

"The greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well-meaning but without understanding."

-Omstead vs United States, 1928
Justice Lewis Brandeis

**Social and Legal Implications of
Managed Care In Psychiatry**

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PART I

HISTORY OF MANAGED CARE AND ITS SOCIAL IMPLICATIONS

During the last decade, managed care and "managed competition" have become a fate accompli in American medicine. Some applaud their development as cost saving mechanisms that will ensure that all Americans receive appropriate medical care,(1-10) and point to the gross abuses of care that profit driven medicine has caused, while others decry their impact on the health delivery system and the medical profession.(11-20) Physicians worry about managed care's impact on their autonomy and professional identity.(19,21,22) Much of the rationale for the increasing support of third party intermediaries has been the cry that patients need to be protected from unscrupulous physicians; that doctors need more control to force them to practice honest and cost efficient medicine.(23) Proponents of managed care argue that it provides better value and increased quality in relation to cost and provides for better accountability of the health care delivery system. They note that managed care permits the assessment of clinical practice, standardizes the types of care delivered and is better suited to provide clear cut outcome measures than individual practitioners. They argue that the alarming increases in the cost of health care mandate that a new system be developed to align incentives in clinical, administrative and economic terms. Many of the proponents of managed care argue that this is a system in transition and represents a first step in equilibrating American medicine, as it evolved into a care delivery system that is affordable, accessible and avails all Americans appropriate care. They argue that managed competition will provide for continuous quality improvement through an outcome driven delivery system. As health care systems mature, other systems are likely to emerge such as physician hospital care organizations, provider controlled health care groups and population-based treatment models. Many advocates of managed care believe that this diversity of programs will enhance patient satisfaction, reduce the cost of care and provide a means to study the outcome of the care given.(1,2,5-8) Advocates of the managed care system feel strongly that payment should be related to outcome and clinical efficiency and advocate the development of treatment protocols, many of which unfortunately, are currently seen as proprietary and thus kept secret. The more far sighted among them believe that as outcome research is undertaken, treatment results will improve and costs will be constrained, a process benefiting both the nation and the consumer.

Physicians on the other hand argue that the profit motive of the managed care intermediaries and large corporate entities is destroying the practice of medicine and that the alleged cost savings that these systems produce are fantasy not fact. Many feel that managed care patients suffer from rationed and inferior care.(19,24-32)

This article reviews some of the social forces important in the development of managed care. A companion article to follow reviews some of the more important recent legal decisions and defines the physician's responsibilities to their patients and to managed care providers.

SOCIAL FORCES AFFECTING MEDICAL PROFESSION DURING THE LAST TWO DECADES

In 1982, Paul Starr's book, "The Social Transformation of American Medicine" (33) received considerable national notoriety. Starr traced the evolution of American medicine over the last two centuries focusing on the changes in attitude toward physicians and the services that they provide. He began with a discussion of Americans' traditional distrust of doctors during the 1800s and followed the physician's social evolution and their establishment of cultural authority and control over the practice of the healing arts. Starr demonstrated how, with the enormous breakthroughs of the twentieth century, American physicians were able to "increase their control until it extended over virtually every aspect of health care." He suggested that hospitals were transformed into medical workshops subsidized by government programs. He noted that as technology became more sophisticated and as medical fees increased, that the public became increasingly disenchanted with the medical care that they were receiving. The humanism so pronounced in 19th century medicine had become tarnished during the last half of the 20th century as technology overtook "compassion" as the basis of medicine. These changes produced a distrust of physicians and of the health care industry as a whole. Starr suggested that unless these factors were reversed, that medicine would become truly regulated and "more bureaucratic and insensitive" than ever before. The past 11 years have proved his predictions most prophetic.

