Health Care Reform Tracking Project
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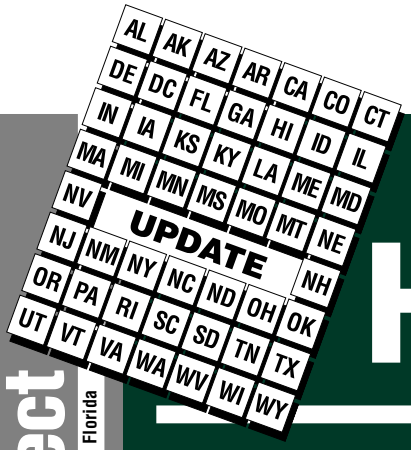

Highlights

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Recent Findings

Background

The Health Care Reform Tracking Project was initiated in 1995 to track and analyze public sector managed care initiatives as they affect children and adolescents with mental health and substance abuse (referred to as *behavioral health*) disorders and their families. The methodology of the Tracking Project has involved two major components: surveys of all states to describe state managed care reforms and impact analyses involving in-depth site visits to a select sample of states to analyze the impact of state policy choices and implementation strategies. To date, the Tracking Project has completed two all-state surveys (the 1995 State Survey and the 1997-98 State Survey) and two impact analyses (the 1997 Impact Analysis, which involved site visits to a sample of 10 states, and the 1999 Impact Analysis, which involved site visits to a new sample of eight states, plus telephone interviews with stakeholders in the 1997 sample of states to assess changes and refinements in managed care systems over time–referred to as the Maturational Analysis). The managed care approaches used by the selected states include both *carve out designs*, which are defined in this project as arrangements whereby behavioral health services are financed and administered separately from physical health services, and *integrated designs*, defined as arrangements in which the financing and administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted). The Tracking Project has explored whether and how different approaches have differing effects on children and adolescents with behavioral health problems.

This paper presents highlights of major findings from the Tracking Project, drawing on and blending the results of the most recent project activities. Specifically, the findings

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presented are derived from: 1) the *1999 Impact Analysis*, including the site visits to the new cohort of eight states and the Maturational Analysis that looked at changes in the 1997 cohort, and 2) the *1997-98 State Survey*, which described managed care reforms affecting behavioral health nationally. Where appropriate, these findings are compared with earlier findings from the Tracking Project.

Planning and Design Issues

- Key stakeholder groups interviewed for the 1999 Impact Analysis reported a gradual, growing involvement in managed care policy deliberations, stemming from their own increased awareness and advocacy and from the need for state planners to engage broader constituency groups in addressing implementation problems. In spite of growing involvement, the 1997-98 State Survey found that families and child welfare systems reportedly have involvement characterized as *significant* in fewer than 40% of reforms nationally, state substance abuse agencies in fewer than 25%, and state child mental health staff in slightly over half of managed care reforms nationally.

- The 1999 Impact Analysis and the 1997-98 State Survey confirmed earlier findings that states using a behavioral health carve out approach tend to cover a broader array of mental health services and more home and community-based services and allow for greater flexibility in service delivery than do states with an integrated physical/behavioral health design. This is not the case for adolescent substance abuse services, in which few services are covered, regardless of the managed care design.

- The 1999 Impact Analysis found that states are including greater coverage of extended care (i.e., more than brief, short-term acute care coverage) in their managed care systems than was the case in the earlier Impact Analysis, and more populations requiring extended care, such as the SSI population and children involved in child welfare systems. This is especially true of reforms with carve out designs, but is occurring in reforms with integrated designs as well. The 1997-98 State Survey found that 60% of reforms nationally reportedly include the child welfare population, and 56% include the SSI population. *Access* to extended care within managed care systems, however, was reported by stakeholders in the 1999 Impact Analysis to be difficult because of rigid application of medical necessity criteria, lack of appropriate services covered or available, insufficient capitation rates, and opportunities to cost shift to other behavioral health funding streams outside of managed care systems. This also was reported by stakeholders in the 1997 Impact Analysis.

- Both the 1999 Impact Analysis and the 1997-98 State Survey found that states are moving toward developing risk adjusted capitation rates for the child welfare population, but not for children with serious emotional disorders or for adolescent substance abuse treatment. The 1997-98 State Survey also found that over half (53%) of reforms nationally include no

risk adjusted rates for either child welfare populations or children and adolescents with behavioral health disorders. The 1999 Impact Analysis found that stakeholders in most states, and particularly in states with integrated designs, do not believe that capitation rates are sufficient to guard against underservice (as was also reported in 1997).

Managed Care Organizations

- Both the 1999 Impact Analysis and the 1997-98 State Survey found that states increasingly (when compared to earlier findings) are contracting with commercial managed care organizations (MCOs). States with integrated designs are more likely to use only commercial companies, while states with carve outs tend to use a mix of commercial companies, nonprofit organizations, and governmental entities to manage care. The 1999 Impact Analysis found that stakeholders continue to view commercial MCOs as being unfamiliar with the needs of children and adolescents with behavioral health disorders; however, there also were increased reports of state efforts to train and educate MCOs in this area.

