A Survey of Pennsylvania Psychologists on Managed Care and Other Issues

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ABSTRACT. A total of 147 licensed psychologists in Pennsylvania responded to a survey sent to an anonymous random sample of Pennsylvania psychologists. The survey was designed to: (1) gather systematic data on the impact of managed care on the quality and accessibility of patient services; (2) update data on the utilization of Medicare and Medicaid treatment by psychologists; (3) gather data on the professional affiliations and political activism of psychologists; and (4) update information on fees and practice patterns of psychologists. Psychologists reported that managed care appeared to decrease the quality of psychological services and access to patient services. Utilization of Medicare has increased over the last 4 years. Political activism appeared directly related to membership in professional organizations. However, the sample responding to the survey was skewed in terms of psychologists in independent practices, thus limiting the generalizability of the data. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]*

Although psychologists and other mental health professionals can report much anecdotal data (Lazarus, 1994; Sederer & Mirin, 1994) con-

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erning the impact of managed care on their practices, this survey was esigned to gather systematic data on the impact of managed care upon the atients of psychologists. The survey also updated data on the fees and ractice patterns of psychologists and on utilization of Medicare and Med-:aid treatment by psychologists. Finally, the survey was used to gather ata on the professional affiliations and political activism of psycholo-ists. The data from the survey was gathered to help the Pennsylvania sychological Association (PPA) plan for future advocacy efforts sur-)unding managed care and other reimbursement issues.

There has been considerable recent interest, both from the public and ofessionals, on the influence of managed care on therapeutic practices. :veral articles have described the possible impact such changing practices id health care reform could have on the practice of psychology (Hersch,)95). Most analyses were critical of the possible impact of managed care ganization (MCO) on psychotherapy services (Kuhl, 1994; Lazarus,)94), but not all views have been wholly critical (e.g., see Zimet, 1994; izarus, 1994). Some arguments against MCO have been vigorous, noting enced psychotherapists and compromised optimal mental health care /ooley, 1993).

The review of the McLean Hospital experience (Sederer & Mirin, 94) suggested several areas of potential problems in MCO influence and delivery of clinical services. The influences have included exclusion of ients, intrusion into doctor-patient relationships, possible psychodynamic)blems with review, liability, confidentiality losses and loss of support training and research. While the tone of most articles emphasizes)blems, some authors (as Moldawsky, 1990) take a more optimistic w, noting that independent private practices may not be as disrupted as ne fear.

What has been generally lacking in most of these views was data to)port the views expressed by the authors. The development of MCOs been so recent that few sound data descriptions, even elementary criptions, have been provided. Only Austad, Sherman, Morgan and lstein (1992) provided clearly defined data to organize their views. :n so, it is clear that psychotherapists and other mental health profes-ials have viewed the impact of MCO with foreboding and pessimism.

n our survey of psychologists in Pennsylvania, our goal was to obtain on the nature of their experiences with MCO. While survey data ers from many limitations, it was believed that the data could provide lance about the experiences of psychologists with MCO.

RESULTS

The survey was sent to 441 randomly chosen psychologists licensed by Pennsylvania's State Board of Psychology. A total of 147 psychologists responded, yielding a response rate of 33%. The responding sample was overrepresented among PPA members and psychologists engaged in the delivery of health care services.

Educational Background

The questionnaire asked respondents for their highest educational degree in psychology. Pennsylvania has licensing for both doctoral and master's level trained psychologists, although future master's level licensing was discontinued in 1995.

In 1986, the Pennsylvania General Assembly renewed the Professional Psychologists Practice Act, but provided for the gradual elimination of new master's level licenses. Students who were enrolled in graduate school before September 30, 1986 had until December 1995 to become licensed at the master's level. Students who enrolled in graduate school after September 30, 1986 could only be licensed at the doctoral level.

Of those who indicated their highest degree, 34% had doctorates in Clinical Psychology, 5% had Psy.D. degrees, 4% had either Ed.D. or Ph.D. degrees in School Psychology, 13% had either Ed.D. or Ph.D. degrees in Counseling Psychology, 20% had doctorates in other fields of psychology, and 25% had terminal master's degrees.

The percentage of respondents with doctoral degrees in School Psychology was lower than the 11% found in a previous survey by Bowers and Knapp (1993). This may suggest that the managed care emphasis of the survey was not viewed as relevant to School Psychologists, who then tended not to respond to the survey.

