Commentary from a Health Economist: Financing Pediatric Psychology: On “Buddy, Can You Spare a Dime?”

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Rae (this issue) succinctly lays out a number of challenges facing the pediatric psychology profession today. Not surprisingly, while concerns about professional acceptance and the ability to develop standards of care and measures for efficacy are present, the principle source of consternation is financial. Like many of their colleagues, pediatric psychologists find themselves trapped in a reimbursement model that worked two decades ago but is increasingly a poor fit today. I would like to highlight a few of the issues raised by Rae and provide an economist’s perspective on them. In particular, I will focus on the issues of: the setting in which care takes place; the types of financial relationships that may be possible; and just who should be “sold” on the value of pediatric psychology services.

The first issue raised by Rae that deserves additional attention from the profession regards the site at which care is expected to take place. As the article points out, the traditional emphasis on having pediatric psychologists as part of the pediatric hospital staff may be less and less viable as time goes on. There are a number of difficulties with having the hospital be the modal site of care for these services. While it is undoubtedly true that such services are needed, a problem arises when the profession seeks to broaden the scope of services offered away from the support of patients and their families through an acute episode of care, and toward the ongoing management of chronic conditions and prevention. Such services are not central to the mission of most hospitals and consequently are “hard sells” for the hospital administration. This leads to the perceived personal and professional devaluation of pediatric psychological services about which Rae is rightly concerned.

However, it is exactly these subacute areas of care into which the profession must expand, according to Rae in this issue. Moving more aggressively into these areas will have at least two important effects: (1) It will diversify the portfolio of services offered by the typical pediatric psychologist, and (2) this will in turn significantly improve clinicians’ ability to weather changes in insurance, demand, and clinical practice. In addition, aggressive diversification into subacute and chronic care can help make pediatric psychologists more valuable to their medical colleagues. (We will return to this issue below.) However, this diversification will mean a de-emphasis on the hospital as a setting for care, and a dramatic shift of care to private clinics—either stand-alone or as part of larger multispecialty office settings.

The next area dealt with in Rae’s article that I want to address comprises the issues surrounding direct reimbursement. He correctly concludes that the direct payment, fee-for-service approaches of the past are not likely to be viable into the future. He worries that the current atmosphere, which seems to give preeminence to managed care, may be inimical to the types of preventative and subacute services to which pediatric psychologists must move.

Several points must be made here. First, managed care is not as dominant as may at first blush appear. Less than 30% of the American public is covered by a health maintenance organization (HMO), and the percentage of people covered by HMOs has fallen in recent years (United States Census Bureau, 2002). Consequently, the difficulties that capitated systems might pose for pediatric psychology practices can easily be overstated. Most managed care today is provided in a setting where care is paid for on a negotiated fee-for-service basis and where there are additional financial incentives (holdbacks, differential copayments, payments that depend on quality-of-care/satisfaction indexes, and the like). Of course, the success of the HMO model in the 1980s and 1990s means that utilization management tools are nearly ubiquitous.
However, the pediatric psychology profession should view this as an opportunity rather than a barrier. One significant trend of the 1990s was the introduction of “carve-outs” from the base insurance product of certain specialized services, especially general mental health services. A carve-out is a designated pool of money set aside by an insurer, to be devoted to specialty care (again, most often mental health services). This is usually in the form of a contract with a separate mental health provider, who agrees to provide care to the insurer’s covered lives, under either a capitated or a negotiated fee-for-service arrangement. As Frank, Huskamp, Newhouse, and McGuire (1996) have argued, these mental health carve-outs serve two roles. The first is to assure that patients can receive the care they need in a timely manner, while limiting the primary insurer’s exposure to risk. The second, and most important, role is to signal to the insurer’s customers that the insurer will guarantee access to quality mental health services. The insurer uses the existence of a carve-out as a type of performance bond to attract enrollees who care about mental health services.

Thus, pediatric psychology professionals must market their services such that patients value them, and so in turn will value insurance options that guarantee access to them. If this is accomplished, then insurers will seek to attract enrollees by creating carve-outs that include pediatric psychological services. This will in turn provide pediatric psychologists with a stable source of income to support their practices—whether capitated or discounted fee-for-service. It will also tap professionals into the large patient pools that managed care organizations have collected.

This brings us to the final point. Rae correctly notes that pediatric psychologists must market their services and that there is nothing inconsistent with their clinical mission about this. As I have noted above, part of that marketing must be to patients, which would empower payers to use access to pediatric psychological services as a means of selling their product. However, there is another audience for marketing efforts: namely, primary care providers. While Rae is correct to emphasize the financial pressures that pediatric psychologists are under, their primary care colleagues are under similar pressures. This creates an opportunity for the pediatric psychology profession. Current estimates are that the typical primary care visit lasts 7 minutes in the face of pressures to increase patient volume. Primary care physician reimbursement, under many managed care contracts, is dependent on patient health outcomes and satisfaction. When pediatric psychologists can step in and improve patient adherence to treatment regimens or improve mental health and patient satisfaction, they become highly valuable members of a treatment team. In this case, primary care providers would be eager to refer patients to the pediatric psychologist.

Rae presents a challenging vision of the current state of affairs in the field of pediatric psychology. Despite the clear challenges that he presents, there are also clear opportunities. Three of these are: shifting the site of care toward private practice; taking advantage of recent trends toward creating carve-outs for mental health services in managed care; and creating stable referral relationships with primary care providers. As the profession pursues these avenues, along with those suggested by Rae in this issue, there are many reasons to be confident of the future.

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References