

*Lessons from
Managed Care*



Chapter 2

Chapter 2: Lessons from Managed Care

Private Sector Managed Care and Children's Mental Health

Introduction

The federal Child and Adolescent Service System Program (CASSP), launched in 1984, has been an important contributor to the movement to make major changes in the way services are provided to children with severe emotional disorders and their families. The principles underlying CASSP call for community-based systems of care that are comprehensive and emphasize coordination among child-serving agencies, service delivery in the least restrictive environment, full involvement of families, and cultural competence. These principles have been widely accepted in the worlds of child welfare, child mental health, juvenile justice and special education. The reform efforts have led to a movement to restructure these four major child-serving capacities into a single community-based, family-focused, culturally competent interagency system of care (Stroul & Friedman, 1986). This systematic approach has encouraged a reduction in psychiatric hospitalization and residential treatment with an accompanying shift toward in-home, community-based modalities that focus on utilizing family strengths, family preservation, family support, and wraparound intervention strategies (Burchard, Burchard, Sewell & VanDenBerg, 1993; Katz-Leavy, Lourie, Stroul & Zeigler-Dendy, 1992; Stroul, 1993).

Over the last decade the system of care concept and philosophy have become the prevailing public service delivery ideology for children and adolescents with severe emotional disorders and

Ira S. Lourie, M.D.

*Human Service Collaborative
6706 Old Stage Road
Rockville, Maryland 20852
202/333-5998
Fax: 202/ 333-8217*

Steven W. Howe, M.S.W.

*Maryland State Director
Pressley Ridge Schools
805 E. Fayette Street
Baltimore, MD 21202-4712
410/576-8300
Fax: 410/576-8383*

Linda L. Roebuck, M.S.S.W.

*Southern Regional Manager
Missouri Department of
Mental Health
P.O. Box 5030
Springfield, MO 65802
417/895-7415
Fax: 417/895-7488*

This summary first appeared in its entirety in Focal Point, Fall 1996, Vol. 10 (2), published by the Research and Training Center on Family Support and Children's Mental Health, Portland State University, Portland, OR. Used by permission.

their families. This shift has been true only with respect to long-term care for children and youth with the most serious problems and needs, and has been limited primarily to the public sector. For those children and families whose care was supported with private sector dollars in the form of health insurance, the vast majority of mental health services provided were still being offered in a traditional mode, with services limited to inpatient and outpatient modalities, delivered without a systematic approach. Families were being denied the more family-friendly, strengths-based, community-based interventions available in the public sector.

By 1992, several private mental health provider agencies were describing the development of services that appeared similar to those used in the public sector, including homebased, crisis intervention/stabilization, respite, and other hospital diversion modalities. The current study was undertaken for the purpose of demonstrating: (1) the degree to which this technology diffusion had occurred; and (2) the degree to which children, adolescents and their families whose care is supported by private resources were having their needs met in a systematic way.

Methodology

This study was designed as a descriptive study of a limited number of sites chosen to represent the state of the art in private systems of care. The stated purpose of the study was to: (1) identify systematic private sector models for delivering mental health services to children, adolescents, and their families; (2) describe such system models; (3) define the elements of those systems that can and should integrate with public systems; and (4) summarize the lessons to be learned from the experience of these systems.

The working definition of a private sector system of care that emerged is: (1) an array of services for children and adolescents with emotional

problems and their families; (2) offered to a population whose care is not primarily supported with public funds; and (3) provided *either* by an agency or group of agencies under a managed care contract with a health maintenance organization (HMO), preferred provider organization (PPO) or insurance company plan, or provided by an insurance *or* managed care provider company (by itself or through contracts with several agencies).

Providers of managed care organizations eligible for selection for the study:

- Must have a continuum of services available to a population of private mental health clients under a fee for service or managed care arrangement; that focus must be either aimed at hospital diversion and/or minimization of hospital stay and must have a focus on nonresidential services.
- Must have— or be moving strongly toward — an array of services that includes most of the following capacities available to the entire population served, including short-term hospitalization, day/partial hospital, therapeutic foster care, crisis residential/respite, intensive home-based services, emergency/crisis response and outpatient services.
- Must be a sufficiently well-developed system of care to be able to serve as a useful example to the field and to receive national attention.
- Should have a mechanism for integrating these services, assuring and promoting matching of needs with the most appropriate service for the child and family through the use of care management, case management, and/or a teaming mechanism (this includes linkages to public systems that offer services needed by the child and family).
- Should have a mechanism for working on system issues and for the coordination of services, if the system includes several cooperating agencies.
- Should have noteworthy accomplishments in other areas, including capacity for long-term care for children and adolescents with severe emo-

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tional disorders; linkages to public sector agencies through provision of care under Medicaid or through purchase of service; special emphasis on inclusion of families in care management, care of their children, and family support; or special emphasis on cultural competence.

The request for nominations was sent to a list of over 130 key informants. The selection process yielded only 26 nominations, 3 of which were generated by one of the investigators.

Five nominees were ultimately found to have met the study criteria. Two of these were managed care organizations (U.S. Behavioral Health, Emeryville, California; Value Behavioral Health, Falls Church, Virginia), two were private for-profit service providers (Choate Health Systems, Inc., Boston, Massachusetts; InterCare Behavioral Health Services, Pittsburgh, Pennsylvania), and one was a private, nonprofit service provider (DePelchin Center, Houston, Texas). Site visit reports were generated from information gathered during the site visits (two days at each location), from study questionnaires and through other materials submitted by the sites.

Major Findings

Despite a nationwide search, only five programs were identified that met the study criteria. An assumption can be made that, whatever progress has been made in adding system approaches to the private sector, the degree of penetration into the mainstream has been very low.

No Private System of Care. Regardless of the degree to which there has been change in private sector service provision, an impression emerges that true systems of care do not exist in the private sector. While many of the system of care principles have been incorporated—which is a significant achievement – the MCO and service provider sites in this study have simply created broader, more flexible and integrated *continuums* of care, rather than systems of

care as defined by CASSP (Stroul & Friedman, 1986). For a system of care to be created—not only must the service array be expanded— but mechanisms for access to services, system-level coordination across agencies, case management and coordination at the client level, and mechanisms for financing of services must also be put in place. For the most part, as represented by the sites in this study, this has not occurred in the private sector, in which there has been a particular failure to offer family support services or to integrate services and funding with that available through schools, child welfare, and juvenile justice systems. As such, any private sector advances in broadening the array of available services pale in comparison to the potential in a well-functioning, public system of care. In order to be fair, however, it should be recognized that most communities do not have well-developed public systems of care and, given this reality, the services offered by the study sites go well beyond those available to many public clients nationwide.

This study identified factors that suggest that a truly systematic approach will be difficult, if not impossible, to create in the private sector. While every community has the potential to create a model public system of care, there are basic limitations in private sector practice that make it difficult to develop a system of care. *The major barrier to system development is the strict adherence to the medical model within private mental health services.* This approach includes two important elements. The first is the *concept of medical necessity.* Under this precept, health care is provided under the aegis of “health insurance,” and, as such, must be directed aimed at the amelioration of a specific disease entity; all other care is seen as supportive, ancillary, and someone else’s responsibility. This categorization of services as either medical or supportive is extremely limiting within a system of care. It separates rather than integrates care components. In addition, the emphasis on medical necessity focuses the treatment planning

process on the pathological aspects of an individual's condition which undermines the use of the strength-based approach that underlies the system of care philosophy.

The second problematic factor related to reliance on the medical model is its *focus on acute care*. Long-term, disabling conditions traditionally have been relegated to a rehabilitation status and, thus, excluded from medical attention. As a result, most children and adolescents with severe emotional disorders have most of their care provided by child welfare, juvenile justice, and special education agencies, rather than health or mental health agencies, supported by public or private health insurance. The focus on acute care has been fostered by the private sector health insurance industry, including managed mental health care, and has reinforced this separation between mental health services and the rest of the system of care. Until a framework is developed that bridges the gap between the medical model and the concepts of rehabilitation and support, private sector clients will continue to be denied access to the system of care until the point at which they become public sector clients.

Positive Potential of Managed Care. While managed care has been a much maligned health care approach, the service delivery philosophies of the managed care organizations in this study appear to be extremely compatible with the system of care philosophy. Both are concerned with offering children and adolescents care for their mental health problems using the most appropriate and least restrictive alternatives. Both understand that one of the primary vehicles that makes this possible is the availability of a full array of services. This has led to development of homebased and other non-institutional service modalities for use by both public and private populations. Although the scope of that array is seen more narrowly by most MCOs,

and some services such as therapeutic foster and group home care and respite are rarely made available, the recognition of the need for a continuum of care within the managed care world has brought the public and private sectors closer together.

Both MCOs and public systems of care rely on some form of case management to coordinate and assure access to services. At the managed care sites in this study, individual clients have their course of treatment followed by a care manager, who is responsible for knowing the client's entire mental health history, accessing the specific services needed, and monitoring the effectiveness of a series of interventions. In systems of care for children and adolescents with severe emotional disorders and their families, case management has these same functions and desired outcome. There are, however, significant differences between these care coordination mechanisms. In systems of care, the case manager's role also includes team building and the provision of some direct, ongoing support to the child and family. In managed care, the care manager role additionally includes the responsibility for the authorization of specific service modalities and amounts of care, as well as for utilization review.

Even the negatively perceived cost containment emphasis inherent in managed care is not inconsistent with the goals of systems of care. In fact, cost savings has been one of the most important aspects of the changes following the introduction of the system of care concepts into public mental health. While this cost saving goal has not been as overtly touted as in the private sector, the perception of reduced costs following the public sector shift from institutional to community-based care has kept system of care development alive.

In both public and private settings, new ways are being developed to best take advantage of the dollars available. In this case, the technology transfer has been primarily from the private to the

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public sector as management strategies utilized by MCOs are now being more scrupulously applied by public systems of care. Most prominent among these are the use of outcome measures to monitor individual progress as well as system efficiency and the use of systematic processes to determine how to focus resources and maximize available funds (Cross & McDonald, 1995). Both of these private sector strengths provide important lessons to the public sector, which has historically done poorly in the areas of outcome measurement and resource allocation and management.