Realman(34) calls attention to a variety of social forces that were operative during the last 20 years that also greatly affected medicine's transformation. In the early 1970's government health advisors, in looking at the British and Canadian medical systems, realized that if America were to move toward a more "regulated" system, that it would require an increasing number of generalists to serve as "gate keepers." Recommendations were made for the government to encourage development of more family practitioners. New government policy, tied to offers of financial support, encouraged medical schools to increase their graduates and placed a selective emphasis on support for family practice residencies. In the late 1970s the government specifically directed that more primary care providers be graduated. These directives were followed by legislation encouraging the development of health maintenance organizations and changes in governmental policy that specifically encouraged For Profit companies to enter "the medical marketplace" previously the professions "mare nostrum."

It was at this time that health care passed from the control of the profession (i.e., physicians and professional hospital administrators) to a series of medical entrepreneurs, some of whom had training and experience in the medical field, others of whom did not. Insurance companies developed health products with careful attention to the bottom line, and the structure of medicine in America began to change. For Profit medical facilities expanded rapidly and companies vied for market niches and competed for paying patients. National hospital occupancy rates fell from 80% in 1970 to less than 70% in 1990. New hospital construction of free standing psychiatric hospitals became rampant, with increasing costs being paid by the mad scramble to fill empty beds. Huge profits were taken.

As physicians became aware that there was an increasing supply of doctors, they became fearful of not being able to maintain their accustomed life style. Many opted for salaried or contracted employment with health maintenance organizations, while others guaranteed their incomes by further specialization or developing new office "procedures." The technology of medicine expanded rapidly, with CTs, MRIs and in some regions of the country PET scanners and new cardiognostic equipment becoming generally available. New advances in all fields of medicine placed an increasing emphasis on "technology." To stay competitive, a hospital had to have the "latest" equipment. Defensive medicine became rampant as medical malpractice suits rose 400% between 1970 and 1990, driving up the cost of physician health insurance and forcing practitioners to practice defensive medicine based on "accepted community standards."

During the late 1970s and early 1980s, law suits, government regulations, and new legislation increased the number and scope of "other qualified providers" (i.e., Pharm.Ds, Nurse Clinicians, Physicians' Assistants, Psychologists). These allied health or alternative providers were permitted by law to perform many of the procedures and treatments that had heretofore been the realm of the physician. In various settings, they could prescribe medications, perform physical examinations, admit to hospital, etc.

Health care moved forward on a two-tiered system; a low tech socially controlled model which offered limited care, available at a reasonable price; and a high tech, high cost system that in non-emergent situations, could in general be accessed only by patients with private indemnity insurance. The commercialization of medicine caused medical professionalism to give way to a new spirit of entrepreneurialism. Physicians continued to lose their relationship with their patients. Lawyers and businessmen began to "deliver lives," that is, broker patients to various providers with patients' choices being determined by the "lowest bid" obtained. It soon became apparent that additional efficiencies could be squeezed out of the system if "vertically integrated systems" could be developed permitting brokers to totally control the site, volume, nature, and providers of care. With these systems, it became possible for the first time for managed care companies to determine the nature and extent of care provided as well as by whom. Just as the bottom line reduced the professional's judgement through protocol driven medicine, it also restricted the type of care that was available and rationed the care available to the patient. Articles began to appear suggesting that patients were receiving less than adequate "managed care".(19,34)

Although often overlooked and understated, the legal changes instituted by the courts had a considerable impact on the evolution of managed care. In the Seminal case of Goldfarb vs Virginia State Bar, 1975, the Supreme Court ruled that the Sherman Antitrust Act which had previously been thought to exclude both the legal and medical profession, should no longer be construed to protect these two groups.(35) The court directed that the Federal Trade Commission Act should be applied to these professions. This ruling: (1) directly encouraged medical advertising; (2) directed competition in health care and was interpreted to (3) encourage physician joint ventures alone and with hospitals and (4)

approved the concept that insurance companies could assume the role of "providers of care" rather than simply remain the financiers of care.