Practice Settings

The survey asked for the primary work settings of licensed psychologists. The survey showed that 70% of psychologists worked in some kind of private practice, including 53% in full-time private practice and 26% in part-time private practice. Psychologists in private practice reported an average of 27 hours of direct service per week.

This survey found a higher number of psychologists in private practice than found in previous surveys. It is possible that the focus of the survey on managed care may have led to a disproportionately large number of private practitioners to respond to the survey.

Professional Affiliations

Of the 147 psychologists responding to the survey, 65% (95) belonged to the Pennsylvania Psychological Association, 70% (103) to the American Psychological Association (APA), 3% (5) to the American Psychological Society (APS), 10% (15) to the Association for the Advancement of Psychology (AAP), and 35% (51) belonged to a regional psychological association. Although PPA members constitute only about 40% of the psychologists in Pennsylvania, they represented over 60% of the respondents to this survey.

Fees and Practice

The mean fee for an hour of individual psychotherapy was $90 and the mean fee for an hour of group psychotherapy was $42. The fees for an hour of individual therapy were slightly higher than the $82 found for Pennsylvania psychologists in Bowers and Knapp (1993) and the $75 found in Knapp, Bowers, and Metzler (1992). This increase may reflect normal inflationary trends, although the rate of increase is much higher than inflation for the time period. The fees for group psychotherapy was also higher than the $33 an hour found among Pennsylvania psychologists in Bowers and Knapp (1992).

Managed Care

Psychologists were asked to rate on a scale of 1 (strongly agree) to 5 (strongly disagree) their reactions to a series of questions dealing with the quality of care provided by managed care organizations (MCOs). As Table 1 shows, psychologists were often critical of managed care, believing that MCO may have harmed the quality of and patient access to care. Other questions asked psychologists to identify ("yes" or "no") whether they had specific experiences with managed care companies. Table 2 describes the nature of specific experiences psychologists have had with MCOs.

Providers believed that the rules regarding parameters of treatment (as duration or frequency) were not clearly explained to them. A large minority (40.2%) of providers complained of experiencing a change in rules or policies, of which they were not informed, that impacted upon patient care. Many (61%) felt frustrated by the failure of the MCO to respond promptly to telephone calls or formal correspondence. The most favorable response came from the communication of the policies regarding utilization reviews. However, even those were rated as slightly negative by the

TABLE 1. Psychologists' Views on Managed Care Organizations (MCO)

	Agree	Neutral	Disagree
–Policies Clearly Defined by MCO	20.5%	24.3%	55.1%
–Provider Choice Clearly Defined	17.0%	17.0%	66.1%
–Concern for Patient Access to Care	7.0%	17.2%	75.8%
–MCO Concern for Patient Choice	1.0%	16.5%	82.5%
–Patients Understand Appeal Process	15.6%	36.4%	48.1%
–Providers Seek Extension Without Penalty	20.9%	29.2%	50.1%
–Clearly Understand Criteria to Appeal	15.6%	36.4%	48.1%
–MCOs Respond Promptly	20.0%	19.0%	61.0%

Note: Percentage may not sum to 100 because of rounding.

psychologists. Psychologists believe that the development of provider panels did not typically show concern for patient access to care and restrict patient access to providers. Many psychologists (60.6%) reported that the active treatment of a patient was disrupted by their rejection from a closed panel.

Psychologists believe that patients know very little about their rights to an appeal for the extension of services. The psychologists themselves do not believe the process is well explained. Psychologists fear being terminated from panels if they appeal decisions, although only a few (5%, n = 5) reported being terminated for appealing decisions.

Medicare and Medicaid

The Health Care Financing Administration and its carrier, Pennsylvania Blue Shield, have divided psychologists into two classes. "Clinical Psychologists" have to have a doctoral degree in psychology and two years of supervised experience, one of which has to be post-doctoral. Clinical

TABLE 2. Psychologists' Reported Interactions with Managed Care Organizations (MCO)

	% Noted
1. Panel rejection causes disruption of care to a patient	60.6%
2. Penalized for requesting extension of services	5.3%
3. MCO rules change impact negatively on patient care	40.2%
4. MCOs show flexibility that impacts positively on patient care	31.0%

Psychologists are able to receive reimbursement under Medicare for a wide range of procedure codes including individual, group, and family psychotherapy. Physician oversight or referrals are not needed for Medicare reimbursement. "Independent Practicing Psychologists" are eligible to receive Medicare reimbursement only for psychological testing upon a physician's referral.