The Growing Private Sector Continuum of Care. The last major finding supports the original hypothesis of the study: some private agencies are now offering private sector clients the type of alternative services seen in the public sector. The service provider sites in this study were each providing several non-hospital programmatic options for those individuals who required a service more intensive and/or supportive than outpatient therapy. These included intensive outpatient treatment, crisis stabilization, crisis respite, and in-home services. One site even offered therapeutic foster and group home care. Although most of these services were delivered within a traditional categorical program paradigm, the potential for them to be used systematically was built into them. In fact, all three study sites had developed their own managed care products and were taking advantage of the potential to integrate their service programs. The ability of providers to offer a continuum of care that supports the positive potential of managed care is growing, and an increasing number of MCOs and other insurers are learning to utilize this capacity.

It is important to re-emphasize that, nationwide, very few provider organizations have developed the capacity for a broad continuum of care. For the most

part, mental health clinics nationwide are still “stuck” in a traditional outpatient therapy mode, while hospitals are still primarily offering acute inpatient services. The valuable lesson to be gleaned from the providers in this study is that, when an array of innovative services is developed, private sector insurers will use them. As one provider said, “If you build them, they will come.” In the past this adage has held true for hospital beds and it is now becoming a reality for community-based, family-centered services.

The Similarity Between Managed Care and System of Care

An unexpected study finding was the recognition that the underlying principles of managed care are similar to and entirely compatible with those of systems of care for children and adolescents with serious emotional disorders and their families. Both sets of principles aim to offer the most appropriate level of care that an individual needs at any moment in time. In the system of care this is represented by the concept of least restrictive environment and in managed care this is represented through levels of care guidelines.

In addition, both system of care principles and managed care principles rely on flexibility in the use of services and in finding innovative approaches. In managed care this is manifest in those instances where managed care contracts allow for an unlimited benefit as incurred by those organizations found in the study. While not as inclusive and malleable as public sector wraparound services, the unlimited and well-controlled benefits offered under some managed care plans are based on the same understanding: the correct amount of the right services leads to the most positive result while also being the most efficient.

For managed care to reach its potential, it must be funded adequately and utilize care management

and service provision policies which emphasize full-service delivery. Similarly, public systems of care can only reach their potential when the efficiencies of care management and fiscal responsibility—the hallmarks of managed care—are utilized.

Critical Practice Issues

When a reasonable managed care product is adequately supported monetarily, its concepts are entirely compatible with the principles of public systems of care. Both managed care organizations in this study were attempting to approximate the theoretical potential of managed care. They have done this by creating an approach that focuses primarily on service delivery rather than on costs. First, they created a clinical model of care management in which licensed and experienced mental health professionals are asked to make clinical judgments within the context of high-level (often psychiatric) supervision. Secondly, they encouraged employers to purchase liberal benefit packages from them.

Each of these organizations offer an unlimited mental health benefit that is closely managed. In doing so, they recognized that the best and most efficient care is that which can be crafted to meet an individual's specific needs and is flexible enough to be modified as necessary. When controlled by a care manager who knows the facts and history of the case and the full range of service alternatives in the community, this care can be more clinically appropriate and, often, less costly

Further, both managed care organizations acknowledged the need to view child and adolescent services as different than those provided to adults. This has encouraged the identification of providers who can offer child-oriented services and the development of mechanisms to support them.

Finally, the leaders of the programs nominated for this study formerly worked in the public com-

munity mental health and child-welfare oriented arenas. Their approach to services focuses on the special needs of children and adolescents and an appreciation for non-institutional, community-based services. These leaders created a full continuum of care heavily focused on hospital diversion.

A Balanced View

This study presents a positive view of managed behavioral health care's potential to provide systematically delivered services; however, it is important to recognize that the dream of managed care is far from reality. While there is a potential within managed care to enhance the delivery of services, much of current managed care practice focuses on cost containment and profitmaking.

Unfortunately, child-serving professionals have rarely had the opportunity to see care managed in a positive way. Rather, they experience service restrictions and demands that require them to practice in a manner contrary to their training. The increased paperwork that accompanies managed care, although necessary for the efficiency of the managed care organization, is burdensome to clinics and agencies alike.

This is similar to the experience of many family members with children and adolescents with more severe mental health problems. They often see limits rather than better care; rigidity rather than flexibility in service allocation. When a child's care needs become intensive and long term, families are faced with being denied further services. When their mental health benefits have been exhausted, the care for their child is most often shifted to public sector agencies such as schools, child welfare and juvenile justice.

Managed care organizations take little responsibility beyond the confines of the individual's benefit package. By definition, they can only offer a partial approach to care—the acute part. While family

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members might initially obtain a systematic, well-designed intervention, when benefit limitations are reached, they get nothing. When there is an avenue of eligibility, their care is shifted to the public sector. While this is not unlike the rest of the health insurance industry and many public mental health programs, it does not live up to the promise of managed care.

The realization of the full potential of managed care and the integration of the system of care principles into the private sector requires the following:

Employers must recognize the value of increased mental health among their employees and their family members. As long as corporate America is satisfied buying a cheap and inadequate mental health service package, there will be no room for improvement in service delivery. The process of educating employers could be facilitated if employees—the consumers of mental health care—understood the need for and demanded more appropriate services and a system of care approach for addressing more severe problems.

Managed care organizations must shift their philosophical balance from cost containment to service delivery. The companies in this study demonstrate that a “service first, cost containment second” approach is feasible, marketable and profitable. Most managed care organizations express this philosophy, but the rhetoric is hollow when they agree to contracts that do not provide adequate resources to actualize it.

Related to the balance in service philosophy is the issue of profit. There are no standards as to the acceptable degree of profit a health care insurer or care management company should reasonably make. While some would argue that it is unconscionable to make any profit on health care, it is probably more realistic to address the limitation of profits. Regulation of profits would make reaching an appropriate balance between cost containment and service delivery easier to attain.

The full range of service modalities must be widely accepted. Many employers, managed care organizations and service providers adhere to an extremely traditional mental health service model that focuses on inpatient hospitalization and outpatient therapy, with some partial hospitalization and short-term residential treatment. This study demonstrates that a broader continuum of care is not only within the bounds of good clinical practice, but also offers better and less expensive services.

An enormous amount of money and other resources must be invested to create a service system that can meet the individual needs of the entire—public and private—child and adolescent mental health consumers population. To date our society has been unwilling to make that investment. Accordingly, we have mis-spent a large percentage of our current funds on overly-expensive inpatient services. As this study demonstrates, however, when we are ready to make the necessary commitments, both the knowledge and the technology are available to create a system of care that can meet the individual needs of the whole population.

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Managed Care's Concept of Medical Necessity and Effects on Family Centered Services

Introduction

With few exceptions, states are considering or implementing some variation of traditional managed care approaches to providing services to Medicaid beneficiaries. Because of the extraordinary variation in most aspects of state-level managed care policy, implementation efforts and services covered also vary. In Nebraska, during the second year of mental health managed care, a serious controversy arose surrounding the concept of "medically necessary" services. Central to this concern were the multiple definitions of medical necessity- the threshold at which all services would be approved.

In an attempt to clarify the intent of medical necessity within behavioral health services, Nebraska officials were prompted by providers and advocates to change or modify the medical necessity concept to some other construction; one that, at the time, appeared more sensitive to ecological considerations to providing treatment to youth within their families, neighborhoods, and communities. The new construction chosen was the concept of *biopsychosocial necessity*. In essence, "necessary services" were to be those that met a biopsychosocial necessity, not medical necessity.

In response to the proposed change, the Health Care Financing Administration voiced serious concerns regarding that change, and remarkably suggested that "biopsychosocial necessity" be considered a second threshold for medically necessary services. This suggestion, if adopted, creates multiple service access gates,

William E. Reay, M.A.
OMNI Behavioral Health
4150 South 87th Street
Omaha, NE 68127
402/331-1598
Fax: 402/331-2143
ReayWE@aol.com

Barbara Huff
Federation of Families for
Children's Mental Health
1021 Prince Street
Alexandria, VA 22314
703/684-7710
Fax: 703/684-5968

and complicates the initial medical necessity concept. This summary presents several important issues related to those problems.

Background

In 1995, the State of Nebraska implemented a separate mental health managed care carve-out for Medicaid eligible children and families. Almost immediately, advocates and providers voiced serious concern regarding the failure of the State to clearly define key concepts associated with its managed care program. As before mentioned, the multiple definitions of medical necessity were central to their concern.

The initial application of the concept “medical necessity” resulted in scores of youth being discharged from in-patient services and transferred to various self-contained residential treatment centers (RTCs). Although this initial transfer of youth appeared to be the first in a series of clinical decisions to match the most appropriate level of care to the needs of each youth, the concept was employed in such a manner to suggest that if the youth did not require RTC care, out-patient care was the only service required or offered. Therefore, the concept actually governed service provision at either pole of the service continuum (inpatient/RTC – outpatient) Alternative services, those typically associated with community-based approaches (e.g., individualized systems of care or wrap-around, foster-care, home support; various models of family support approaches) were, and continue to be, considered social programs—not services addressing medical conditions.

In an attempt to prompt the State of Nebraska to adopt a more comprehensive and contemporary understanding of behavioral health care, providers and advocates continued to call for what appeared to be a more appropriate concept of service necessity—the concept of biopsychosocial necessity. The State

responded to the call, proposed the change, and requested a position from the United States Department of Health and Human Services-Health Care Financing Administration (HCFA), regarding the proposed change.

HCFA’s Response

The Health Care Financing Administration (HCFA) responded to Nebraska’s request by commenting on the intent of the Medicaid program. HCFA reported in an official memo dated September 26, 1996: (1) The Medicaid program is intended to provide financial assistance for medical services as provided for by Federal statute. A client must currently meet medical necessity criteria to be eligible for any of the Mental Health or Substance Abuse Services; (2) Biopsychosocial aspects of patient care normally includes discussion of the relevance of social, biological, and familial factors in the development and treatment of illness; (3) Inasmuch as this information may be important in assessing the likely outcomes of various treatment, these services would not be medical or remedial in nature or involve direct patient care; (4) While we acknowledge that treatment of family members may be beneficial, and sometimes, even necessary for the treatment of the recipient, nothing in the Medicaid statute or regulations would allow for services provided to treat family members of Medicaid recipients. Services provided must be directed exclusively to the effective treatment of the recipient; and (5) Services that are social in nature are covered under the definition of rehabilitation. Social skills are defined as redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques.