- Both the 1999 Impact Analysis and the 1997-98 State Survey found that states increasingly are pushing full risk to MCOs. Both studies also found that, particularly in carve outs, risk is not being pushed down to behavioral health providers, who continue to be paid on a fee for service basis, for the most part.

- The 1999 Impact Analysis confirmed earlier findings that stakeholders view the use of multiple MCOs statewide or within regions as creating more problems than offsetting advantages, including administrative complexities for providers, monitoring challenges for states, and navigation difficulties for consumers. Stakeholders interviewed for the 1999 Impact Analysis confirmed stakeholder reports in 1997 that choice of providers is more important to consumers than choice of MCO.

Clinical Decision Making

- The 1999 Impact Analysis found that most of the reforms in the 1999 sample that include substance abuse are utilizing patient placement criteria for adolescent substance abuse treatment (compared to only one reform in the 1997 sample). Further, more reforms in the 1999 sample reportedly use patient placement criteria for substance abuse services than level of care criteria for children's mental health services. However, the 1999 Impact Analysis also found that stakeholders do not perceive these criteria as necessarily improving consistency in clinical decision making. Criteria are perceived to be either too broad, applied too rigidly by MCOs, or rendered meaningless by a lack of available services.

- Both the 1999 Impact Analysis and the 1997-98 State Survey found that states are broadening their medical necessity criteria to include psychosocial considerations (39%

of reforms nationally according to the results of the all-state survey). However, the 1999 Impact Analysis found that, even with this expansion, stakeholders perceive MCOs as interpreting and applying medical necessity criteria narrowly.

Service Coverage and Access Issues

- Although many states have broadened the range of *covered* services, at least for mental health, stakeholders in the 1999 Impact Analysis reported that access to services, even initial access, is compromised by insufficient service capacity and rigidly applied utilization management and clinical decision making processes. Service shortages that pre-existed managed care, which are particularly acute in the adolescent substance abuse treatment area and in rural communities, remain unresolved issues in managed care systems.

- Stakeholders in the 1999 Impact Analysis confirmed earlier findings that inpatient hospitalization continues to be difficult to access in most states as a result of managed care implementation, and that children are being discharged prematurely from hospitals without adequate step-down or alternative services in place. However, stakeholders also reported a gradual trend in states to develop alternative levels of care, such as crisis services, intensive home-based services, and therapeutic foster care.

Children and Adolescents with Serious Behavioral Health Disorders and Systems of Care

- The 1997-98 State Survey found that about half (51%) of reforms nationally do not incorporate a dedicated planning process, special management mechanisms or differential benefits for children and adolescents with serious behavioral health disorders. The 1999 Impact Analysis also confirmed earlier stakeholder reports that most states have not used their managed care reforms as a strategic opportunity to further the development of local systems of care, even in states with federal grants from the Comprehensive Community Mental Health Services for Children and their Families Program. Both findings apply especially (though not exclusively) to states with integrated designs.

Early Intervention and Physical/Behavioral Health Coordination

- The 1997-98 State Survey and the 1999 Impact Analysis found that most managed care reforms (93% nationally reported through the survey) are incorporating the Early Periodic Screening Diagnosis and Treatment Program (EPSDT). However, stakeholders in the 1999 Impact Analysis confirmed earlier reports that managed

care is having little impact on the early identification of behavioral health problems, primarily due to lack of financial incentives and training for primary care providers (PCPs) to identify and refer for behavioral health problems. Stakeholders in 1999 also confirmed earlier reports that coordination between physical and behavioral health care, a pre-existing issue, has not improved in managed care systems, regardless of design.

Family Involvement and Cultural Competence

- The 1997-98 State Survey and the 1999 Impact Analysis found that family involvement at the system level in managed care policy deliberations is increasing, but at a slow rate, and is more likely to occur in states with carve outs than in states with integrated designs. Both studies also found that, in comparison to earlier reports, more states are requiring family involvement at the service delivery level; however, stakeholders indicated that, in spite of these requirements, MCOs are not facilitating family involvement in planning and delivering services to their own children and that the focus of services in most states is limited to the identified child, not taking into consideration related family needs.

- The 1999 Impact Analysis confirmed earlier reports that managed care reforms are not increasing the financial burden on families and, by expanding income eligibility, may actually be decreasing financial burden in some states. The exception noted was families who have children with serious behavioral health disorders who are not eligible for Medicaid or the State Child Health Insurance Program (SCHIP), for whom fewer resources may be available through the public mental health system as dollars have gone into managed care systems. There continue to be reports of families' having to relinquish custody of their children to access services through the child welfare system, an issue that pre-existed managed care reforms.

