Helping Clients with HIV Disease Navigate Managed Care
Perry N. Halkitis, PhD and Tracy Mayne, PhD

The move towards managed care raises concerns not only for those who have HIV disease, but also for the health and mental health practitioners who work with them. At the heart of the movement is the desire to contain costs. Critics argue that cost-cutting results in more limited access to appropriate health care; supporters claim that enrollees in well-run managed care plans benefit from increased efficiency and lower costs in primary care.

At the federal level, programs such as Medicaid are rapidly making the transition from fee-for-service to managed care. As of 1994, 42 states had implemented programs covering approximately 24 percent of all Medicaid beneficiaries nationwide.1 While most states have focused on relatively healthy low-income families, recent efforts have targeted Medicaid beneficiaries with disabilities, including people with AIDS. The change to managed care is not restricted to government programs. More than half of all mid-sized companies in both the public and private sectors are offering only managed care plans to their employees; the proportion of Americans in private managed care plans has grown from 55 percent in 1992 to 74 percent by the end of 1996.1

Client Satisfaction Survey
Some evidence suggests that older patients and patients with chronic conditions fare much worse in managed care plans than their counterparts in traditional plans.2 This is especially true for those with HIV disease. The basis for such arguments is that most managed care practitioners are not experienced in providing services to people with HIV disease.3

In a 1997 study, conducted by the Gay Men’s Health Crisis in New York, researchers compared client satisfaction for participants enrolled in managed care, government funded, and private indemnity plans.1 Of the 29 HIV seropositive individuals, 50 percent were African-American or Latino and approximately 90 percent were male. Half of those interviewed were enrolled in managed care plans, and three-quarters of these reported that their plans permitted members to see doctors outside the health maintenance organization (HMO) network. The majority of participants (81 percent) had their medications covered through the New York State AIDS Drug Assistance Program (ADAP).

The vast majority of the participants acknowledged both strengths and weaknesses in their managed care plans, and opinions were often based on reactions to specific experiences, rather than on global assessments of the plans themselves. Satisfaction was most strongly correlated with perception of the plan’s convenience, relationship with a person’s primary care physician, and limits on out-of-pocket expenses. Dissatisfaction, on the other hand, was associated with inefficient service, limits on choice of provider, and limits on the ability to receive state-of-the-art care.

Some participants believed managed care to be unsuitable because the complexity of HIV disease exceeded their primary-care physicians’ HIV-related knowledge. They also reported prejudice and a lack of compassion toward people with HIV disease. For example, one participant said choosing a doctor from an HMO network is a game of chance: “You cross your fingers each time you pick . . . because you don’t know who the doctors are. And you better hope that this doctor is compassionate towards people with AIDS, has dealt with the AIDS com-
Editorial: Managing the Manager

Robert Marks, Editor

The concept of managed care is tantalizing. It promises the efficient delivery of appropriate health care, and who could argue with that? The rosier predictions suggest that it will significantly lower national health care costs and result in coverage for millions of uninsured people. But when commercial and financial interests become the priority of health care providers, appropriate treatment comes dangerously close to being synonymous with merely adequate care. And cost savings—at least, so far—seem destined neither to lower health care premiums substantially nor to usher in universal health care coverage.

Even in the days when managed care was an experiment, health insurers viewed mental health treatment with suspicion, much the same way as society saw mental illness: as an unmentionable circumstance, like teenage pregnancy and "venereal disease."

In this climate, mental health care was reserved only for people with serious mental illness, and the treatment of choice for chronic disorders was institutionalization, psychoactive drugs, or both. "Therapy" was the playground of the urban and angst-ridden middle class and rarely warranted insurance reimbursement.

Today, there is a much greater appreciation of the relationship between mental health and social functioning, productivity, and physical health—concrete standards that can be measured and correlated. But people who seek mental health services suffer stricter limitations, higher copays, and lower reimbursement rates than people seeking medical care. All of this spells "optional" care, the same category occupied by nose jobs and tummy tucks.

Under managed care, as becomes clear from this month’s articles by Perry Halkitis and Tracy Mayne, and Ruth Clifford, mental health treatment for people with HIV disease is likely to continue to undergo scrutiny related more to cost than efficacy, to be reviewed by people who are not trained in this area, and if approved, to be brief.

Wise therapists will go beyond these articles to understand managed care standards so that when appropriate, they can marshal the strongest arguments in support of coverage for their clients. In the morass of forms that comprise the raw material of an insurer’s utilization review, mental health providers need only to look into their clients’ eyes to grasp the slippery definition of medical necessity.