The State of Nebraska, through administrative law procedures, held public hearings aimed at implementing the change to include “biopsychosocial necessity” as an additional threshold to the “medical

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necessity” standard. Biopsychosocial necessity was defined by a series of eight conjoined criteria of what *service* must reflect. Most criteria relate to behavioral outcomes, treatment requirements, and similar non-client related conditions. Behavioral health outcomes were defined as improving adaptive ability, preventing relapse or decomposition, stabilization in an emergency situation, or resolving symptoms.

The definition required that all eight conditions be met before services could begin. The youth must *first* present a medically necessary condition at the EPSDT. If he/she passes that threshold, a second gate of biopsychosocial necessity must be passed to get services. At this gate, not only is the youth evaluated on the relative merits of his/her medically necessary behavioral health condition, but treatment procedures will be evaluated for efficacy and cost. If any of the biopsychosocial conditions related to treatment or service provision fail to reach the threshold, the youth fails to meet the criteria. In other words, the youth may present a medically necessary condition, but be unable to receive services based on the failure of the available services to meet biopsychosocial necessity due to a very poor prognosis, specific chronic condition, no providers qualified to provide the service, or inconclusive outcomes associated with the proposed treatment or service procedures.

The general treatment outcome literature associated with child and adolescent mental health services has not been very favorable or helpful in providing guidance on matching service type with problems presented (see Kutash & Rivera, 1996). Requiring service providers to use only those services with demonstrated efficacy seriously limits the pool of services available for each youth. Until the research literature provides a clearer picture of what works with whom under certain circumstances, the immediate challenge may be to define the importance of the non-traditional service system

within the concept of medical necessity; researchers must provide disciplined reasons and research results aimed at demonstrating the utility of all types of services for behavioral health within a broader context.

Historical Use of the Concept Medically Necessary Services

Medically Necessary Services is a concept borrowed directly from the commercial insurance industry. Prior to the 1960s, insurance policies contained no explicit medical necessity limitations or review mechanisms. Within defined fiscal limits, insurance companies covered all care ordered by any physician. Insurers first began questioning the judgment of hospital facilities for such purposes as weight reduction or resting up from a fall (Hall & Anderson, 1992).

In response to these practices, insurers began to revise their contracts with physicians and hospitals by inserting explicit requirements of “medical necessity” to the services offered in the package of benefits. As originally used, the term “medical necessity” was not intended to mean life-or-death necessity, but merely medically appropriate or medically beneficial. The intent is to exclude coverage for care that is harmful, or of no benefit, or nonstandard (Dallis v. Aetna Life, 1983).

By the end of the 1970s, many insurers had adopted two new contractual revisions in response to limitations based upon further caselaw. First, was the specification that medical necessity was to be determined in the insurer’s judgment, and second, exclusion of payment for “experimental” or “investigation” procedures. A typical provision excludes coverage for treatment that is “not medically necessary, i.e., when in the judgment of the Carrier that medical services did not require the acute hospital bedpatient (overnight) setting,” and states that, “the fact that a physician may prescribe,

order, recommend, or approve a service or supply does not, of itself, make it medically necessary.” (Franks v. Louisiana Health Serv. & Indemn. Co., 382 So. 2d 564, 1066 [La. Ct. App. 1980]).

During the 1980s a number of studies questioned the appropriateness of many of the procedures commonly ordered by physicians. Other studies found wide variations in hospital admission rates across geographic areas that could not be explained by demographics, health status, economic status, or other relevant factors. The general consensus of the researchers was that much of the variation in medical practice could only be explained by a discretionary “medical practice factor.” These studies encouraged insurers to begin reviewing the appropriateness of medical procedures more closely and in advance of treatment (Hall & Anderson, 1992).

Cost containment became a policy objective for several reasons, none of which more important than policy makers within state and the federal governments saw the portion of their budget going for medical services increase rapidly, constraining their ability to fund other programs. All of this was occurring within the backdrop of health services research findings that suggested a significant portion of medical care is inappropriate and delivered in widely varying patterns that could not be explained by variations in health status or other factors (Pepper Report, 1990). While there have been attempts to control new technology, the growing consensus at that time was that more rigorous assessments of the actual health outcomes of treatment modalities will be an effective mechanism for eliminating unnecessary or inappropriate medical procedures and expenditures.

The Role of the Benefit Manager

The premiere question regarding this role for the insurer is simply stated: Can insurers be trusted to make decisions in their subscribers’ best interest? In the case of public services, who is the customer? The concern over financial self-interest is apparent in models where the benefit manager provides their own in-house medical necessity determinations. The concern over insurers’ financial incentives becomes more forceful under arrangements where the benefit manager bears the financial risk. Many public plans are designed to share the public risk with private parties.

Strategies to Refine the Meaning of Medically Necessary Services

Lee Newcomer has outlined three contractual mechanisms for coping with the problems presented by the use of the concept medically necessary services in the private sector. First, list out the specific exclusions for all services that are deemed to be unsafe, unnecessary, or uninsurable (Newcomer, 1990). Although this technique has proven troublesome in commercial physical medicine, it may have some utility in the public sector mental health system. Secondly, specify the criteria that will be used to assess medical necessity or experimental status of a procedure or treatment process. It should be noted that the Pepper Commission estimated that only 10-20% of medical procedures have been subjected to clinical trials (1990). The same standard should apply to mental health care. A third strategy could be to incorporate, by reference, the medical technology assessment decisions made by specified organizations (Kalb, 1989). It would be a simple matter for a contract to read that it will not cover a procedure that is determined by any of these organizations to be unsafe, unproven, ineffective, or outmoded.

One possible prototype coverage process is offered by Mark Hall (1992) and suggests that the parties to the contract agree to the following:

1. Particular treatments the parties know in advance they do not wish to cover;
2. Standards to determine under what circumstances unspecified treatments are covered
3. An entity to apply these standards in making prospective assessments of medical treatments. These assessments would be general rulings that apply to all patients;
4. The same or a different entity to make case-specific applications to particular patients of the specified exclusions in treatments (1 above); the standards used to determine the circumstances unspecified treatments are covered (2 above); and the general rules of medical treatments (3 above);
5. Criteria for determining when sufficient additional information requires the entity to reconsider its general (3) or specific (4) rulings;
6. The processes to be used in (3), (4) and (5), and an agreement that the determinations these processes produce are within the sole discretion of the specified entities and are binding on all parties; and
7. An agreement that the role of the courts is limited to assuring that the processes actually followed are a reasonable interpretation of what the contract specifies, and an agreement that the primary remedy for any defect in process is to have the case properly reconsidered using the correct procedures, not for the court to decide the issue itself.

According to Hall, the most critical question continues to be who should conduct the assessment process, i.e., the entity to apply [these] standards in making prospective assessments of medical treatments, where the assessments would be general rulings that apply to all patients.

Public Mental Health/ Behavioral Health Care

Lourie, Howe, & Roebuck (1996) have argued that the strict adherence to a medical model within the private mental health system has been a barrier to system of care development. More specifically, these authors suggest that the concept of medical necessity within traditional “health insurance” models promotes an underlying approach to care which has, at its focus, the direct amelioration of a specific disease entity, where all other care is seen as supportive, or the responsibility of someone else. Among other claims is the assertion that the emphasis on medical necessity focuses the treatment planning process on the pathological aspects of an individual’s condition which undermines the use of the strength-based approach that underlies the system of care philosophy (Lourie, Howe, Roebuck, 1996).

According to the Bazelon Center for Mental Health Law (1996), the principle objective of the concept of medical necessity should be to ensure that the intervention [used] is focused on the impairment and that the individual will benefit from the intervention. Furthermore, they suggest that: “Any managed care plan operating under an agreement with the state to deliver covered services to covered individuals whenever those services are necessary, must devise mechanisms to decide what services it will provide to whom and under what circumstances. Otherwise, the plan will have no control over expenditures and cannot operate effectively.”

Clearly, the mechanisms offered by Hall provide a reasonable place to begin discussions. The concept of medical necessity is recognized as a key element in public sector managed behavioral health care, one that is central to both the contracting process and service provision process. However, the concept is not being understood or applied consistently in the

public sector. Both providers and consumers appear to be confused by the multiple possible uses. Government officials responsible for contract language would be well advised to fully evaluate the historical use of concepts borrowed from industries they wish to copy.

One commonly held belief about what constitutes necessary care is the promise of various levels of treatment being called upon to treat different circumstances of the individual. For children, the federal rules regarding the medical necessity standard require states to furnish: "necessary health care, diagnostic services, treatment and other measures (authorized under law) to correct or ameliorate defects and physical and mental illnesses and conditions... whether or not such services are covered under the State plan." An adequate response to this requirement calls for all interested persons to know the treatment or outcome literature in order to make informed decisions. We have seen that the treatment literature is of little help in this area.

Medical necessity, regardless of how difficult to define or operationalize, has been subjected to numerous revisions and clarifications. It is clear that the majority of the revisions were a direct result of a specific legal question and challenge. These challenges have led to a medical necessity concept and application that appears to be more socially negotiated, and less prone to be defined by medical evidence. It is very unlikely that the same challenges to medical necessity will occur in the public sector. Therefore, the need to quickly simulate processes aimed at determining the scope and breadth of services provided becomes as important to public sector services as it is with private commercial plans.

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Symposium: West Virginia: New Directions in Medicaid Reimbursed Behavioral Health Services

Introduction

New Directions in Medicaid Reimbursed Behavioral Health Services includes a series of changes and strategies that are part of a larger system initiative: *New Directions in the West Virginia Behavioral Health System*. The more comprehensive initiative has four goals: 1) to improve the quality of behavioral health services for children and adults; 2) to ensure that consumers receive the services they need, when needed, and the amount needed; 3) to establish a rational system of cost containment; and 4) to integrate various funding streams so that they support a coherent system of behavioral health services.

In West Virginia, as in many other states, there has been an increasingly large gap between the number of persons with identified behavioral health needs and the resources that are available to fund these services. In recent years West Virginia has narrowed this gap by turning to Medicaid as a major source for funding. This has had a dramatic impact on the state's ability to serve more people and expand the service base. The shift in funding source, however, has been associated with two major problems.