The Act specifically forced the AMA to change its standard of medical ethics. In 1957, the AMA Code of Ethics contained clear anticommercial recommendations to physicians, stating that "The principle objective of the medical profession is to render service to humanity." "In the practice of medicine, a physician should limit the source of his professional income to medical service actually rendered by him, or under his supervision, to his patients."⁽³⁶⁾ After the Goldfarb decision this Code was changed to read "1. Physician advertising is permissible as long as it is not deceptive; 2. Investments in health care facilities are permissible if allowed by law, disclosed to patients, and do not interfere with the physician's primary duty to his or her patients; 3. Competition is 'not only ethical but encouraged'." The new interpretation of the Antitrust laws stopped hospitals from negotiating with one another so that there could be orderly development of services within a community and specifically precluded them from sharing such expensive equipment as MRIs, CT scanners, etc. It specifically forbade them to agree not to duplicate services. The net result of this ruling was to dramatically increase the cost of health care, rather than to diminish it, since hospitals marketed themselves by assuring the public that they possessed the latest technology.

The Goldfarb ruling spurred a rush toward investor-owned health care organizations where outcome was measured by the bottom line. Throughout the country, there appeared new hospitals, clinics, nursing homes, diagnostic laboratories, CT scanning centers, day care facilities, ACLFs etc. Today the majority of nursing homes, private psychiatric hospitals, freestanding therapeutic and diagnostic facilities are investor-owned. Two third of America's HMOs which provide care to almost 40 million Americans are investor-owned.

Corporate health care became protocol driven, the development of these protocols being heavily influenced by profit. Profit in these systems was maximized by a bureaucracy that (1) limited access to costly technology and therapy, (2) recruited the healthiest citizens for managed care plans, (3) reduced the availability of specialists and (4) encouraged the provision of treatment by the least costly professional, a fact particularly relevant to psychiatry. Realman⁽³⁴⁾ in a brilliant article reviewing these changes encouraged medicine to look carefully at itself and to regain control of the doctor-patient relationship.

The commercialization of medicine affected medicine as a profession, challenged the values upon which it was based, set new expectations for ethical commitment to patients, diminished professional self regulation, reduced professional identity, encouraged physicians to follow protocols rather than to develop new methods of practice and some would argue, reduced clinical excellence while providing the public with a more homogeneous and cost efficient "product." The physician's commitment to his/her patients became suspect when it became clear to the public that many managed care physicians' economic interests were at variance with providing the best patient care.

The new commercialism, some argued, also bred increasing compliance, as managed care organizations increasingly chose only physicians who were "managed care friendly," i.e. obedient to management's directives. Compliance was valued over competence. This focus on compliance bred mediocrity and a physician commitment to the managed care company rather than to the patients he/she served.

The initial savings that were expected from managed care, particularly through third party regulatory intermediaries, have not been realized.(37) Dickey and Azeni(37) in evaluating the effects of managed care strategies, were able to show only limited effectiveness for psychiatric concurrent review programs and no support for the effectiveness of the prior approval review mechanism. These authors raise the question, "Why do we find so little impact from managed care programs, when so much has been promised". They suggest that patients hospitalized in these programs were "more seriously ill" as evidenced by (1) increasing lengths of stay; (2) an increase in the number of patients with major mental illness; (3) an increase in co-morbid conditions (i.e. psychiatric and substance abuse secondary diagnoses). Wickizer(38) notes that most of the savings claimed by managed care companies have not been rigorously evaluated and the majority of the information about them in the past has been anecdotal. He summarizes the studies published that report reduction in both the use of services and their cost but notes that the data supporting these claims is not convincing. In what Dickey and Azeni describe as "The most analytically sophisticated research to date, two studies tested the effect of managed care programs on measures of utilization and on expenditures. They found that the programs reduced hospital use and expenditures by 8%. Not an overwhelming figure when one considers the cost of these monitoring programs.(39,40) The initial savings were more the result of displaced care than reduced waste. As managed care became more inequitable and expensive, and as the quality of care declined, the public became more and more disenchanted with physicians, on the one hand seeing them as the culprits producing the rapid increases in medical costs and on the other hand, as individuals who were no longer committed to their Hippocratic Oath or their patients. They did not direct their anger toward the businessmen or the government for their plight (in fact, surveys showed patients were more satisfied with their managed care than with physicians in general). The public held physicians responsible for health care's plight, thus seriously eroding the nobility and altruism of medicine that in Starr's analysis had always given medicine its authority.

