studies are presented to illustrate the authors' points about the negative impact of utilization review on inpatient psychiatric care. The authors conclude with a call for better outcome studies on the cost-effectiveness of extended hospital treatment and for increased collaboration between payer and provider.

Keywords: utilization management

392. Glazer, W., & Morgenstern, H. (1993). The impact of utilization management on hospital length of stay and illness outcome. *Administration and Policy in Mental Health*, 21, 41–49.

This article presents an experimental model to determine the effect of utilization management on the cost and outcome of inpatient psychiatric treatment. Two hypotheses would be tested: that utilization management feedback results in a reduction in the average length of stay, and that utilization management does not adversely affect illness outcome after hospitalization. The design and methodological factors that must be considered to implement such a study are also discussed.

Keywords: utilization management

393. Goldstein, J. M., Bassuk, E. L., Holland, S. K., & Zimmer, D. (1988). Identifying catastrophic psychiatric cases: Targeting managed-care strategies. *Medical Care*, 26, 790–799.

Many utilization review programs have developed standardized criteria (generally diagnosis-based) to identify and monitor potentially catastrophic and high-cost cases. These criteria, however, do not consider several factors that might predict catastrophic illness, such as age, gender, and treatment setting and location. The study, based on claims data from more than 3,000 psychiatric inpatient admissions, demonstrates that these factors together and alone may contribute to long stays and high costs. High costs and long stays were more likely to be associated with adolescent admissions and admissions involving major affective, organic, and eating disorders. Catastrophic admissions were also more likely to occur in free-standing psychiatric hospitals. Long stays were more likely in the Northeast, and high-cost cases in the West. These findings suggest that case managers take patient and setting characteristics—not just diagnosis—into account when determining which cases should receive special attention.

Keywords: utilization management

394. Goldstein, L. S. (1990). Linking utilization management with quality improvement. *Psychiatric Clinics of North America*, 13, 157–169.

This article compares and contrasts utilization management and quality improvement and describes how utilization management can lead to quality improvement. The goal of utilization management is efficiency. Preadmission authorization, admission review, case management, and drug use evaluation are examples of utilization management. The goal of quality improvement is to ensure that the structure and process of care is effective. Quality improvement activities include the development of normative and empirical criteria, and outcome studies. Despite their different goals, utilization management data, such as patterns of resource utilization, can be used to ensure quality. The article describes a drug utilization evaluation that identified potentially problematic prescribing practices at a psychiatric unit. The findings catalyzed efforts to educate psychiatrists to ensure quality.

Keyword: quality assurance, utilization management

395. Gotowka, T. D., & Smith, R. B. (1991). Focused psychiatric review: Impacts on expense and utilization. *Benefits Quarterly*, 7(4), 73–81.

This article reports the results of an evaluation to determine whether Focused Psychiatric Review (FPR), Aetna's utilization review program, reduces the use and costs of psychiatric hospitalization. Hospital utilization was compared using claims data for approximately 16,000 beneficiaries who were subject to FPR, and 11,000 non-FPR controls. The study found that FPR resulted in lower admission rates and lengths of stay, and that initiating case management before admission led to shorter lengths of stay and lower hospital costs. The study also found that length of stay is affected by day of admission, because Tuesday through Friday admissions are often carried over an additional weekend. FPR has a greater impact on psychiatric disorders than on substance abuse disorders and on nonpsychoses than on psychoses. These reduc-

tions were found in every age group except young adults ages 19 to 34. These findings suggest the need to do case management before admission and to plan care for substance use, psychoses, and depression.

Keywords: substance abuse, utilization, utilization management

396. Hennessy, K. D., & Green-Hennessy, S. (1997). An economic and clinical rationale for changing utilization review practices for outpatient psychotherapy. *The Journal of Mental Health Administration, 24*(3), 340–349.

Given the trend toward managed mental health organizations, there has been increased cost-consciousness in the financing and delivery of mental health and substance abuse services. In this paper, the authors examine how management strategies that result from these pressures have affected mental health and substance abuse services. After reviewing the evolution and application of managed care to behavioral health, they argue that pressures to reduce costs have led to the over-application of utilization review (UR) in a way that may be economically and clinically counterproductive. They provide several rationales for changing UR for outpatient psychotherapy as well as some alternatives to micromanaging outpatient psychotherapy benefits in an effort to promote a balance between economic and clinical goals.

Keywords: economics, psychotherapy, substance abuse, utilization management

397. Hersch, R. G. (1994). Mental health's contribution to the financial performance of a utilization management program. *Managed Care Quarterly, 2*(2), 71–78.