The first problem is that the tremendous growth in behavioral health services has been a contributing factor to a large deficit in the Medicaid program. The second problem relates to the use of state dollars to provide the state match for the Medicaid

Helen C. Snyder
West Virginia Office of Behavioral
Health Services
1900 Kanawha Blvd, East
Building 6, Room B717
Charleston, WV 25305
304/558-0627
Fax: 304/558-1008

Sharon Carte
Bureau for Medical Services
7012 McCorkle Ave
Charleston, WV 25304
304/926-1700

John Bianconi
Bureau for Community Support
Bldg 6, Room 617
Charleston, WV 25305
304/558-0298

James P. Terry
Chief Clinical Officer
Potomac Highlands Guild, Inc.
PO Box 1119
Petersburg, WV 26847-1945
304/257-4678 Fax: 304/257-1945

Warren Galbreath
Children's Home of Wheeling
14 Orchard Rd
Wheeling WV 26003
304/233-2367

Terry Toothman
Mountian State Parents
1143 Main St. Suite 1B
P.O. Box 6658
Wheeling, WV 26003-0906
304/233-5399

program; these dollars were previously targeted for other services. Since 1992 there have been various attempts to address these problems. The first effort related to cutting rates for specific services (short-term strategy) and the development of a managed care program (long-term strategy).

In 1993, the state did a functional analysis of managed care to determine how best to prepare the behavioral health system for its implementation. It was determined that outcome and satisfaction measures, practice guidelines, and an increased data analysis capacity needed to be developed. In 1994 it was decided that revision of the manuals for Medicaid, case management, clinic and rehabilitation would assist in preparing for managed care while controlling costs in a more appropriate way than simple rate reductions. In 1995, outlier analysis was implemented, and teams were established to develop a universal grievance process and identify performance indicators. In 1995 the state was also informed that a 1115 waiver would not be approved and there were serious issues related to the approval of a 1915(b) waiver. Based on these problems, the state decided to abandon seeking a waiver and determined that the efforts that had been made to prepare the behavioral health system for managed care would serve as a good framework for the actual managed care program. It was clear that the efforts would have to be integrated. The revisions in the case management, clinic and rehabilitation manuals were identified as the most appropriate means to integrate these efforts.

Revision of the case management manual was completed in October of 1995. This publication more clearly defined medical necessity to include both diagnosis and functional impairment. Similarly, the revisions to the clinic and rehabilitation manuals, which are the focus of this summary, provide the basis for improving the method for determining medical necessity, as well as improving management of services by reducing over utilization.

The New Directions initiative described by this summary will have an impact on behavioral health services funded by Medicaid in West Virginia. It will also have an impact on services funded through state general funds and federal grants from the Department's Office of Behavioral Health Services and Office of Social Services. A two phase plan has been implemented which outlines key events and time lines in the areas of service provision, data collection and analysis, feedback and technical assistance, and management and funding stream integration.

Development of the New Directions Initiative

The New Directions initiative was developed through a process in which key stakeholders met and evaluated the strengths and weaknesses of the current Medicaid system and endeavored to integrate the efforts of various groups that had met to develop strategies to implement managed care. Several drafts of the Behavioral Health Clinic and Rehabilitation Manuals were developed and general comment was solicited. Current system data were used to identify areas of over-utilization, and changes in medical necessity determination process were based on information from the Best Practices and Outcome groups that had been developed for various disability populations.

Redefining medical necessity. Medical necessity must exist in order to determine when treatment/ services are eligible for reimbursement under Medicaid or other payment sources. For purposes of determining medical necessity for Medicaid recipients accessing services through the West Virginia Behavioral Health Clinic Services Option or the West Virginia Behavioral Health Rehabilitation Services Option, determinations are based on the evaluation of four critical factors: (a) diagnosis, (b) functional impairment, (c) clinical stability, and

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(d) level of support. Service access, therefore, is based both on diagnosis and evaluation of functioning.

By utilizing these four critical factors to determine medical necessity, a more comprehensive system of evaluating “level of care – level of need” can be developed. A standardized group of required measures of functioning can be instituted to standardize evaluation, and to support delivery of the most appropriate treatment service. These revisions to the definition of medical necessity also promote a more comprehensive approach to intake and crisis services, which are keystones of a quality service system.

Previously, any Medicaid recipient with a DSM-IV diagnosis or a deferred diagnosis could receive Behavioral Health Clinic or Rehabilitation Service regardless of their level of need. Under the current system, Medicaid consumers with a targeted diagnosis and *functional impairment* receive services based on the assessment of their need. The previous use of diagnosis as the sole criterion for determining medical necessity presumed that there is a close relationship between diagnosis and treatment services, or between treatment services and outcomes. There is little research to demonstrate a close relationship between these variables. The use of diagnosis as the major criterion to drive care frequently resulted in provider belief systems and financial considerations shaping care for individuals. Diagnoses of mental disorders, substance abuse disorders, and developmental disabilities generally lack specificity, and categories of diagnosis have a high degree of symptom overlap. Knowing the diagnosis for a client may be useful in setting general, long-term treatment goals, but provides little information about the level of care needed or the specific course of treatment necessary for an individual.

Data collection informs service system planning.

In addition to improving the process for determining medical necessity, the goals of the New Directions

initiative address providing standardized assessment across agencies to improve the quality and comparability of data. An improved system for determining medical necessity also serves as the foundation for establishing a database to be used for gathering data on consumer, cost and system outcomes. Data will be used by consensus panels to standardize the process for matching consumer need to service provision. This holistic problem solving approach preserves access to services for the most needy individuals while reducing over utilization, and provides a reasonable alternative to cost cutting measures that target specific codes and impact all providers and consumers regardless of need for the service.

Implementation of the New Directions Initiative

The implementation of the New Directions project carried several challenges for the revision team. Past teams simply relied on the policy and administrative entities of the Bureau of Medical Services to set an implementation date and send out the changes to the manuals. Since the New Directions project made significant changes, not just to the manuals, but to all facets of service delivery, the first challenge was to develop a mechanism to ensure governmental and provider network support for the project. Without the full backing of the government agencies, implementation of the revised definition for medical necessity would inevitably fail. Similarly, the revision committee felt that the provider community could create challenges to implementation if they were not fully informed of the potential for negative impact inherent in a “straight rate cut” strategy. To create buy-in, the Medicaid Revision Task Team developed an implementation strategy that would minimize conflicts and provide stakeholders with ways to improve service delivery while implementing the

required Medicaid changes. Subcommittees were established to develop plans in two basic areas: (a) implementation procedures and timelines; and (b) training.

The first subcommittee met to establish a time line of implementation and to put in writing the rationale, potential system impact, and final assessment protocols. This subcommittee addressed various aspects of system change both within the provider network and within governmental agencies, including issues related to data collection, circulation of draft reviews and comments, assessment protocols, and outcome measurement. In this context, the existing capabilities of the system needed to be fully surveyed so that necessary components such as data management could be developed or bought to ensure the success of the project. The subcommittee worked closely with a variety of stakeholders and participated in multiple meetings with them to ensure that the time lines were adjusted and changed based on the concerns that were discussed. The committee further planned for stages of implementation so as to not overwhelm the various providers with too much change at one time. It also was important for each concern or change in the time line be sent in writing to avoid inconsistencies. Each stakeholder, from the largest to the smallest provider, was given full documentation of all questions, concerns, comments and responses by the revision team in order to minimize communication problems.

The second subcommittee dealt with training aspects that would support implementation of the project. This subcommittee focused on training details, including recruiting trainers, time lines, placement within the state, target population, and necessary materials. Since the project included the use of a specific protocol for evaluation, the subcommittee needed to prepare a variety of techniques for training a range of providers, from

the most technologically and clinically advanced, to those in settings without computer support and only part-time clinical staff. They also focused on a plan to train and educate consumers of service who were being impacted by the change. Special care was taken to have the committee fully balanced with consumers, providers and state agency staff so that all areas would be fully represented and bring forward their unique perspectives.

System Integration

The New Directions initiative impacts the system of care for children and families at two levels. The first relates to the challenge of integrating the change into the overall system of care and the second is at the individual provider and consumer level.

Systems integration. The primary challenge was to integrate the New Directions changes into the balanced system of care plan adopted by the Department of Health and Human Resources. The balanced system of care plan was developed to ensure the delivery of therapeutically sound family focused and cost effective services for children and youth with emotional or behavioral disabilities. Regional Summits have surveyed existing resources and shaped the system of care to approximate the level of need for all types of services. Services in the array that can be funded by Medicaid have been identified, as have the children and youth eligible for these services. Additionally, special attention was given in the New Directions plan to children and youth involved with Child Protective Services (i.e., children and youth in custody and those children identified as at risk for out of home placement).

The initiative also meshes with the behavioral health care reform activities that have focused on (a) developing a more accountable system of care; (b) developing objective measures to determine

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functional needs; (c) developing objective measures of outcome and consumer satisfaction; and (d) the identification of services which produce desired outcomes of rehabilitation and recovery (best practices). The New Directions focus on standardizing data collection provides information to all segments of the system to further the development and identification of needed services and the delivery of only necessary services (best practices). Standardized data collection reinforces the legitimate billing processes and improves utilization management by making data available for prior authorization and retrospective review. Improved data collection aids in evaluating consumer satisfaction by increasing comparability and access to services statewide.

Support for providers and consumers. On the provider and consumer level the current changes help to sustain and improve efforts already underway. Many agencies have already begun to implement utilization management processes and evaluation of outcomes. The data collected can be integrated into existing processes to enhance current efforts. For providers not engaged in these processes, the data collection procedures can establish a foundation for implementing managed care principles which will support efficient operation.

The introduction of functional measures is a first step in standardizing the intake process. Standardization also provides latitude to add missing components for those providers who have an already defined intake process. It should be seen as a method of transforming the subjective information currently collected into objective data. All providers need to evaluate the information they are collecting at intake and streamline the process as much as possible both for the benefit of the clinician and the consumer. The information chosen for collection and the critical factors for determining medical necessity are compatible with intake

requirements for Medicaid review, Behavioral Health Licensure, JCAHO, and other accrediting bodies and private insurers. For providers who do not currently have a standardized intake process, this offers an opportunity to implement a core set of evaluations for effective care management.

The impact on consumers will be monitored through the collection of consumer satisfaction data. A satisfaction survey has been designed by the Mountain State Parents Child and Adolescent Network which evaluates access and satisfaction with services. Consumers have also been involved in the identification of performance measures that indicate a quality service system and have been involved in the development of the grievance process in the New Directions system.