Of all psychologists, 64% were enrolled with Medicare as "Clinical Psychologists" and 11% were enrolled as "Independent Practicing Psychologists." The number of Clinical Psychologists treating Medicare patients had increased over the last several years and the number of Medicare patients being treated by individual psychologists increased as well. As Table 3 shows, only 1% of Clinical Psychologists were treating 5 or more Medicare beneficiaries in 1991, whereas 15% of Clinical Psychologists were treating 5 or more patients in 1994. While the percentage of psychologists treating 5 or more Medicare patients has increased, the number remains small.

In 1994 the Department of Public Welfare in Pennsylvania made psychologists eligible for Medicaid reimbursement for diagnosing or treating some children under 21. Unlike Medicare, eligibility for Medicaid reimbursement was uniform for all licensed psychologists.

About 33% of all psychologists had acquired a Medicaid number, 4% of psychologists were treating 5 or more Medicaid patients, 1.4% were treating 3 or 4 patients, and 3% were treating 1 or 2 Medicaid patients.

Political Activism and Association Membership

As can be seen in Table 4, membership in professional associations is related to political activism. For purposes of this discussion, psychologists who belonged to PPA or APA were combined. Psychologists who belonged to professional organizations reported voting significantly more often than psychologists who did not belong to professional organizations (91.9% vs. 73.9%). Psychologists who belonged were actually less likely to report knowing the name of their state representative (50.0% vs. 76.5%). Nevertheless, those psychologists who belonged to professional organizations were significantly more likely to have sent a letter to a government official on a psychology issue in 1994 (62.7% vs. 37.5%). Only one nonmember psychologist met with a government official on a matter related to psychology in 1994 (compared with 11 professional association psychologists). However, the difference did not reach statistical significance.

TABLE 3. Psychologists Treating Medicare Patients

	1990 Survey	1994 Survey
5 or more	1%	15%
3 or 4	8%	8%
1 or 2	24%	31%

TABLE 4. Political Activism Among Psychologists According to Association Membership

Action in 1994	Total	AAP	Both APA/PPA	Neither APA nor PPA
	(N = 147)	(N = 15)	(N = 123)	(N = 72)
Voted election	86%	100%	91.9%	73.9%
Knew winning State Rep.	43%	20%	50.0%	76.5%
Letter to Gov. official on psychology issue	58%	87%	62.7%	37.5%
Met with Gov. official on psychology issue	12%	13%	14.7%	< 1%
Contributed to PennPsyPAC	32%	67%	44.4%	12.5%
Contributed to AAP/PLAN	27%	80%	34.7%	8.3%

Contributions to Political Action Committees

The data on contributions to AAP/PLAN and to PennPsyPAC (a Pennsylvania Psychological Political Action Committee) is highly suspect because nonmembers overestimated the frequency with which they contributed to AAP/PLAN and PennPsyPAC. Although the survey was sent to a sample of 10% of the psychologists licensed in Pennsylvania, 6 non-PPA members from this sample claimed they contributed to PennPsyPAC in 1994. Extrapolating from that data and accounting for the differential response rate, we would expect that between 60-200 non-PPA members should have contributed to PennPsyPAC in 1994. However, PennPsyPAC data showed that only 5 non-PPA members contributed to PennPsyPAC in 1994-1995. Clearly, many nonmembers who did not contribute to PennPsyPAC reported that they did. It is possible that some nonmembers gave some money at some time to something they believed was related to psychology. However, they greatly overestimated the likelihood of contributing to PennPsyPAC.

Similarly, the data also showed that 27 non-AAP members contributed to AAP/PLAN. This was not plausible because AAP/PLAN can only solicit money from AAP members. It was possible that some non-AAP members had contributed to one of the fund-raising campaigns that activist psychologists in Pennsylvania had conducted for various federal candidates in 1994, or had confused AAP/PLAN with the APA Special Assessment, or another fund-raising activity.

DISCUSSION

The data has the limitations inherent in all survey research. As detailed below, there were reasons to believe that some psychologists gave inaccurate responses to some of the questions to the survey. Furthermore, the response rate showed that respondents tended to be skewed towards those who were PPA members or psychologists in independent practice. This is not surprising because the major purpose of the survey was to identify problems psychologists were having with managed care.