- The 1999 Impact Analysis confirmed earlier reports that managed care reforms are having little impact, one way or the other, on the cultural competence of behavioral health service delivery, in spite of contractual requirements related to cultural competence in most reforms (80% nationally, according to the 1997-98 State Survey).

Providers

- The 1997-98 State Survey and the 1999 Impact Analysis found that managed care reforms are resulting in an expanded range of providers (in comparison to Medicaid fee-for-service systems); however, stakeholders in the 1999 Impact Analysis also confirmed earlier reports that smaller, indigenous and nontraditional providers are having difficulty surviving in managed care environments either because they cannot meet credentialing requirements or because they lack the necessary administrative or financial capacity.

- The 1999 Impact Analysis confirmed earlier reports that managed care reforms are not disrupting relationships between therapists and the children and families they serve for

the most part. Stakeholders reported efforts by states to preserve existing therapeutic relationships in the transition to managed care.

Interagency Collaboration

- The 1999 Impact Analysis confirmed earlier reports that, in many states, fragmentation in child and adolescent services has intensified with managed care reforms by adding new players, tightening the parameters around the dollars included in managed care systems, and leaving other behavioral health financing streams outside of managed care systems. Allegations of cost shifting continue to be widespread, although only one state in the 1999 sample reported that it is tracking cost shifting.

Use of Medicaid for Behavioral Health Services and Reinvestment

- Stakeholders in the 1999 Impact Analysis reported that, within carve outs but not in integrated reforms, managed care has made it easier to use Medicaid to fund behavioral health services for children and adolescents by covering a broader service array and allowing more flexibility than was the case under Medicaid fee-for-service. Stakeholders indicated that integrated designs make it more difficult to use Medicaid by constraining the benefit and rigidly applying medical necessity criteria.

- The 1997-98 State Survey found that about half (48%) of reforms–all carve outs–require reinvestment of savings into behavioral health services. Reinvestment was reported to be a critical issue because of severe shortages of services, and, in most states, stakeholder reports of growing waiting lists in spite of access standards.

Accountability Issues

- Stakeholders in the 1999 Impact Analysis confirmed earlier reports that state-level management information systems (MIS) are inadequate to track and monitor managed care reforms. While MCO MIS systems were judged to be better, there also were widespread reports of states' being unable to obtain encounter data from MCOs. The 1999 Impact Analysis found that most states are not yet able to produce data on service utilization, quality, or outcomes related to child and adolescent behavioral health services, even though the 1997-98 State Survey found that most reforms (two-thirds nationally) reportedly are tracking such measures. Most are in early developmental stages.

Conclusion

The Tracking Project overall, and the 1999 Impact Analysis in particular, suggest a "good news, bad news" picture. The good news is that, increasingly, in their policy decisions and purchasing specifications, states–particularly those with carve outs–are moving toward choices and changes that would seem to benefit children and adolescents with behavioral

health problems and their families. These include broadening medical necessity criteria and the array of covered services; incorporating family involvement, cultural competence, level of care criteria and interagency collaboration into purchasing specifications; involving key stakeholders more in planning and redesign; doing more training of MCOs on the needs of the population; beginning to create more home and community-based services and alternatives to inpatient hospitalization; and working more collaboratively across child-serving systems to problem solve.

The bad news, however, is that stakeholder reports indicate a major disconnect between state policies and contractual requirements and what actually is occurring at the implementation level. For example, in spite of broader medical necessity criteria, clinical decision making and management is perceived as rigid. In spite of a broader array of covered services, home and community- based services reportedly are in short supply, access is difficult, and waiting lists persist in spite of contractual access standards. Though interagency problem solving is growing, reports of cost shifting and fragmentation of services, especially for children with serious behavioral health disorders, are widespread. In spite of increased attention to issues of family involvement and cultural competence in contractual specifications, knowledge reportedly is lacking about how to operationalize these concepts at policy and service levels, and, thus, progress is incremental.

As they did in 1997, stakeholders in 1999 identified more disadvantages for children with behavioral health disorders in states with integrated physical/behavioral health managed care approaches than in states with behavioral health carve outs.

Most stakeholders recognize managed care reform as a developmental process in which, initially, states focus on getting managed care "up and going" and, after a year or two, begin to focus on particular population issues, cross-agency issues, quality and outcomes measurement, and the like. Developmentally, there is a lag between state policy decisions that reflect this more deliberate focus and the effects of those decisions being felt at the implementation level. Thus, the Tracking Project is finding a certain dissonance within stakeholder perceptions–a level of optimism over policy changes at state levels, particularly in states with carve outs, and a degree of pessimism over continued implementation problems.

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Health Care Reform Tracking Project

Health Care Reform Tracking Project:

Tracking State Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families

1999 Impact Analysis

By: Sheila A. Pires, M.P.A. • Beth A. Stroul, M.Ed.
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