Medicaid Capitation in Colorado: Impact on Youth Discharged from State Hospitals

Introduction

The mental health system in Colorado is moving rapidly toward a capitated, managed care model of providing services to people eligible for Medicaid-funded mental health services (see timeline in Figure 1). In August and September of 1995, capitated systems were implemented in about 69% of the state.

After the implementation of capitation, community mental health providers who had previously relied heavily on the two Colorado Mental Health Institutes (CMHIs) for treating youth with severe emotional disturbances began to make extensive use of community alternatives to these inpatient placements. Treating youths in the community has long been a desirable system goal. However, the fiscal incentives inherent in managed care to avoid expensive inpatient treatments raised concerns that some youths would be discharged prematurely to community placements that would not be able to provide an adequate level of care. Thus, this investigation was undertaken to understand the impact of a capitated system of care on Medicaid-eligible children and adolescents who have serious emotional disturbances. Because of the concern over the appropriateness of alternative placements, the most important outcome variable of the study was the *fit* between the needs of the youth and the services provided to them.

David A. Bartsch, Ph.D.
Director of Decision Support
Mental Health Services
CO State Department of
Human Services
3824 West Princeton Circle
Denver, CO 80236
602/657-8578
Fax: 602/657-8579

Mary Elizabeth Callaway, Ph.D.
NASMHPD Research Fellow
Mental Health Services
CO State Department of
Human Services
3824 West Princeton Circle
Denver, CO 80236
303/866-7433
Fax: 303/866-7428
me.callaway@state.co.us

**Anita Saranga Coen, M.S.W.,
L.C.S.W.**
Evaluation and Program Specialist
Mental Health Services
CO State Department of
Human Services
3824 West Princeton Circle
Denver, CO 80236
303/866-7412
Fax: 303/866-7428
coen.anita@state.co.us

Diane C. Patrick, M.U.A.
CASSP Coordinator
Mental Health Services
CO State Department of
Human Services
3824 West Princeton Circle
Denver, CO 80236
diane.patrick@state.co.us

William G. Bane, M.S.W.
 Director of Child and Family Services
 Mental Health Services
 CO State Department of
 Human Services
 3824 West Princeton Circle
 Denver, CO 80236
 303/866-7406
 Fax: 303/866-7428
 bill.bane@state.co.us

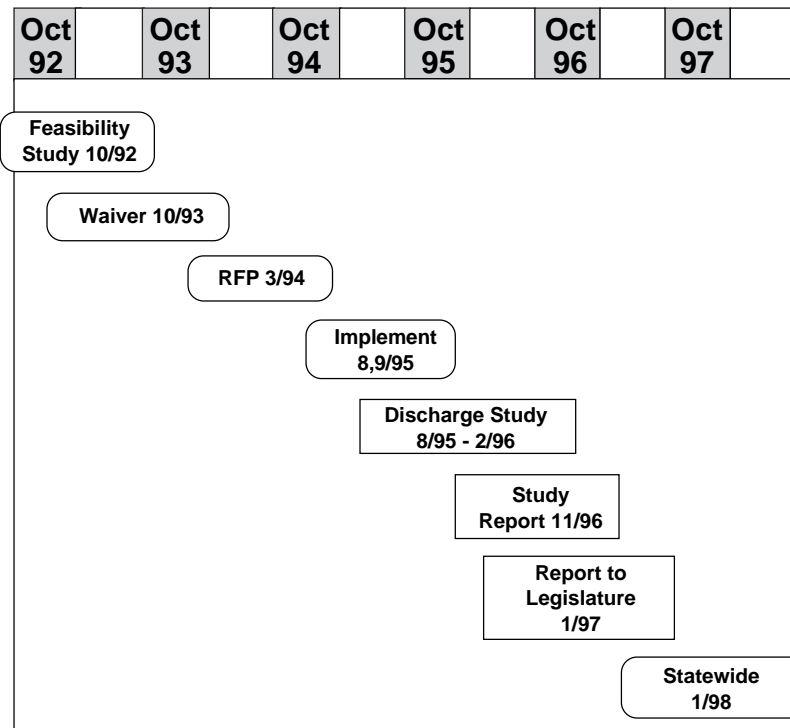
Craig Hamilton, M.S.S.
 Program Specialist
 Mental Health Services
 CO State Department
 of Human Services
 3824 West Princeton Circle
 Denver, CO 80236
 303/866-7416
 Fax: 303/866-7471 TDD
 craig.hamilton@state.co.us

Method

Two groups of youth were studied (see Figure 2). The early capitation cohort was composed of all 68 Medicaid youth who were discharged from the state hospitals in 1995, during the two months immediately following the start of the capitation pilot. The pre-capitation cohort included the 59 Medicaid youth who were discharged during the same two-month period in 1994, exactly one year before the implementation of capitation. A variety of information about these two cohorts was collected from the state data base, the CMHIs, and the community mental health provider organizations who were participating in the capitation pilot.

In addition, subsamples of 20 pre-capitation youth and 24 early capitation youth were selected from the two cohorts for more intensive study. Records from the hospitals and the provider organizations were reviewed. Telephone interviews were conducted with parents, clinicians and, occasionally, child welfare and youth corrections case managers.

Figure 1
 Implementation Timeline for Medicaid Capitation in Colorado



Results

Clinical Characteristics

The pre-capitation cohort showed significant increases during their hospitalizations in all nine domains of functioning measured by the Colorado Client Assessment Record (Ellis, Wackwitz, & Foster, 1991). The early capitation group improved in five. Yet despite this small variation in improvement, the two cohorts did not differ significantly on any of the nine domains at the time of discharge, nor did they differ on the average number of days they spent in the hospital (86)¹.

¹ Recall that the early capitation cohort consists of young people who were discharged during a period starting on the first day of the capitation pilot and continuing for two months. Consequently, most of the youths in the early capitation cohort were actually admitted to the institutes prior to capitation.

Medicaid Capitation in Colorado

Discharge Process

The majority of parents (or guardians), prior to and after the implementation of capitation, said that they were included in the decision to discharge and that they were satisfied with their level of involvement. However, *more* early capitation parents thought that their children were ready for discharge than did parents in the pre-capitation subsample (72% versus 56%).

Goodness of Fit

Parents (or guardians) and clinicians were asked if the post-discharge placements and services the child experienced either fit, partially fit or did not fit their child's needs. They made this determination for the setting where the child was placed immediately after leaving the hospital and for the setting where the child was four months later.

Their responses indicate that the settings where youth were placed immediately upon discharge did not meet their needs in a large proportion of the cases (see Figure 3). This was true for youths in both the pre-capitation and early capitation subsamples. Only approximately 40% of parents in each year thought their child was discharged to a setting where his or her needs were met.

More complicated results were found concerning the goodness of fit of the placement and services the youth were receiving four months after discharge. Clinicians thought that even fewer youth were in placements that fit their needs four months after discharge than had been the case

immediately upon their release from the Institutes. This decrease in fit between the time of discharge and 4-months later occurred in both years under investigation. However, clinicians rated more 4-month placements as a good fit after capitation (50%) than they did before capitation (36%).

Parents provide a very different picture of the 4-month placement. Parents thought that *more*

Figure 2
Study Design

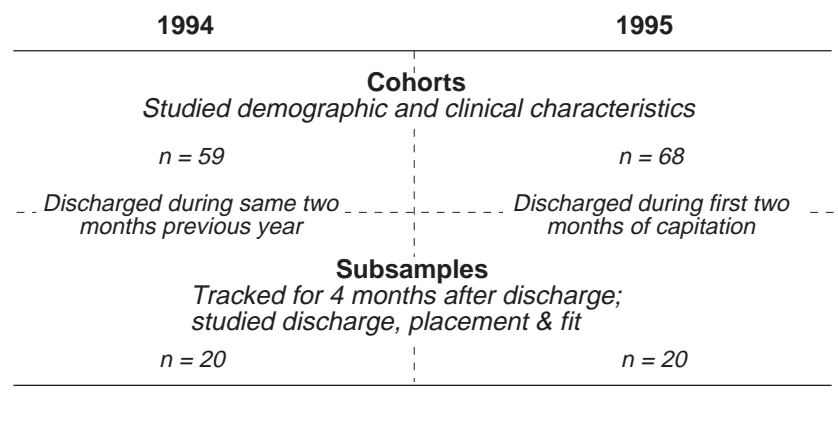
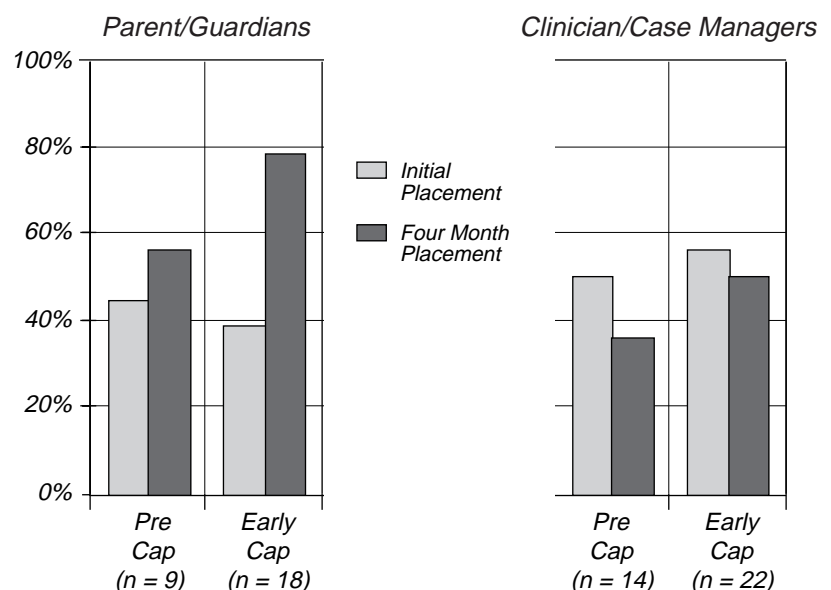


Figure 3
Percent of Informants Rating Initial and 4-month Post Discharge Placement as a Good Fit for Youth Needs



children were in placements that fit their needs four months after discharge than had been the case immediately upon their release from the Institutes. The increase in the number of well-fitting placements was evident both prior to and after capitation, but the increase was dramatic in the post-capitation year. Only 39% of post-capitation parents thought their child's initial placement was a good fit, but 78% thought that the four-month placement fit their child needs.