It’s hard not to be cynical about health insurance when insurers have such a powerful stake in denying care. But, I have a hunch that many utilization reviewers on the front lines, aside from, or perhaps instead of, being "bean counters," anxiously await clear and appropriate standards as managed care evolves.

To reach out to educate these allies, to advocate for clients, and to rebuff opponents, mental health providers need to marry a healthy cynicism with an heroic idealism. It will require both in order to break through this faceless bureaucracy and develop managed care approaches that work for people with HIV disease, that can serve the goals of "cost containment," preventative medicine, ethical practice, and . . . mental health.

References
Managed Care and Mental Health

In the 1980s, concern about large mental health-related expenditures pushed public and private insurers to implement managed care programs for services beyond medical treatment. While the resulting restrictions have had predictably negative effects, some mental health providers suggest that managed care has enhanced communication among mental health professionals, primary care providers, and specialists. In addition, increased provider accountability can actually improve care for people with HIV disease.

Concerns about managed care regulation of mental health services have fallen into three categories: treatment, ethical issues, and quality of care. Among the treatment issues are concerns about rationing, which may lead to inadequate care and the inappropriate application of a medical model of care. This model seeks adequate functioning, rather than psychological growth of the client, and may limit treatment options to short-term and drug therapies.

Managed care practice may pose a number of ethical issues. Managed care plans often advertise coverage for a certain number of therapy sessions annually, but the reality is not so straightforward. For example, a plan that advertises a 20-session annual limit, may actually deliver far fewer for several reasons: the primary care physician must approve the care; approved care begins with only one session for assessment; a plan administrator, who is not always a mental health professional, reviews the assessment and approves care often only if it includes a formal diagnosis from the Diagnostic and Statistical Manual-IV (DSM-IV); approval covers only a limited number of sessions—for example, five—and any treatment beyond this requires a review of therapist notes (additional sessions are often meted out in three to five visit allotments). By comparison, while indemnity plans also limit the number of sessions per year, coverage often does not require a physician’s referral and review occurs only if the total number of permitted sessions is exhausted and additional sessions are deemed necessary by the mental health professional.

Dealing with potentially deceptive advertising puts the therapist in the position of explaining to clients the realities and limits of the system without engaging in undermining the integrity of the managed care plan. There is also the potential for breach of confidentiality, as a therapist sharing case notes and evaluations with the insurer and with primary care physicians has no control over who has further access to these notes. This is particularly important when primary care physicians play the role of gatekeeper in the managed care process. For example, for clients who have not informed their primary care physicians of their HIV serostatus, therapists might violate client confidentiality if they mention HIV in clinical notes. Further, therapists may face a conflict of interest if plans pressure them to make therapeutic decisions based on cost containment. Finally, practitioners may confront the desire to inflate diagnoses to ensure clients get coverage, conflicting with personal ethics and professional integrity.

Quality of Care

These conflicts may lead to treatment decisions based on factors other than the client’s best interests and needs. When the apparatus of managed care “invades” the therapeutic process, it may engender transference and countertransference that have the potential to undermine care. While managed care may redefine the role of the therapist, that role has already been expanded by the experience of treating people with HIV disease. Mental health providers already act as educators and advocates. In the context of managed care, mental health providers may need to help clients understand the managed care system, how to access services, and how to fill out forms to obtain benefits. As has always been true for HIV disease, until clients meet basic health care needs (not to mention food, clothing, and housing), it may be impossible to attend to psychotherapeutic issues.

When the issue of managed care “invades” the therapeutic process, it may engender transference and countertransference that have the potential to undermine care.


*See also “Managing Mental Health Care,” on page 5 of this issue of FOCUS.
Mental health workers must also be ready to act as medical liaisons, sometimes taking a more active role than is usual for a therapist. For example, a therapist may notice a symptom that the client is denying or minimizing (for example, a cough indicative of pneumonia). If a recommendation to visit a physician is ignored, the therapist may contact the client’s primary care physician directly, going so far as to schedule an appointment directly after the therapy session, and even walking the client to the appointment. The therapist in this case not only acts to further care, but also has the opportunity to explore with the client anxiety, avoidance, and transference issues. Such processes can actually be facilitated by managed care, which imposes a therapist-physician relationship. In this context, it is probably counterproductive, and potentially damaging, for a therapist not to find a way to work within the medical model and interact with treating physicians.

Primary care physicians will often support the “medical necessity” of additional sessions if therapy addresses important treatment issues such as protease inhibitor adherence. However, as many people with HIV disease experience suddenly renewed health and face a difficult adjustment to a “normal” life, therapists may have difficulty justifying further treatment to an insurer’s satisfaction—although an adjustment disorder diagnosis might qualify. Similarly, primary and secondary HIV prevention are clearly important medical issues but may be difficult to justify in terms of treatment.

