XIV. Providers

Since its inception, the Tracking Project has investigated and tracked a range of issues related to the impact of managed care on behavioral health providers, including both provider agencies and individual practitioners. The 2003 State Survey explored a number of provider-related issues, including how managed care has affected the inclusion of various types of providers in provider networks, the impact of new credentialing requirements on agencies and practitioners, administrative burden, reimbursement rates, and the financial viability of provider agencies. In addition, the survey assessed the extent to which front-line practitioners have the capacity to meet the goals of the managed care systems.

Provider Inclusion and Exclusion

Impact analysis results indicated that, in most states, managed care resulted in the participation of an expanded range of providers, but also made it more difficult for certain types of providers to participate. Reasons for the expanded range of providers noted by stakeholders were the inclusion of new types of practitioners and new types of provider agencies, as well as new services in the benefit plan, such as targeted case management, respite, and in-home services. At the same time, interviewees observed that smaller and nontraditional agencies were facing challenges, primarily due to a lack of infrastructure to meet the administrative and fiscal demands of managed care, particularly with respect to assuming financial risk.

The 2003 State Survey continued to investigate issues related to the inclusion or exclusion of providers from behavioral health managed care provider networks. As shown on **Table 104**, approximately two-thirds of managed care systems include school-based behavioral health providers (62%), certified addictions counselors (65%), and culturally diverse and indigenous providers (70%). About half of the managed care systems reportedly include child welfare providers, paraprofessionals, and student interns; only one-quarter (24%) include family members as providers.

Table 104

Percent of Managed Care Systems Including Various Types of Providers in Provider Networks

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Child welfare providers	53%	71%	31%	54%	1%
School-based behavioral health providers	62%	67%	56%	62%	0%
Certified addictions counselors	68%	76%	50%	65%	-3%
Culturally diverse and indigenous providers	82%	81%	56%	70%	-12%
Family members as providers	32%	33%	13%	24%	-8%
Paraprofessionals and student interns	50%	62%	25%	46%	-4%

Except for school-based behavioral health providers, inclusion of the various types of providers occurs far more frequently in carve outs than in integrated systems. For example, child welfare providers are reportedly included in provider networks by 71% of the carve outs as compared with only 31% of the integrated systems, and culturally diverse and indigenous providers are included by 81% of the carve outs as compared with 50% of the integrated systems.

It is interesting and encouraging to note that in both 2000 and 2003, about two-thirds of the managed care systems reported the inclusion of certified addictions counselors in managed care provider networks, an area that had been raised in the impact analyses as potentially problematic. Of concern, however, are the decreases from 2000 in the reported inclusion of culturally diverse providers (12% decrease) and of family members as providers (an 8% decrease).

Certification and Credentialing Requirements

The 1997/98 State Survey found that approximately one-third of managed care systems had new or revised standards or licensing requirements for individual practitioners or provider agencies. Stakeholders in both impact analyses observed that, in some states, the new requirements were more restrictive than previous requirements and, therefore, limited the types of professionals that could be included in provider networks. The 2000 and 2003 State Surveys investigated whether new certification or credentialing requirements limit the inclusion of particular types of providers. In addition, the surveys collected descriptive information on how new credentialing requirements affect provider inclusion in managed care systems.

Consistent with 2000 findings, respondents for two-thirds of the managed care systems (66%) in 2003 indicated that new credentialing and certification requirements were not impeding the inclusion of particular types of providers in provider networks; requirements posing impediments to provider participation were reported in only a third (34%) of the managed care systems (**Table 105**). Credentialing requirements are more frequently impediments to provider participation in integrated systems, with more than half (57%) reporting this as compared with only 19% of carve outs.

Table 105

Impact of New Credentialing Requirements on the Inclusion of Behavioral Health Services Providers

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
New credentialing requirements are impeding the inclusion of particular types of providers	32%	19%	57%	34%	2%
New credentialing requirements are not impeding the inclusion of particular types of providers	68%	81%	43%	66%	-2%

Some states where credentialing and certification requirements are impediments provided more detailed information about how the requirements limit provider inclusion:

- Credentialing requirements in managed care organizations are more restrictive than state licensure requirements in some categories, thus excluding some qualified, licensed mental health professionals that are approved under Medicaid.
- Requirements eliminate Master's level clinicians other than social workers or marriage and family therapists, excluding other types of clinicians.
- Requirements specify that managed care entities contract with licensed community mental health agencies, thus eliminating other types of provider agencies.
- Cumbersome credentialing procedures that discourage the participation of providers.

Administrative Burden of Providers

Stakeholders in both impact analyses reported that managed care had resulted in substantial increases in administrative and paperwork requirements for providers. In addition to the new credentialing and licensing requirements described above, interviewees described new document requirements for service authorization, frequent utilization and concurrent reviews, and increased requirements to collect and report both encounter and outcome data.

The 2000 and 2003 State Surveys explored this issue further, by assessing whether administrative burden for providers under managed care is considered to be higher, lower, or unchanged from the previous system. In 2000, 61% of managed care systems reported that administrative burden was higher with managed care, supporting the observations noted in the impact analyses. Representing a dramatic change, however, in 2003 only 23% of the managed care systems reported that administrative burden is higher than pre-managed care (**Table 106**). About the same proportion of managed care systems (12% in 2000, and 15% in 2003) noted that administrative burden was lower under managed care; in 2003, 62% of managed care systems indicated that there has been no change in administrative burden as compared with pre-managed care.

