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Managed Care

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What Is Managed Care?

Under managed care, budgets rather than professional guidelines set the standards for medical practice, while managed care organizations (MCOs) make large profits and pay huge salaries to their executives. Since the world moved into third-party payment, treatment decisions are made by those who pay the bills. *The doctor examines the patient and establishes a treatment plan*, but some other person who has never seen that patient—another physician, a nurse, social worker, psychologist, or even a clerk with no medical training—decides whether the patient receives the recommended treatment. Furthermore, although these decisions are sometimes based on guidelines known to the physician treating the patient, more often they are not. Although doctors would like to use guidelines supported by scientific medicine, often they do not know who developed the guidelines for approving treatment decisions and have no input into guideline revisions. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients if they consider the MCO decision to be contrary to the patient's best interests. Yet if an attending physician disagrees with the MCO decision and appeals, the original MCO decision stands. Even when MCO actions harm patients, doctors cannot sue the MCO because it is protected by a federal law called the Employee Retirement Income Security Act of 1974 (ERISA).

Patients trust that their doctors will come to their aid—this trust is the very basis of the doctor–patient relationship. As part of the process of giving informed consent, physicians should disclose all treatment alternatives, regardless of cost and regardless of whether the



MCO pays for that particular treatment. However, when physicians want to explain to the patient what alternative treatments are scientifically appropriate, many MCOs “gag” the doctor from discussing alternatives not approved by the MCO. In addition, patients in acute distress who would like to go to a nearby hospital emergency room for immediate attention cannot do so because most MCOs require advance approval to obtain emergency services. The tradition of a patient choosing his or her doctor applies only when the desired doctor is a member of the MCO panel; if the doctor is dropped from the panel, the patient must find a new doctor from the approved list. In most cases, the right to see a specialist applies only when the patient is first seen by a primary care physician in the MCO.

Physicians must place the patient’s interests ahead of their own, including financial remuneration. However, MCOs often compensate physicians with capitation fees that give doctors a financial advantage to withhold treatment. Instead, financial incentives should be based on demonstrated quality of care rather than on the quantity of services.



Effects of Managed Care on Medical Practice

All of the criticisms above have been leveled at the managed care industry, although not all apply to every managed care plan. Because decisions are made outside of the doctor–patient relationship and are based on cost to the plan, vigorous and even violent complaints have been made about the managed care industry. Some of those complaints have been heard by government, courts, legislators, or by the MCOs themselves; and some of those practices (e.g., the requirement to see a primary care physician for referral to a specialist) have been modified over the past year or two. However, there continues to be widespread dissatisfaction with the managed care system, and physicians have asked themselves whether they can ethically practice medicine under such a system.

The criticisms apply to general health plans operated by MCOs, but many of these MCOs have turned over the responsibility for mental health treatments to a system of “carve outs” for mental illness and behavioral health. The rationale has been that specialized systems are needed for mental health services. Psychiatrists usually deal with the specialized behavioral health MCOs, and criticisms of these organiza-

tions have been similar to those of the general managed care system.

Psychiatrists who deal with managed care organizations should use guidelines that will permit them to be comfortable with the ethical standards they follow in these transactions. Such guidelines have been developed by the American Medical Association, the American Psychiatric Association, and experts on ethics in managed care, such as Sabin. These particular guidelines are delineated below for reference.

Guidelines Developed by the American Medical Association¹

1. The duty of patient advocacy is a fundamental element of the physician–patient relationship. Physicians must place the interests of their patients first.
2. When managed care plans place restrictions on care, the following principles should be followed:
 - a. Allocation guidelines that restrict care and choices (beyond the cost–benefit judgments made by physicians) should be established at a policymaking level, not on an ad hoc basis by individual reviewers.
 - b. Physicians must advocate for any care they believe will materially benefit their patients.
 - c. Physicians should be given an active role in contributing their expertise to any allocation process. Guidelines should be reviewed regularly and updated.
 - d. Adequate appellate mechanisms for both patients and physicians should be in place.
 - e. Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information.
 - f. The physician’s obligation to disclose treatment alternatives is not altered by any limitation in the coverage provided by managed care.