Conclusion

Although managed care does have the potential to constrain psychotherapeutic treatment, and may pose specific ethical dilemmas for providers, concerned and motivated therapists can also take advantage of opportunities offered by the system. Understanding managed care plans can lead to creative approaches to working within these constraints that help clients without violating personal or professional ethical standards.

Among the chief advantages of managed care is that it promises a close relationship between mental health providers and primary care physicians, which opens the door to truly integrated, multidisciplinary treatment. Medical issues clearly have a psychological impact, and psychological treatment can have clear medical benefits, and this connection is nowhere more apparent today than in terms of adherence to protease inhibitors.

Concerns that managed care may contaminate the therapeutic relationship are reasonable, but these fears also can be used therapeutically, especially within the context of brief dynamic models. The pressures of managed care may raise in clients displaced anger, avoidance, denial, and other defenses. The challenge for therapists is to address these issues effectively within the constraints of insurer-imposed time limits, and in ways that neither defend nor criticize the plans. While in some cases, this will compromise treatment, in others it will lead to a therapist’s honest review of his or her techniques and treatment efficacy, and such periodic evaluation benefits both client and provider.

If cost-effectiveness can be mustered to increase therapist effectiveness without sacrificing quality of care, then in some contexts managed care may work to the advantage of both therapists and clients. As Victor Frankl so eloquently proposed, individuals can control their own responses even to the worst of circumstances.

Clearinghouse: Managed Care

References


Spitz HI. The effect of managed mental health care on group psychotherapy: treatment, training, and therapist-
Managing Mental Health Care
Ruth Clifford, PhD

As managed care increasingly dominates health service delivery, it may compromise the effective integration of mental and physical health care that is crucial to people with HIV disease. This article briefly defines managed care concepts, discusses mental health in the context of managed care systems, and examines implications for people with HIV disease.

Types of Managed Care
Managed care refers to a variety of cost control methods used to reduce health and mental health treatment spending. There are a number of different types of managed care organizations, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Mental health services may be managed either through a special mental-health-only managed care organization, called a behavioral health care carve-out company, or as part of a full-service HMO or PPO.

HMOs usually charge a set premium, which they use to pay all the services a person (the “enrollee”) might need. HMOs either employ their own doctors and other caregivers (“providers”) or contract with provider groups, who serve all the health care needs of a group of plan members for a flat fee per person. This arrangement is called capitation. Provider groups bid against each other for HMO contracts, which are likely to be awarded to the group that charges the lowest fee. The provider group then bears the risk that the fee will be sufficient to cover the costs of delivering necessary care while still paying the providers in the group. While HMOs usually cover services only if performed by a plan provider, some permit enrollees to use any licensed provider—in exchange for higher premiums and larger copayments.

Unlike HMOs, PPOs contract with individual providers or provider groups who agree to accept a discounted fee for each service, for example, for each session of psychotherapy. A PPO will charge plan members lower rates when they use providers who belong to the plan. In general, PPO members have more choice when picking doctors and therapists than do HMO members. PPOs may pay providers on a fee-for-service basis, that is, for every service rendered, or on a case-rate basis, that is, a set amount for the entire course of each patient’s care.

Under case-rate as well as capitation systems, providers have a financial incentive to perform as little service as possible. In all managed care systems, plans refer fewer enrollees to providers who use more services, especially costly ones. Plans may also threaten to expel providers who do not comply with plan directives about care.

Both HMOs and PPOs have rules about how members access care from mental health professionals. Some plans allow members to select a therapist from a directory of all the plan providers in a geographical area. Others use a gatekeeper, who evaluates a member’s complaints and decides whether to refer him or her to a specialist. The gatekeeper may be a telephone hotline operator, who may or may not have mental health expertise, or the person’s primary care physician, who sometimes has only a few weeks of exposure to psychiatry. Studies show that primary care

References

Existing managed care plans seem to save on mental health costs by impeding the delivery of care.

Agencies
The following organizations provide information on managed care for people with HIV disease:
AIDS Policy Center for Children, Youth and Families, 918 16th Street, NW, Washington, DC 20006, 202-785-3564.
Health Resources and Services Administration (HRSA) Center on Managed Care, 5600 Fishers Lane, Rockville, MD 20857, 301-443-0863.
AIDS Policy Center for Children, Youth and Families, 918 16th Street, NW, Washington, DC 20006, 202-785-3564.
Health Resources and Services Administration (HRSA) Center on Managed Care, 5600 Fishers Lane, Rockville, MD 20857, 301-443-0863.