The impact of these changes was more profound for psychiatry than the rest of medicine, in spite of the fact that there have been no substantive change in the principle diagnoses made in psychiatric patients from 1987 to present. (i.e. affective disorders are diagnosed in about 45% of patients; schizophrenia in 10-12%; substance abuse in at 8-9%; alcohol related diagnoses in at 8-9%; anxiety, somatoform and dissociative diagnoses in 5%; pre-adult disorders in 5%; organic mental disorders in 3%; personality disorders in 2% and other psychotic disorders in approximately 4%.(41) Our patients haven't changed but the care we provide them has diminished!

Most psychiatric care in America today remains outpatient, (77% of patients); 5% are treated in partial hospital programs while 18% are cared for in inpatient settings.(42) The

total expenditure in 1986 for inpatient psychiatric care was 18.9 billion dollars with 6.4 billion dollars being spent at State Hospitals; 3.7 billion at multi-serve mental health organizations (i.e. CMHCs; HMOs); 3.2 billion in general hospitals; 2.8 billion in private psychiatric hospitals; 1.5 billion in residential treatment centers, partial hospitals and outpatient clinics and 1.3 billion at Veterans Administration Hospitals.(44) The vast majority of patients receive treatment in the least restrictive setting. The assumption that these costs can be dramatically changed through the appropriate provision of lesser levels of care, has not been demonstrated to date. The Office of Technology Assessment has, however, documented that properly delivered psychiatric care, administered in a timely fashion is remarkably effective.(45)

The new emphasis on outcome research will be helpful to psychiatry, as it will define in a much clearer way the efficacy of what we do. Nationally, perhaps 10-20% of hospitalized patients could be appropriately served in a less restrictive or costly setting. The remaining patients require an acute inpatient stay and assumptions that inpatient admissions and for that matter, outpatient treatment can appropriately be cut by one-half to three-quarters are short sighted and will ultimately result in increased costs being passed on to society through increased morbidity. One need only look at the closing of the state hospitals in New York, with the resulting increase in psychotic homeless living on the streets to understand the impact of these decisions.(29,30)

The evolutionary trend in managed care development suggests that these programs are moving toward vertically integrated systems (Figure 1). The administrative costs of many managed care systems are extraordinarily high. A recent common cause survey showed that health insurance administrative costs increased from between 10% to 21% in 1980, to between 20 to 37% in 1990.(43) Third party managed care intermediaries monitoring psychiatric practice may add an additional 10 to 25 cents of every premium dollar to this already inflated figure. Some authors have suggested that the need to disallow admissions by various managed care corporations has either consciously or unconsciously led to inappropriate behavior on the part of their employees who deny even the most clearly appropriate admissions to hospital. In a recent study, Thompson et al(44) showed that case managers assigned considerably higher GAF scores (indicating less severe illness) to patients than did practitioners and subsequently used these scores as a reason to disallow hospital admission.