¹Council on Ethical and Judicial Affairs, American Medical Association 1995, pp. 330–335

- g. Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.
3. Financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care. Health plans and other groups should develop financial incentives based on quality of care.



Guidelines of Practice for Managed Care Reviewers

These guidelines were approved by the American Psychiatric Association Board of Trustees, October 18, 1999.

The American Psychiatric Association defines these guidelines of practice as applicable to psychiatrists functioning as medical directors and medical reviewers working for MCOs. Psychiatric reviewers working in medical review, precertification, retrospective review, and necessity of ancillary service utilization and diagnostic test utilization are bound by sound clinical principles and judgment. Psychiatrists who render judgments that deny a patient the care recommended by their treating psychiatrist or other mental health clinicians should do so only after obtaining a full and complete medical understanding of the facts and the situation of the patient by reviewing appropriate records, tests, and procedures and consulting with the patient's treating physician.

Reviewers should not selectively entertain data to support their decisions while eliminating contradictory data from discussions and consideration. Their decision should be based on sound medical principles embraced by the medical community and should not be arbitrary or capricious. If patients are seriously ill and there is a dispute concerning judgment that relates to the patient's immediate safety and security, the attending physician's judgment should prevail. The managed care medical directors or reviewing physicians should understand that some courts have ruled that some reviewers are making medical decisions related to patient care when they override the judgment of the treating physician or disallow recommended care.

Psychiatric reviewers should only practice in systems that have a prompt and competent system of decision appeal. In reviewing medical necessity for treatment and precertification, reviewers must

- (1) use standards appropriate to the community where the patient resides when determining the medical needs of the patient; and
- (2) make determinations based upon “reasonable” need and the likelihood that the patient will benefit from appropriate treatment.

The reviewer’s job is to ascertain the appropriateness and necessity of recommended medical treatment, not simply to curtail costs. The reviewer should never refuse or reduce needed treatment. The American Psychiatric Association affirms the position of the American Medical Association that no managed care director or reviewer should receive compensation based on bonuses obtained by the reduction or elimination of care, nor should they receive compensation from hold-backs based on performance of disallowal of care. Managed care reviewers should treat both patients and their colleagues with dignity and respect. They should provide specific written reasons for the disallowal of requested treatments and procedures and include information about the appeals process. Reviewers, like treating physicians, are subject to legal and ethical sanctions for misconduct.

In summary, medical directors and managed care reviewers should consider themselves physicians first, dedicated to the constructive use of resources in an attempt to provide assistance to patients rather than deny care. They should work with treating physicians as colleagues and neither override nor disallow decisions without a sound medical basis that is then communicated in writing.

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Sabin’s Credo for Ethical Managed Care in Mental Health Practice²

1. As a clinician, I am dedicated to caring for my patients in a relationship of fidelity and at the same time, to acting as a steward of society’s resources.
2. As a clinician, I believe it is ethically mandatory to recommend the least costly treatment unless I have substantial evidence that a more costly intervention is likely to yield a superior outcome.

²Sabin 1994, pp. 859–860

3. In my stewardship role, I need to advocate for justice in the health care system, just as in my clinical role, I need to advocate for the welfare of my patient.
4. If a potentially beneficial intervention does not meet the explicit public standards for third-party coverage in a just system, as a clinician I believe the ethical course is to withhold the intervention and to discuss the situation openly with my patient.


Conclusion

Managed care has afforded major ethical challenges to the psychiatrist. The comments and cited ethical standards in this chapter may offer some guidelines to the practitioner.


References

- Council on Ethical and Judicial Affairs, American Medical Association: Ethical issues in managed care. *JAMA* 273:330–335, 1995
- Sabin JE: A credo for ethical managed care in mental health practice. *Hosp Community Psychiatry* 45:859–860, 1994