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Ruth Clifford, PhD, California Coalition for Ethical Mental Health Care, 355 West Olive Avenue, Sunnyvale, CA 94086, 650-967-0509.
Jeffrey Crowley, MPH, National Association of People with AIDS, 1413 K Street, NW, 7th Floor, Washington DC 20005, 202-898-0414.
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Tracy Mayne, PhD, Gay Men’s Health Crisis, 119 West 24th Street, New York, New York 10011, 212-367-1470, tracym@gmhc.org (e-mail).

See also references cited in articles in this issue.
Managed Mental Health and HIV Care

In this time of rapid change, it is difficult to know how people with HIV disease and mental health care needs will fare under managed care. However, the emerging picture of mental health care suggests that there is cause for concern. While statistics show that managed care has led to savings in behavioral health care costs, this result has been achieved largely through massive reductions in the amount of mental health service per patient, whether inpatient, partial hospitalization, or outpatient care. In fact, existing commercial managed care plans seem to save money by impeding the delivery of care: delaying or refusing diagnostic tests, rejecting “experimental” or unproven treatments, limiting the amount of time spent with a provider, and disrupting the continuity of care.

A general concern with managed mental health is the criteria used to determine medical necessity. Some plans define medical necessity broadly in terms of a deficit in quality of life that has the potential to improve through treatment. Frequently, however, plans construe necessity narrowly to mean an imminent risk of death or disability that could be corrected or avoided through brief treatment. In this context, most mental health needs seem minor or even spurious. Even suicidal intention may not be considered an emergency. Criteria for medical necessity need instead to reflect the centrality of emotional distress in the HIV disease process as clients struggle to cope with a life-threatening illness, rigorous treatment regimens, upheavals in self-image and social role, and stigma and discrimination. In addition, as people with HIV disease live longer, it is becoming increasingly important to use counseling as a bridge to adjustment to new lives, relationships and work situations. Plans also need to recognize that improved mental well-being can have a significant positive impact on physical health.

Several related concerns are worth noting. The use of restrictive drug formulas—lists of approved drugs—may result in the denial of coverage for newer and more effective medications. The perception of pain as a subjective complaint, and therefore not “legitimate,” may lead managed care organizations to discourage aggressive pain management and related mental health care. Finally, hospice patients may be denied palliative care, since they are “going to die anyway.”

Managing Managed Care

Providers within managed care settings might consider three suggestions. First, providers should maintain thorough and accurate documentation of current symptoms, functioning, and response to each step of treatment. It may be wise for clients or their family members or friends to keep such records as well.

Second, providers should be prepared to assist clients in appealing denials of treatment that they believe are necessary. It is useful to present evidence that a requested service may reduce the need for more expensive care. Third, providers should inform clients what their plans cover and exclude, how to appeal plan actions, how to file a complaint with the agency that regulates the plan, and how to contact local advocacy groups that might help them.

Conclusion

Currently there is almost no regulation of managed care organizations that addresses the concerns raised here. The future will tell whether clients will have access to insurance benefits, compassionate, well-coordinated care, and services that are genuinely necessary, not only to avert momentary crises but also to improve health and quality of life.
Practitioner Reaction to Managed Care

The majority of mental health care providers have had problems with the utilization review process, have concerns that the politics of managed care jeopardizes client confidentiality, and have made less money and experienced a decline in referrals as a result of managed care insurance plans, according to a study of 139 mental health professionals. The research also found differences in attitudes toward managed care among respondents with different professional degrees.

Subjects from suburban and urban communities in the eastern United States were randomly selected from telephone directories, lists of managed care providers, and other sources. The mean age of the sample was 46, and practitioners had an average 15 years of clinical and six years of managed care experience. More than half had PhD-level professional training, 19 percent were MA- and MS-level professionals, and 17 percent were MSW-level professionals. Sixty-seven percent identified as primarily cognitive-behavioral in therapeutic orientation.

According to responses to a multiple-choice questionnaire, 80 percent viewed the utilization review process as wasteful, 88 percent perceived utilization reviewers as insufficiently qualified, and 74 percent believed the process to have an adverse effect on client care. In addition, 65 percent of the respondents reported exaggerating patients’ symptoms to obtain authorization for additional sessions.

Among the practitioners in the study sample, negative feelings toward managed care were not associated with extent of experience with managed care, but were significantly associated with greater clinical experience and higher numbers of clients—regardless of their type of insurance. This association may be explained by the fact that more experienced clinicians tend to be more familiar with a time when fee-for-service health care was the rule and thus more sensitive to the changes brought about by managed care. Overall dissatisfaction with managed care was highest among PhD-level psychologists, perhaps due in part to their greater clinical experience and, on average, larger weekly case loads.