Characteristics of Service-Need 'Fit'

Parents and clinicians were asked to explain their assessment of the goodness of fit between their child's needs and his or her post-discharge placement. Both groups of respondents in both years expressed the same themes when explaining their ratings of fit. The themes depended upon whether they felt the placement fit or did not fit the needs of the youth. A fit occurred when the placement:

- was based on an assessment of the child's needs;
- provided a level of care compatible with those needs;
- facilitated a successful transition or step-down from the previous placement;
- involved the family;
- had a level of intensity and structure to meet the child's needs; and
- was geographically located in a way that made it accessible.

Conversely, a placement did not fit when:

- the youth needed more restrictive placements;
- wraparound services (services fully integrated to meet the youth's needs) were lacking;
- child and family support services were lacking; and
- the clinician/case manager was unprepared to meet the needs of the child.

Number of Placements

More early capitation children had at least three placements during the four month period following their discharge than did pre-capitation children (42% versus 26%). Likewise, fewer early capitation children remained in a single setting for this period (38% versus 58%).

Restrictiveness of Placements

The placements that the youth experienced after their discharge were rated for restrictiveness using the Restrictiveness of Living Environment Scales (Hawkins, Almeida, Fabry & Reitz, 1992). The ratings showed that the level of restrictiveness of the placements did not differ significantly between the pre-capitation and the post-capitation groups, neither at discharge nor at four months.

However, the restrictiveness pattern of placements did differ between the subsamples. Prior to capitation, the initial discharge placements were more restrictive than the four-month placements. After the implementation of capitation, the pattern was in the opposite direction; the four-month placements tended to be more restrictive than the initial placement.

Rehospitalization

Twenty percent of the pre-capitation subsample was rehospitalized during the four month period following their discharge. Thirty-three percent of the early capitation group was rehospitalized during the comparable period the following year. Given the small sample size, this difference was not statistically significant. Further analysis of the subgroup who was rehospitalized revealed an association between lack of fit at the initial discharge placement and subsequent rehospitalization. That is, youths who were rehospitalized during the four month study period were more likely to have been in an initial community placement that did not fit their needs than were youth who were not rehospitalized.

Discussion

Youth who were discharged during early capitation improved in fewer areas of functioning while hospitalized compared to youth discharged in the previous year. This raises the question of whether the youth were discharged prematurely because of capitation pressures. For three reasons, this does not seem to be the case. First, the overall level of functioning of the early capitation cohort was quite similar to that of the youth discharged the previous year. Second, the average length of stay in the hospital was the same for the two groups. Finally, parents were *more* likely to say their children were ready for discharge after the start of the capitation pilot than before.

Rather than premature discharge, the disturbing issue raised by the results is the inadequacy of community placements for children and adolescents when they are ready to leave an inpatient setting. Although parents felt the youth were ready for discharge, parents and clinicians in both years were dissatisfied with the fit of their child's initial discharge placement in a substantial portion of the cases. Four months later, a majority of the youth in the early capitation group were in a placement that fit their needs according to parents, but according to the clinicians the situation had not improved.

The fit of the child's placement at four months may have been better than it was at discharge because the child was moved from his or her initial placement to a more suitable setting some time during the four months. Frequent changes in placement were, in fact, especially common among the early capitation youths. The changes do not appear to be the result of an orderly, step-down progression to the least restrictive setting. To the contrary, early capitation youth tended to move to settings that were *more* restrictive than their initial discharge placement. A third of them were eventually transferred to one of the most restrictive settings, a

private or public psychiatric hospital. These children who were rehospitalized were particularly likely to have been placed in an initial setting that did not meet their needs. Thus, the frequent moves noted among the early capitation subsample may have been caused by a poor match between the child's needs and the service capacities of earlier placements.

One of the explicit goals of the study was to assess the relative performance of the capitated system on services to the moderately impaired population of youth represented by the children and adolescents who were discharged from the state institutes. Compared to the traditional fee-for-service organization of Medicaid reimbursement, the capitation pilot produced mixed success. Neither the pre- nor early capitation systems did well at placing children in suitable settings at the time of discharge. The capitated system may have been more successful at providing services that fit the needs of children four months after discharge. On the other hand, the capitated system resulted in children being moved more often. A clearer picture of the impact of capitation on services for children may emerge from a replication of this study which will be completed in the autumn of 1997.

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West Virginia Partnerships for Care: Managing Inpatient Care for Indigent Youth

Introduction

The Partnerships for Care Project is a statewide network of crisis services for youth referred to the Office of Behavioral Health Services for possible payment assistance for inpatient psychiatric or alternative services. The project was developed as a collaborative effort between the Office of Behavioral Health Services and the Comprehensive Behavioral Health Centers to coordinate the screening and approval of inpatient services for indigent children and adolescents at a regional/local level.

Development of the project was derived from the system of care value that psychiatric hospitalization for children and youth should be utilized only when all other appropriate alternatives have been exhausted. Studies have indicated that some children with serious emotional disturbances or substance abuse problems end up in more restrictive, costly inpatient care because appropriate screening and community based alternatives are not available. And, if a child appropriately receives needed inpatient care, the length of stay is sometimes extended due to inadequate assessment and review (Friedman & Kutash, 1992). West Virginia's utilization of inpatient psychiatric care for children and youth was consistent with these trends. Review of inpatient psychiatric care led to the identification of specific issues which served as the basis for development of the project's goals.

Helen C. Snyder

*West Virginia Office of Behavioral Health Services
1900 Kanawha Blvd., East
Building 6, Room B717
Charleston, WV 25305
304/558-0627
Fax: 304/588-1000*

James P. Terry

*Chief Clinical Officer
Potomac Highlands Guild, Inc.
PO Box 1119
Petersburg, WV 26847-1945
304/257-4678 Fax: 304/257-1945*

Authors' Note

Thanks to the committee who worked on the development of the Partnerships for Care Training Manual - Emma Steelman, Valley Comprehensive Community Mental Health Center, Inc.; Karen Yost, Shawnee Hills, Inc.; Cindy Largent, Shawnee Hills, Inc.; Robert Hansen, Prester Center for Mental Health Services; Steve Morris, Northwoods Health Systems, Inc., Electa Mulvanity, Northwood Health Systems, Inc.; William C. Snoberger, Potomac Highlands Guild, Inc.; Mike Clancy, Westbrook Health Systems.

Thanks to the Partnerships for Care Board for their ongoing review and monitoring of the project - Teri Tootham, Mountain State Parents-Child and Adolescent Network; Arry Green, Westbrook Health Systems; Emma Steelman, Valley Comprehensive Community Mental Health Center, Inc.; Karen Yost, Shawnee Hills, Inc.; Don White, Prester Center for Mental Health Services; Sue Lewis, Appalachian Community Health Center, Inc.; William C. Snoberger, Potomac Highlands Guild, Inc.; Charlie Kirby, Eastridge Health Systems, Inc.; Sharon Carte, Bureau for Medical Services, West Virginia Department of Health and Human Resources.

Thanks to Dr. Robert Hess, Director, Office of Behavioral Health Services; William D. Hagerty, Chief Executive Officer, Potomac Highlands Guild, Inc. and John Bianconi, Acting Commissioner, Bureau for Community Support for their support, encouragement and expertise in implementing and funding the project.

Thanks to Bruce Blackhurst, Chief Fiscal Officer, Office of Behavioral Health Services for assisting in the financial tracking of the project.

Thanks to Marilyn Atkinson for editing, typing and copying the training materials.

Thanks to Richard Snyder and Lorrie Terry for their support and tolerating the long hours required to implement and monitor this project.

Primary goals for the project were:

1. monitoring admissions and length of stay at the regional level;
2. reducing overall length of stay for appropriate admissions;
3. providing a fiscal incentive to decrease inpatient utilization and provide alternative care when possible and;
4. utilizing cost savings from the project to improve regional crisis services for children.

The Office of Behavioral Health Services, Division of Children's Mental Health Services, had been monitoring inpatient hospitalizations that utilized state funds and had instituted a process for approval of inpatient care. This was a case management oriented process that utilized clinical judgment and recommendations from practitioners, but did not utilize a formal evaluation process for determining eligibility. Partnerships for Care refined that process and moved approval away from the state level to a regional/local level. The project instituted a process whereby dollars could be used to fund alternatives to inpatient services and utilized regional savings to fill gaps in crisis services. This alternative was designed to allow the community mental health centers to develop a crisis system that was more effective and clinically responsible, and that would emphasize the primary use of community-based treatment resources whenever possible. Finally, it was intended that Partnerships for Care would slow the increasing costs of inpatient care, while ensuring appropriate inpatient care for children in need.

Although inpatient care is recognized as an important part of the array of services for children and youth, project staff worked on the assumption that it should only be used when other services are not appropriate to meet the needs of the child. This project provided a method for evaluating the necessity of inpatient care and the availability of

appropriate alternatives. Additionally, when a child was hospitalized, the process ensured that discharge planning occurred to facilitate return to the community and linkage to necessary aftercare services. Authorization for long term residential care was not an option under this project. If a child required long term residential or inpatient services, referral was facilitated by the Regional Network Representative and alternative funding sources were utilized.

Methods

Screening Protocols

The project utilized six Regional Networks, with identified lead agencies that provided authorization for inpatient funds. The six Regional Network Representatives reviewed and approved referrals from local liaisons. Any child referred to the Regional Network for authorization of inpatient care was screened utilizing the established protocol. The screening included basic client demographic information, mental status examination, screening for suicidality using an approved scale and evaluation of available resources and alternatives to inpatient care. This protocol was intended to assist the inpatient facility and assigned case manager to ensure that major needs areas were addressed during the admission and in the development of the discharge plan. It also assures that least restrictive alternatives to hospitalization were evaluated for appropriateness prior to hospital admission.

The screening criteria for inpatient admission approval followed several criteria related to the target population and the civil commitment codes within the state of West Virginia. The child must meet the target definition for SED and be ineligible for Medicaid, SSI or private insurance benefits. The child must meet the minimum standard under the civil commitment code for involuntary hospitalization and the application must exhibit evidence of multi-disciplinary team involvement, aftercare planning and some level of family involvement. A child could be admitted

West Virginia Partnership for Care

voluntarily under this project. There was no requirement that civil commitment be completed, however, the child or adolescent must essentially meet the criteria for involuntary commitment under the West Virginia statutes.