This study uses data from a national utilization management program, covering approximately 3.4 million individuals from 1989 through June 1993, to analyze the costs and benefits of mental health utilization review compared with medical, surgical, and maternity management. Analysis revealed that while the costs of performing mental health utilization management are significantly greater than for the medical areas, so are the returns on investment. Indeed, in 1993, the management of the mental health hospitalizations provided seven times as much in absolute dollar savings as a surgical case, and 20 times as much as the management of a maternity case. The article also discusses the implication of full mental health benefits for health care reform.

Keywords: costs, utilization management

398. Langman-Dorwart, N., Wahl, R., Singer, C. J., & Dorwart, R. A. (1992). Managed mental health: From cost containment to quality assurance. *Administration and Policy in Mental Health, 19*, 345–353.

This article describes the managed care approach of one national managed health care company over the past 5 years, with an emphasis on the integration of quality assurance into utilization review. Through a case-study approach of this company, the authors explore the ways in which an emphasis on quality may, in the long run, lead to increased cost-effectiveness and efficiency. The authors conclude that clinically oriented utilization review can control mental

health costs while monitoring and improving quality of care. They anticipate future changes in mental health cost containment efforts such as increasing reliance on utilization and quality data, improved match between clients and approved clinicians based on acuity and appropriateness of service, and continued redirection of patients to outpatient settings.

Keywords: quality assurance, utilization management

399. Lewin, R., & Sharfstein, S. S. (1990). Managed care and the discharge dilemma. *Psychiatry, 53*, 116–121.

This article describes the ways in which efforts by “fourth party” case managers to contain costs may lead to premature hospital discharge for severely mentally ill patients. A case study of a borderline patient exemplifies the potentially deleterious effects of early discharge on patients such as the “sicker and quicker” phenomenon leading to repeated short-term hospitalizations, pressure to inappropriately use high doses of medicines or electroconvulsive therapy in order to produce a rapid clinical response, and compromise of treatment goals. The authors argue that there is an urgent need for outcome studies that justify the costly treatment in inpatient care for a subset of patients and that document the negative impacts of premature discharge. Further, they advocate increased reimbursement for community-based residential care for chronically mentally ill persons.

Keywords: serious mental illness, utilization management

400. Oehm, M. J. (1992). Information systems. In S. Feldman (Ed.), *Managed mental health services* (1st ed., pp. 143–164). Springfield, IL: Charles C. Thomas.

An efficient, reliable, and flexible computer information system can enhance the quality of utilization management. Despite its advantages, few utilization management companies have implemented such a system because they prefer “tangible” recordkeeping and fear high costs and frequent downtime. The author describes the key features of an information system and how it can address these concerns. The system should be fast and reliable and include data about patients, providers, benefits, and clinical criteria. Among other features, it should perform coding and “flag” certain cases, assign case numbers, and automatically transfer information to the claims system. Although the most effective systems are internally developed, the author concludes that packaged systems can be successfully adapted for use.

Keywords: information systems, utilization management

401. Panzarino, P. J., & Wetherbee, D. G. (1990). Advanced case management in mental health: Quality and efficiency combined. *QRB Quality Review Bulletin*, November, 386–390.

The case manager in a managed mental health care system can serve as the patient’s ombudsman to provide high quality care. Treatment effectiveness data, outcome studies, and utilization patterns, rather than simply availability and cost of treatment, guide case

managers' decision making. There are four steps to the decisionmaking process: preadmission certification, triage, concurrent review, and individual case management or creative benefit reallocation. A case example illustrates how these steps can be employed to ensure a continuum of care in appropriate, cost-effective outpatient programs.

Keywords: case management, utilization management

402. Reinhardt, B., & Shepherd, G. L. (1994). Behavioral health case review: Utilization review or case management? One company's view. In S. A. Shueman, W. G. Troy, & S. L. Mayhugh (Eds.), *Managed behavioral health care: An industry perspective* (pp. 76–91). Springfield, IL: Charles C. Thomas.

This chapter describes the process of managed behavioral health care as it is conducted by one case management company. The authors focus on (1) the role of the case manager; and (2) what the case management company can do legally and practically to affect patient treatment. They present some of their own experiences with case management.

Keywords: case management, utilization management

403. Sturm, R., McGlynn, E. A., Meredith, L. S., Wells, K. B., Manning, W. G., & Rogers, W. H. (1994). Switches between prepaid and fee-for-service health systems among depressed outpatients: Results for the medical outcomes study. *Medical Care*, 32, 917–929.

The authors found that the lowest rate of plan switching was among patients of mental health specialists in fee-for-service plans, compared to general medical patients in fee-for-service plans and both types of patients in prepaid plans. Additional findings of this longitudinal study are presented and discussed.

Keywords: capitation, utilization management

404. Tischler, G. L. (1990). Utilization management of mental health services by private third parties. *American Journal of Psychiatry*, 147, 967–973.