Demographic and Fee Data

The demographic data on the educational backgrounds and work settings of psychologists may not be useful because of the skewed nature of the responses. The data on the average fees for individual and group psychotherapies appears accurate and is consistent with previous surveys, but demonstrating a moderate but clear increase.

Managed Care

As a group, psychologists do not perceive that managed care is in the best interests of their patients. Managed care companies are perceived as providing conflicting and ambiguous information to providers and patients. In an open response portion of the survey, psychologists expressed frustration with being unable to receive information from MCOs. One psychologist noted that "MCOs grow, are bought, change policies at will. Providers are told after the fact, if at all." Another noted that "fees and coverage of active patients has changed several times without any prior notification to me." Other psychologists complained about the "telephone tag" or frustrations of going through answering machines or voice mail devices.

Psychologists also complained about the highly variable forms and standards that come from different managed care companies. Many commented that "patients knew little or nothing" about their benefits. One psychologist who worked in an inpatient facility noted that some patients received large and unexpected bills because their MCO had not communicated clearly to them about their financial responsibilities. Others noted that patients are often unfamiliar with the gatekeeper requirement or are unaware that their choice of providers is limited.

The formation of panels was another concern for psychologists. Many psychologists noted that many patients had their treatment disrupted when new provider panels were created or merged. Some psychologists complained that provider panels were formed with concern for getting the cheapest providers. Other psychologists, who were licensed with a master's degree, complained that they were excluded from panels because they did not have a doctorate. It appears that the formation of panels varies considerably with the MCO, especially in the emphasis given for academic credentials and training.

Generally speaking, psychologists saw the role of case managers as one of denying treatment. One psychologist stated that "what is clearly communicated is get the patient out of your office quick or we will have patients see someone else." Furthermore, appeals procedures were described as poorly understood by patients and poorly explained to psychologists.

Several respondents were able to identify case managers who used authority to extend patient benefits or services. Nevertheless, even then more than two-thirds of psychologists were unable to recall situations

where MCOs showed flexibility to benefit the patients. One psychologist commented, "There is not one MCO that has ever improved on patient [care] . . . ever."

MCOs were perceived as being punitive towards psychologists who advocated on behalf of their patients, although only 5% of psychologists actually reported being removed from panels for appealing decisions. Psychologists believe that the reprisals may be severe (termination from the panel), although also possibly subtle. One psychologist noted that providers who extend services to their patients eventually receive fewer or no referrals. Another offered a personal experience where

> I was disenrolled with no explanation (contract included a clause for termination without cause). The one patient I was treating in the MCO required intensive, long-term treatment and I had filed two appeals for approval to use her benefits.

Medicare and Medicaid

Psychologists are more involved with Medicare and Medicaid than in the past. In 1993, Pennsylvania Blue Shield expanded its definition of Clinical Psychologists, thus greatly expanding the number of psychologists who became eligible to receive reimbursement for treating Medicare beneficiaries. Furthermore, psychologists were treating more Medicare beneficiaries than they did several years ago. It is not clear how much of the increase was due to the expansion of the pool of psychology/Medicare providers and how much was due to the dissemination of general knowledge that psychologists could treat Medicare patients. Medicaid utilization by psychologists was low, probably reflecting the newness of the program to including psychologists as providers of services to children under 21.

Political Activism

Three conclusions can be drawn about political activism among psychologists from this data: (a) most psychologists vote; (b) psychologists who belong to psychological associations are significantly more politically active than psychologists who do not belong; (c) a large number of psychologists confuse PennPsyPAC and AAP/PLAN with other organizations. The widespread ignorance or confusion about PennPsyPAC and AAP/PLAN is especially problematic because it means that many psychologists do not understand the roles of (let alone the names of) the various professional advocacy organizations.

The data suggests that the ability of psychologists to overcome the abuses of managed care organization rests upon the degree of their support for advocacy organizations. Unfortunately, many psychologists do not understand basic information about their advocacy organization, including the names and purposes of these groups. Further, the problems in gaining a reliable or accurate picture of political activism of psychologists could reflect the socially desirable nature of such responses. Survey questionnaire studies, such as the study here, benefit from attempts to have respondents describe independently verifiable responses rather than only opinions.

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