Recent dissatisfaction with various aspects of managed care has produced dramatic changes in the acceptance of these systems.(12) From 1987 through 1990 the number of U.S. employees in unmanaged (conventional) insurance plans declined from 41% to 5%. Initially, many of the patients who joined managed care programs were enrolled in staff model HMOs, however, from 1986 through 1990 there has been a dramatic reduction in the percentage of patients who enrolled in staff model MHOs because of dissatisfaction with these systems, particularly the patient's inability to choose their physician. From 1986 through 1991, patients began to shift their allegiance from staff model HMOs to PPOs which by 1991 controlled 70% of the new enrollments to managed care because

they offered freedom of choice of physicians and provided what patients perceived as enhanced care.(46)

To understand some of the practice aspects of managed care, particularly as it effects psychiatry, one needs to understand the cost containing mechanisms employed by these systyems. The first is to insert a level of control between the patient and the physician. This may adversely effect the physician-patient relationship by impugning the motives and duty of the physician to the patient. Second, one must understand that in a managed care format, profit is derived by controlling cost. The means of controlling cost include (1) controlling the utilization of services; (2) limiting expensive treatments; (3) reducing follow up visits; (4) limiting diagnostic studies; (5) controlling formularies; (6) limiting visits to specialists; (7) reducing or eliminating laboratory procedures; (8) reducing or eliminating "heroic" measures to preserve life; (9) providing care by utilizing the least expensive professional (i.e., substituting an LPN for an RN, a Bachelor's for a Master's level counselor for a Ph.D, a social worker or psychologist for a physician, etc.), and finally by placing the gate keepers and providers at financial risk.(47)

Industry often attempts to reduce its cost by employing a utilization review company to act as an intermediary between an insurance company and the patient's physician. These managed care intermediates constrain utilization by making the treating physician "request" authorization and by giving "permission" for the patient's treatment (i.e., determining "the medical necessity"). They determine what health care the patient's insurance company will "approve."

Much of the physician dissatisfaction with these systems has to do with what doctors perceive as the ethically questionable behavior modeled by some of these companies such as training their staff to "just say no" (i.e., disallow as much as possible) with the assumption that only 10% of cases will be appealed because of the paperwork burden that is placed on the provider. Increasingly managed care companies have attempted to discourage treatment by demanding excessive paperwork or requiring daily phone reviews which are seen by physicians as harassment.(20) Companies may send letters to patients stating that they have disallowed their "request" for reimbursement because their physician was "unavailable" or "uncooperative" producing a potential doctor-patient conflict which places the physician at risk for suit. Several managed care companies have developed complicated provider compensation methods which reward contracted reviewers and providers for disallowing hospitalization and reducing services and therefore costs. These companies also provide financial disincentives for physicians in their networks who "over-utilize" care.(19) In addition, they continually "update" their physician panels and drop physicians who spend more on patient care than do other more "efficient" physicians in the system.(47) They continue to employ physicians who are willing to rigidly follow company protocols.

The hiring of physician reviewers by these companies permits a physician to be the agent of treatment disallowal. If reviewers are too provider friendly they are replaced with physicians who more carefully follow company protocols. Finally, some managed care

firms attempt to develop slow and cumbersome appeals processes that they feel must be exhausted before final denials and litigation can begin.

Our current system of managed care intermediaries raises several legal and ethical questions for the practicing psychiatrist. To whom does he owe his allegiance? What is the extent of confidentiality of the patient's personal information? How far should the physician go in appealing the patient's need for ongoing treatment? How much of a patient advocate should a non-managed care physician be? Should additional consultation be sought before accepting controversial managed care decisions? What is the authority and liability of the physician reviewer? For whom does the private physician work - the patient or the insurer? To whom is duty owed? Does the patient contractually have to let a managed care provider make his decisions? Can he exercise additional free choice? Does managed care represent community care (i.e. community practice standards)? Can the physician ethically withhold diagnostic procedures that he feels are in the patient's best interest because a reviewer determines them medically unnecessary? If care is disallowed and the patient is frightened to continue to seek treatment because of financial ruin, does the physician have an ethical or moral obligation to follow the patient in a setting that he feels is inappropriate? What rights and authority do physician reviewers have relative to the treating physician? What legal obligations do they incur for their disallowal of treatment? The second part of this article will address the above concerns and provide a review of some of the more important recent litigation in this area.

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