In utilization management a third party—rather than the physician—is the final arbiter of treatment. This article describes three utilization management approaches: preadmission certification, concurrent review, and case management. Utilization management raises a number of issues, such as professional bias in treatment, what constitutes an effective community substitute for inpatient care, the role of utilization management in shifting costs from Federal to State agencies, the lack of privacy safeguards, quality control, and practitioner liability. The author concludes that there is a need for further study of the implications and efficacy of utilization management.

Keywords: utilization management

405. Tischler, G. L. (1990). Utilization management and the quality of care. *Hospital and Community Psychiatry, 41*, 1099–1102.

Utilization management has implications for the availability, appropriateness, and effectiveness of mental health care. This article discusses the history of utilization management in both the public and private sectors, and the development of peer review approaches to care decision making. The author identifies clinical and economic factors that influence care decisions, and suggests ways to determine whether systematic biases exist in reviewer decision making. He concludes that more research is needed on the impact of cost-containment initiatives on access and outcome.

Keywords: utilization management

406. Trabin, T. (1994). How will computerization revolutionize managed care? *Managed Care Quarterly, 2*(2), 22–24.

This brief article presents an imaginary scenario of how computerization will help clinicians and case managers access and communicate patient data for behavioral health services in the near future. The author uses this scenario to demonstrate how computerization of behavioral health information is revolutionizing the way payers, managed care companies, and providers use and exchange information. He describes some of the benefits of this advanced technology and obstacles to attaining these gains.

Keywords: information systems, utilization management

407. Wanerman, L. (1993). Managed mental health for children and adolescents. *New Directions for Mental Health Services, 59*, 13–26.

In this chapter, the author uses a series of cases to illustrate the ways in which managed care can provide comprehensive and cost-effective mental health and substance abuse treatment for children and adolescents. The author briefly describes the Focused Adolescent and Child Treatment team at U.S. Behavioral Health (USBH), a national managed care company. The team includes mental health professionals from a variety of disciplines who work with providers to coordinate care from intake to referral and continual case monitoring. The author argues that this approach can protect generally limited and restrictive mental health benefits so they are available when truly needed. USBH's guidelines for level-of-care decisions in mental health for children and adolescents are included in an appendix.

Keywords: children, managed behavioral health care organizations, utilization management

408. Wickizer, T. M., & Lessler, D. (1998). Do treatment restrictions imposed by utilization management increase the likelihood of readmission for psychiatric patients? *Medical Care, 36*(6), 844–850.

This article describes a 5-year study on more than 2,000 privately insured psychiatric patients and uses logistical regression analysis to determine how utilization management programs affected restrictions on length of stay and the likelihood of readmission. The findings indicated

that those patients whose length of stay was restricted by utilization management (UM) were more likely to be readmitted. The authors view readmissions as a sign of poor quality service and believe UM programs might best serve patient populations by improving clinical outcomes as well as containing costs.

Keywords: utilization management

409. Wickizer, T. M., & Lessler, D. (1998). Effects of utilization management on patterns of hospital care among privately insured adult patients. *Medical Care*, 36(11), 1545–1554.

Although utilization management (UM) is one of the primary tools of an HMO in cost containment, there has been little research on the effects of this practice on patterns of care. In this study, researchers examined pre-admission review and concurrent (continued stay) review of 49,654 privately insured adult patients undergoing utilization review between January 1989 and December 1993. The focus of the study was to examine how often UM denied care at time of admission, to what extent UM restricted hospital length of stay, which diagnoses and procedures were most affected by UM, and whether UM became more restrictive with time. The study found that fewer than 1 percent of patients were denied care at time of admission. Restricting length of stay through concurrent review accounted for 83 percent of the total reduction in inpatient care. Utilization management was the most restrictive for mental health patients, who represented 5.7 percent of the study population but accounted for 54.7 percent of the total reduction in requested days.

Keywords: utilization management

410. Wickizer, T. M., Lessler, D., & Travis, K. M. (1996). Controlling inpatient psychiatric utilization through managed care. *American Journal of Psychiatry* 153(3), 339–345.

This article reports the results of a study of the effect of utilization management on psychiatric hospital inpatient care. The authors analyzed data on utilization management review activities conducted by a single large commercial insurance carrier during 1989–1992. Measures included percentage of admission requests approved, number of days requested and approved, and number of additional treatment days granted. In addition, the authors examined how the number of days approved by utilization management compared with lengths of stay of patients with similar diagnoses in the general population as reported by the National Hospital Discharge Survey. The authors discuss the limitations of the study, and stress the need for studies on the effects of managed care on patient outcomes and the quality of care.

Keywords: utilization management

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