Table 106
Impact of Managed Care Reforms on Administrative Burden for Providers

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Administrative burden is higher in the managed care system	61%	25%	20%	23%	-38%
Administrative burden is lower in the managed care system	12%	10%	20%	15%	3%
No change	27%	65%	60%	62%	35%

There are several potential explanations for the reduction in reports of higher provider administrative burden. This may be explained by the relative maturity of managed care systems; 90% are in late stages of implementation in 2003. Perceptions of increased administrative burden on providers may decrease as agencies and individual practitioners become accustomed to the new administrative and reporting requirements and as they increasingly have the infrastructure and systems in place to comply with managed care administrative, fiscal, and reporting requirements. In addition, managed care entities may have refined,

streamlined, and simplified administrative processes, resulting in reductions in administrative and paperwork requirements for providers. For example, there has been a steady increase in the proportion of managed care systems that allow provision of certain services up to a specified amount without prior authorization. Further, some states and MCOs offer consultation and ongoing training to providers to assist them in such tasks as completing reports and submitting claims. Finally, in a number of states, fewer MCOs currently are involved, as MCOs have pulled out of Medicaid markets and have consolidated. Fewer MCOs in a state typically translates into less administrative burden on providers.

Financial Viability of Providers

Provider Reimbursement Rates

Providers who were interviewed for the impact analyses reported that, in some managed care systems, provider payment rates were too low to support effective treatment and best practices. The 2000 and 2003 State Surveys investigated whether provider reimbursement rates in managed care systems are higher, lower, or unchanged than in the previous systems. In 2000, lower provider reimbursement rates were reported for nearly a third (32%) of the managed care systems. Representing a departure from previous findings, in 2003, only 13% of managed care systems reported lower provider reimbursement rates in comparison with pre-managed care. As shown on **Table 107**, about two-thirds (66%) of systems report that provider reimbursement rates are, in 2003, higher under managed care than previously (compared with higher rates reported for only 23% of the systems in 2000). Of note is that higher provider reimbursement rates under managed care than in the previous system are reported more often by systems with integrated designs (75%) than by carve outs (60%).

Table 107
Impact of Managed Care Systems on Provider Reimbursement Rates

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Provider reimbursement rates are higher in managed care systems	23%	60%	75%	66%	43%
Provider reimbursement rates are lower in managed care systems	32%	15%	8%	13%	-20%
No change	45%	25%	17%	21%	-23%

Again, a potential explanation is the maturity of the managed care systems and the changes that have occurred as managed care systems have evolved. As noted previously, changes in rates paid to MCOs since 2000 have occurred in most managed care systems (82%), and over half (57%) of these rate changes have been increases (see **Tables 60** and **61**). Thus, it appears that in addition to increased capitation and case rates for MCOs, provider reimbursement rates have been adjusted upwards.

Closures or Severe Financial Hardship

Reports of provider closures and financial hardship surfaced through the impact analyses, but few data were available to accurately judge the extent to which managed care resulted in providers experiencing severe financial hardship and/or having to cease operations. The 2000 and 2003 State Surveys investigated the impact of managed care on providers' financial viability.

According to survey respondents at both points in time, managed care has not led to closure or severe financial hardship for provider agencies in most systems. In 2003, 86% of the managed care systems reported no severe financial hardship, an even greater proportion of systems than in 2000 when 71% reported this (**Table 108**). Reports of provider financial hardship or closure have decreased from 27% in 2000 to 14% in 2003. This finding is not surprising, given the higher provider reimbursement rates, reported decrease in administrative burden, and few changes in licensing and credentialing requirements found in 2003. In addition, the closures of some types of programs or agencies may have occurred during the earlier stages of implementation. The reduction in provider closures or severe financial hardship for providers is another indicator of the "settling" in the public sector managed care landscape.

Table 108

Impact of Managed Care Reforms on Financial Viability of Children's Behavioral Health Provider Agencies

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Systems are resulting in closure or severe financial hardship for some agencies	27%	19%	7%	14%	-13%
Systems are not resulting in closure or severe financial hardship for some agencies	73%	81%	93%	86%	13%

Capacity of Front-line Practitioners

In both impact analyses, respondents in most states indicated that managed care necessitated training for providers in new skills and approaches, including short-term outpatient treatment modalities, home and school-based services, and wraparound and intensive in-home services among others.

Given the documented need to provide training and technical assistance for providers and practitioners, the 2000 and 2003 State Surveys investigated whether front-line practitioners were considered to have the skills, knowledge, and attitudes to meet the goals of the managed care system. As indicated on **Table 109**, about three-quarters of managed care systems in both 2000 and 2003 reported that front-line practitioners have the capacity to function effectively in managed care systems, with carve outs somewhat more likely to report adequate capacity for front-line providers than integrated systems (80% versus 71%). In addition to training that has been provided to upgrade the capacity of front-line providers, respondents noted that more rigorous licensing criteria and accreditation standards have contributed to the improvement in practitioner skills and knowledge.

Table 109

Capacity of Front-Line Practitioners to Meet Goals of Managed Care Systems

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Front-line practitioners have skills, knowledge, & attitudes to function effectively	71%	80%	71%	76%	5%
Front-line practitioners do not have skills, knowledge, & attitudes to function effectively	29%	20%	29%	24%	-5%