Insurance Type and Satisfaction

Seropositive men with fee-for-service health insurance were more satisfied with their health care provider relationships and less satisfied with the financial aspect of care than counterparts in managed care plans, according to a study of gay and bisexual men in San Francisco and Denver. There were no significant differences in overall health coverage satisfaction between men with public insurance and those with managed care; as expected, uninsured men rated lowest on every measure of satisfaction.

Researchers recruited from public health clinics 593 seropositive men without AIDS, of whom 80 percent were White. Participants were categorized by type of medical coverage: fee-for-service (34 percent), public insurance (8 percent, including Medicaid, Medicare, and Veteran’s and Military), managed care (35 percent, including both health maintenance and preferred provider organizations), or uninsured (23 percent). Participants rated the following specific aspects of their medical care: access and convenience, technical quality, interpersonal relations, communications, time spent with the provider, and financial aspects. Researchers compared results to those from a baseline 1986 Medical Outcomes Study (MOS) of adults with one or more chronic conditions.

Compared to those in the MOS study, satisfaction among research subjects was significantly lower for every aspect of care. Most respondents were more satisfied with their health care providers than with their systems of care. While type of insurance did affect satisfaction with care, differences across insurance type were small in comparison with the differences between those with insurance and those who were uninsured.

Patient satisfaction has been associated with quality of care as well as greater adherence to medical treatment and high-
er utilization of services, all crucial components of HIV-related care. Understanding differences in satisfaction across insurance type is particularly important as the proportion of HIV-infected people in managed care plans grows.

**Pros and Cons of Managed Care**


Managed care may do a better job than traditional fee-for-service plans in delivering comprehensive and coordinated care to people with HIV disease, according to an analysis of health care plan options. However, a system in which physician reimbursement is tied to financial performance may limit access to care.

Coordination of services is important not only because of the medical complexity of HIV, but also because of its social and psychological complexities which require the involvement of a variety of providers. In particular, during hospitalization, people with HIV disease rely on multidisciplinary teams of physicians, counselors, and social workers to meet all of their needs. At the same time, a combination of fiscal pressures introduced by a managed care perspective and the desire of patients to remain at home has led to an increase in home-based services, potentially paving the way for the routine reimbursement of complex and beneficial outpatient treatments.

On the other hand, managed care may encourage physicians to tend toward under-treatment as opposed to the overtreatment often encouraged by fee-for-service plans. Fiscal pressures may restrict a patient’s access to expensive and experimental drugs or treatments. In addition, HMOs and point-of-service plans which reimburse for each person whether or not they use services have a financial incentive not to enroll expensive patients, and individual physicians with large numbers of patients with HIV disease may not be able to afford to participate in such reimbursement plans.

**Culture and Barriers to Managed Care**


A review of new models of mental health care delivery concluded that managed care models have not adequately considered the needs of ethnic minorities, in particular, barriers related to language and culture.

Ethnic minorities tend to experience a greater proportion of illness and disease, have fewer financial resources to obtain appropriate services, and experience lower quality of care than White people. They are also more likely to be uninsured or underinsured. Barriers to mental health care among ethnic minorities include sociocultural differences that can lead to difficulties in conducting precise psychological assessments, differential or discriminatory treatment, and therapist preferences for client characteristics that place people of color at a disadvantage.

Studies show people of color enrolled in independent practice associations, health maintenance organizations, and fee-for-service plans are less likely to use health care services than White people. Though less use may be appealing to third-party payers in the short run, in the long run, individuals who do not receive adequate mental health care, including preventive care, are forced ultimately to use higher cost services when they do present for mental health treatment. Encouraging earlier utilization of services, however, may require a stronger link between mental health and primary health care, in this way reducing the stigma of mental health interventions for some ethnic populations.

**Next Month**

In the age of the internet, when everyone is predicting the demise of the printed page, publishers continue to print and their readers continue to seek information from books. This year, in special recognition of paper and ink, *FOCUS* publishes its fifth annual book review issue.

Among the materials our reviewers will critique is the first book devoted to HIV disease among people with serious mentally illness—*AIDS and People with Severe Mental Illness: A Handbook for Mental Health Professionals*, edited by Francine Cournos and Nicholas Bakalar, and two new anthologies regarding HIV-related counseling: *HIV Mental Health for the 21st Century*, edited by Mark Winiarski, PhD, and *Treating the Psychological Consequences of HIV*, edited by Mark O’Connor, PhD.
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