The testing protocol utilized in the Partnerships for Care project was designed to meet several criteria. First, the instrument protocol needed to measure specific outcomes and, therefore, utilize time-frame specific instruments that could be administered both prehospitalization and post-hospitalization. Since the instruments were to be used for admission criteria and for outcome of hospitalization, the instruments needed to be an accurate screening of symptom patterns. Second, the instruments needed to be mobile without test conditions that would contaminate results. The instruments were likely to be administered in homes, clinics, emergency rooms, etc. and needed to be easily administered and scored in short time frames. Third, the instruments must be able to be administered by both professional and para-professional staff with training, since the profile of crisis workers throughout the state varied in both level of experience and clinical training. Finally, as with most protocols, the instruments needed to be cost effective to purchase and administer.

The instruments chosen met the above criteria and were selected to represent the symptoms most likely seen in individuals applying for hospitalization. For children, instruments in the protocol included the *Child Depression Inventory* (Kovacs, 1982), the *Child Anxiety Scale*, and the *Stress Response Scale* (Chandler, 1993). For adolescents the protocol consisted of the *Reynolds Adolescent Depression Scale* (Reynolds, 1987), and the *Suicide Probability Scale*. (Cull & Gill, 1988) were administered. The project's referral form included areas for the required demographics including financial information, instrument scores and interpretation, DSM IV Diagnostic Impression, review of alternative placement options and discharge planning.

Cut-off scores for eligibility were determined for each instrument based on the author's determination of clinical significance for the instrument. While the instruments were utilized as a guideline for admission, the regional network representative could determine that the scores were invalid or insufficient to make a determination based upon data presented by the clinician presenting the case. Additional factors utilized to make a determination included symptomatology and functioning based upon the clinical interview and mental status examination. In these cases, the regional network representative had the authority to override the scores and either authorize or deny admission based upon data presented. In either case, there an appeal process could be initiated by the child, family or professional related to denial or access to service. Additionally, a grievance process allowed staff from the Division of Children's Mental Health to make a determination within 24 hours that confirmed or overturned the Regional Representative's decision. The project board reviewed all appeal and grievance determinations at the next board meeting and provided input to both department staff and the regional network representatives.

Funding

The regional networks for the project were allocated funds based upon a formula developed by the Children's Mental Health Division of the West Virginia's Office of Behavioral Health Services. The methodology for funding the networks combined historical usage and current population for the region. By using a historical usage base for first time allocations, it was determined actual savings and decrease in hospital bed days could be more accurately analyzed to measure the success of the project. As an incentive to complete quality assessments and determine actual hospitalization need, the could utilize surplus dollars from realized savings to improve crisis programs to children in the region. As a safety net, the board and the state could re-assign

dollars to regions showing a higher need than was determined in the initial allocation methodology.

The funding allocations and the project management were maintained through a participatory board consisting of representatives from the regional network “lead agencies,” representatives from the West Virginia’s Office of Behavioral Health Services, a representative from the Bureau for Medical Services (Medicaid) and a representative from the consumer association. The board met on a quarterly basis to review the data on admissions, length of stay and hospital diversions. The Board reviewed denials, functioning of the local networks and the funding appropriations to ensure that quality service was being provided.

Results

Evaluation of the project’s first full year of operation indicated overall success with regard to the projects goals. There were dramatic decreases in inpatient costs, stronger use of assessment leading to appropriate inpatient placement, improvements in the regional crisis services to children realized through the savings and decreases in overall length of stay for children and youth placed in inpatient settings.

Data analysis indicated that first year cost savings for the project was \$189,510 over the previous year’s utilization. An analysis of the individual regional networks indicated savings ranging from 0% to 89% over the previous year with the mean savings overall of 37% (see Table 1). The savings were allocated to the regions for improvement in regional crisis services for children and were utilized for program upgrades and training. There were 76 referrals statewide to the project with 48 approvals for inpatient admission, 16 denials due to inability to meet the target population definition and 12 diversions to less intrusive service options. The greatest number of referrals occurred in regions with urban centers and higher population density. Of the 16 children denied due to financial reasons, 9 met Medicaid eligibility requirements after screening (see Figure 1). This compares to the previous year of 56 admissions statewide indicating a reduction of 15% in admissions since the projects implementation (see Figure 2).

Length of stay for admissions was greatly decreased, with the mean length of stay being 6.1 days. Range of length of stay was 2 to 14 days. Modal length of stay was 3 days. This compares to the previous years mean length of stay at 13.4 days indicating a decrease in average length of stay by 7.3 days (see Table 2). Consumer satisfaction data was

Table 1
Partnerships for Care Funding: Regional Allocation Expenditures and Savings
(Fiscal Year 1995-1996)

Region	Allocation	Expenditures	Savings	%of Savings
Region 1	\$60,950.00	\$60,950.00	\$0.00	0.00%
Region 2	\$116,250.00	\$38,751.00	\$77,499.00	66.00%
Region 3	\$53,150.00	\$5,795.00	\$47,355.00	89.00%
Region 4	\$53,700.00	\$37,585.00	\$16,115.00	30.00%
Region 5	\$ 157,950.00	\$ 121,976.00	\$35,974.00	22.00%
Region 6	\$58,000.00	\$45,433.00	\$ 12,567.00	21.00%
Total:	\$500,000.00	\$310,490.00	\$ 189,510.00	37.00%

West Virginia Partnership for Care

incomplete and therefore unreportable at this time, however subjective statements indicate overall satisfaction with expediency of response and timeliness of intervention.

Figure 1
Disposition of Referrals Statewide
(N = 76)

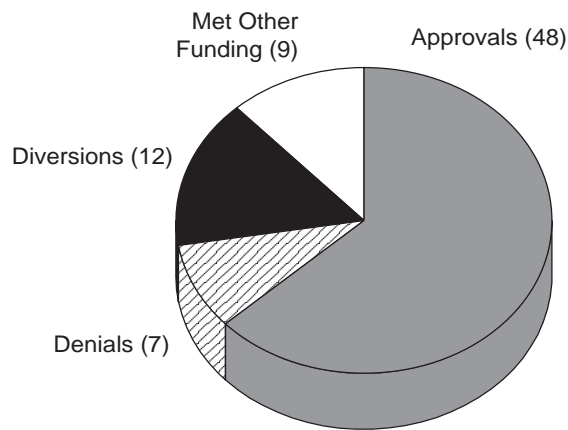
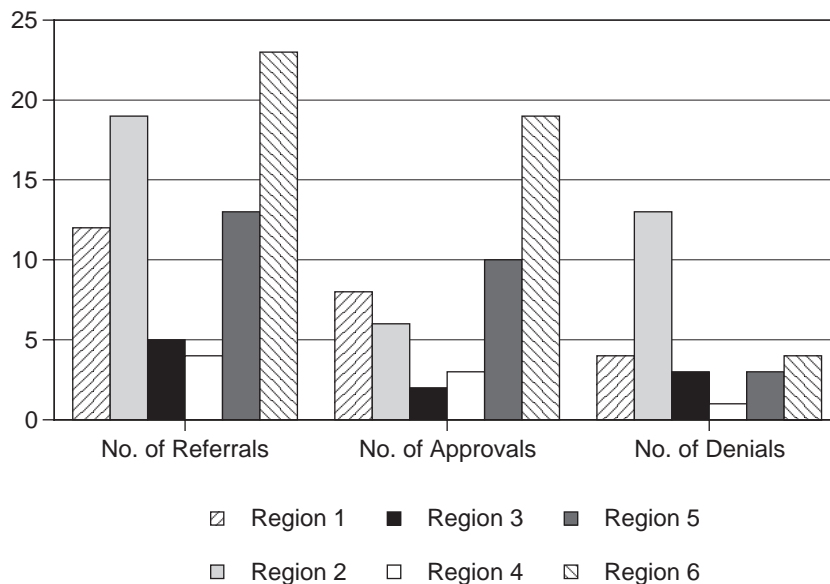


Figure 2
Disposition of Referrals by Region
(N = 76)



Discussion

Overall, the Partnerships for Care project met the previously stated outcome goals during its initial year and showed promise for gate keeping at the local/regional level. While initial data indicated increased efficiency, further data needs to be collected on consumer satisfaction with the process. The format for consumer feedback was developed, however, only two forms were completed. It will be critical to improve collection of this data to adequately evaluate the efficacy of the project.

The allocation methodology appears sound with all regions having sufficient funds to handle referrals. It is recommended that the current funding methodology be continued. For the period of July 1, 1996 to June 30, 1997, \$500,000 were allocated on the approved funding methodology. Surplus funds in the initial project year were allocated to the comprehensive behavioral health centers who determined how to spend the funds to improve crisis services. Allocation of future savings should allow centers the flexibility to spend the funds on any service that increases community alternatives to inpatient care.

The screening protocol has been evaluated and can accommodate recent changes in determination of medical necessity for Clinic and Rehabilitation Services for Medicaid eligible individuals.

In reviewing the data, there is an indication that regions with alternative services were more successful in diverting inpatient admissions. In particular, areas with child/adolescent Crisis Stabilization Units would appear to have higher rates of diversion and alternative placement, indicating that local regional development of alternative crisis services other than outpatient services would

further decrease inpatient utilization. While the system values local regional placement through gatekeeping as inherently more therapeutic than out of region/out of state placement, the geographical barriers and population density of the local regions make it impossible to have small inpatient units in each region. Development of local regional state supported crisis residential units could prevent inpatient hospitalization and allow for the individual consumer to receive diversionary treatment in a local setting.

The project's process should be evaluated for expansion into the current Medicaid utilization review for inpatient hospitalization of children and adolescents. It also seems appropriate to develop similar protocols and processes for managing indigent and Medicaid funded hospitalization for adults. There is potential for the program to be expanded to determine eligibility and level of care through utilizing similar protocols for other services. The project has clearly demonstrated the value of protocol and collaboration in improving service and system outcomes. However, the protocol will have to be further evaluated if a proposed regional gatekeeping mechanism is instituted for all Medicaid eligible consumers rather than the current state managed utilization review process.

The direction of the current environment toward managed care for behavioral health services remains an uncertainty with respect to preserving the overall quality of services. The success of the Partnerships for Care Project provides a model for

effective and efficient gatekeeping and treatment of children and adolescents. The potential applications of the model to West Virginia planning efforts has been recognized as an integral part of the infrastructure necessary to provision of services in a managed care environment.

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Table 2
Comparison of Goals for
Fiscal Year 1995-1996

Goals	Fiscal Year 1995	Fiscal Year 1996
Mean Length of Stay	13.4 days	6.1 days
Total Expenditures	\$500,000	\$310,490
Admissions	56	48

Keeping Children at Home: New York's Home and Community Based Services Waiver

Introduction

The New York State (NYS) Office of Mental Health is the government agency which creates opportunities for children and adults with psychiatric disabilities to safely and effectively work toward recovery. These opportunities (a) recognize that persons can recover; (b) include comprehensive services organized at the local level to promote recovery; and (c) promote a holistic approach to services that is individualized, flexible, measurable of high quality and user friendly.

On January 1, 1996, the Federal Health Care Financing Administration approved New York's request to waive three statutory requirements of Section 1915c of the Federal Social Security Act. *Stateness and comparability* were waived to allow implementation of the Home and Community Based Services (HCBS) Waiver on a demonstration basis in a limited number of counties. Secondly, the requirements relating to *amount, duration and scope of services* were waived making it possible to add six Medicaid services (individualized care coordination, respite care, skill building services, intensive in-home services, crisis response services and family support services) to the State Medicaid Plan. The third statutory requirement waived was *parental deeming rules*. Children enrolling in the HCBS Waiver are considered a "family of one," their parents/guardians' income and resources are not considered when determining Medicaid eligibility.

Stephen J. Conti
Project Administrator
Bureau of Children & Families
NYS Office of Mental Health
44 Holland Avenue, 6th Floor
Albany, NY 12229
518/474-8394
Fax: 518/473-4335
coopsjc@bmh.state.ny.us

Steven Huz, MPA
Research Scientist
Bureau of Evaluation &
Services Research
NYS Office of Mental Health
44 Holland Avenue, 6th Floor
Albany, NY 12229
518/474-7359
Fax: 518/474-7361
coevsjh@omh.state.ny.us

Diana Marek, MA, MBA, RN
Resource & Reimbursement Program
Development Specialist
Bureau of Strategic Financial Planning
NYS Office of Mental Health
44 Holland Avenue, 1st Floor
Albany, NY 12229
518/474-6911
Fax: 518/473-6723
cofpdmm@omh.state.ny.us

Erlinda Rejino, MA
Mental Health Specialist
Bureau of Children & Families
NYS Office of Mental Health
44 Holland Avenue, 6th Floor
Albany, NY 12229
518/474-8394
Fax: 518/473-4335
coopenr@omh.state.ny.us

The goals of the HCBS Waiver are to:

1. Enable children to remain at home or in the community, thus decreasing institutional placements;
2. Use the individualized care approach to service planning, delivery and evaluation; this approach is based on values of planning for one-child-at-time, partnerships with families and focuses upon the strengths of the family;
3. Expand funding and service options currently available to children and adolescents with serious emotional disturbances and their families;
4. Provide services that promote positive outcomes and are cost-effectiveness; and
5. Demonstrate a model of service delivery that fosters a transition to managed care.

Method

Participants

The HCBS Waiver has the capacity to serve 150 children and adolescents who meet the following criteria:

- seriously emotionally disturbed;
- between the ages of 5 and 18 years;
- demonstrate complex health/mental health needs;
- require institutional level of care;
- at imminent risk of admission to institutional level of care or have a need for continued hospitalization;
- service and support needs cannot be met by just one agency/system;
- Medicaid eligible;
- can be served at less cost than institutional level of care;
- capable of being cared for in the home and/or community if Waiver services are provided; and
- have a viable and consistent living environment with parents/guardians who are able and willing to participate in the HCBS Waiver and support their child in the home and community.

Sites

The HCBS Waiver operates in eleven rural and urban sites across the state. Each site has the capacity to serve between 8 and 24 children and families at any one time.

Local Infrastructure

Each site has an Individualized Care Coordination (ICC) Agency, or lead agency, responsible for development and administration of a network of service providers. The ICC agency was also responsible for hiring, supervising and training the Individualized Care Coordinators (ICC), coordinating and monitoring all the services the child and family received, and mentoring the service provider network. Finally, the ICC lead agency handles the billing of Medicaid Waiver services, and monitors the costs and program reporting requirements associated with each child's care.

Each lead agency must ensure that the full array of HCBS Waiver services are available and accessible to each child and family as needed. The development of these services and/or service networks is done in consultation with their respective county Department of Mental Health.

The county Department of Mental Health determines eligibility for the HCBS Waiver, approves service plans and accompanying budgets. The county departments assist the ICC agency in monitoring the costs associated with services provided through the HCBS Waiver. This monitoring of costs serves as a learning tool for a county's entire system of care.

Services

The six Waiver services were developed based on a survey of county departments of mental health and families. The survey collected information about the primary and ancillary services most needed to support the target population in their

New York's HCBS Waiver

homes and community. These services must be available at each site. Individualized Care Coordination is the only service required for each child, all others are accessed based on individual need.

The HCBS Waiver services are defined as follows:

Individualized Care Coordination includes the components of intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring and consultation. Individualized Care Coordinators work with no more than 8 children and families at a time.

Crisis Response Services are activities aimed at stabilizing occurrences of child/family crisis. These services provide the ability to do an assessment, provide consultation, and immediate intervention wherever necessary.

Intensive In-home Services are ongoing activities aimed at providing intensive interventions in the home. These interventions may include psychoeducation, crisis de-escalation, parent-child relationship building, and improvement of parenting skills.

Respite Care are activities that provide a needed break for the family and the child to ease the stress at home and improve family harmony. These activities include aid in the home, getting a child to school or program, aid after school, aid at night or any combination of the above. It may be provided on a planned or emergency basis either in-home or out-of-home.

Family Support Services are activities designed to enhance the ability of the child to function as part of a family unit and to increase the family's ability to care for the child in the home and in community based settings.

Skill Building Services are activities designed to assist the child in acquiring, developing and accessing functional skills and supports, both social and environmental, needed to function more successfully in community environments.

Fiscal Model

The Waiver fiscal model provides an average \$54,254 per slot in annual Medicaid as compared to approximately \$93,000 for institutional level of care (see Table 1 and Figure 1). This cap was calculated from historical Medicaid expenditure data for a similar population, and survey information regarding needed volume of service per category. Per slot average includes ambulatory mental health costs, waiver services plus licensed Medicaid mental health outpatient services, capped at approximately \$44,250. Individualized Care Coordination is paid through a monthly case payment rate which also includes program overhead for coordination of the other five services. The other five services are primarily delivered and billed by the hour or day fee-for-service basis. Rates for waiver services are based on local costs and service network design.

Risk for psychiatric inpatient, medical/surgical costs, and all other Medicaid expenditures is managed in several ways. Agencies receive monthly management reports on all Medicaid expenditures to use as a tool for managing their enrollees' costs. Children are automatically disenrolled after 60 inpatient days in a 75-day period or if assessed as needing long-term inpatient placement. Families are encouraged to enroll children in Medicaid managed care plans. A risk pool is created by withholding \$2,000 for each slot that does not have managed care coverage.

Measurement

Evaluation of Child and Family Outcomes.

To evaluate child and family outcomes data are collected on children and families at intake, 6, 12, 24 months and/or discharge. At intake, the Child Description Form (CDF) is used to gather information on: basic demographic information, functional status, education levels, behavior symptomatology and treatment history. In addition, data are collected on family stressors and strengths. Follow-up data collected repeat assessment of the child's functional

status and symptomatology, utilization of services and family strengths. In addition, follow-up instrumentation elicits data on the provider's assessment of level of need in nine life domains and individualized care plan strategies. Parent satisfaction with services is measured at 6, 12 and 24 months. At discharge, a Program Discharge Form is completed to assess the child and family's status as well as reasons for discharge and post-discharge service plan.

Cost Evaluation. Costs incurred for each child enrolled in the HCBS Waiver are collected and monitored through reports generated from the Medicaid Management Information System (MMIS) monthly. Annualized year-to-date amounts are compared to the agency's budgeted amounts per service category and to the \$44,267 cap for ambulatory mental health and the \$54,254 cap for total Medicaid expenditures per slot. Variances of greater than five per cent are more closely analyzed to identify utilization patterns which may prove costly and/or clinically ineffective.

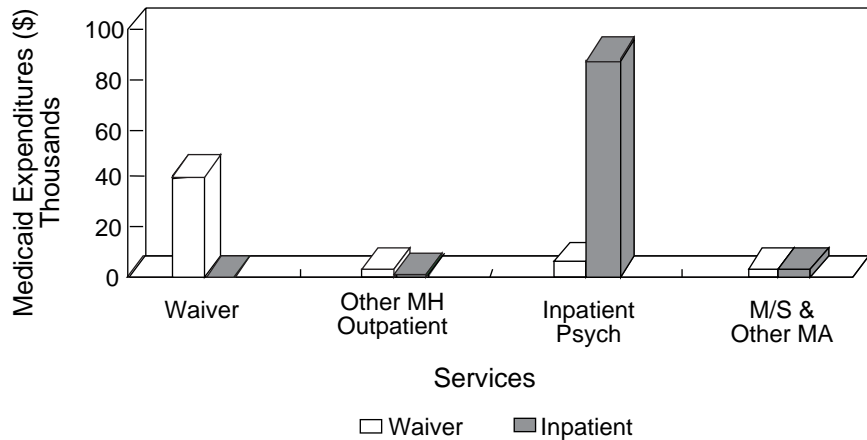
At the time of this evaluation, the available Medicaid claims data were not adequate to begin to evaluate the fiscal performance of the Waiver.

Table 1
Comparison of Estimated Annual Costs per Child (Waiver vs. Inpatient Level-of-Care)

Service	Waiver	Inpatient
Waiver:		
ICC	\$8,774	
Respite	\$10,548	
Family Support	\$2,200	
Skill Building	\$10,796	
Intensive In-Home	\$4,386	
Crisis Response	\$4,386	
Total Waiver	\$41,090	\$0
Other MH Outpatient	\$3,177	\$1,589
Inpatient Psych	\$6,000	\$87,587
M/S & Other MA	\$3,987	\$3,987
Total	\$54,254	\$93,163

Sources: NYS Medicaid Management Information System data for FFY93 and surveys of providers and consumers regarding anticipated utilization.

Figure 1
Comparison of Estimated Annual Costs per Child



Results

Preliminary Evaluation Findings

Based on intake data for 94 children and outcome data for 19 children and caregivers preliminary findings are as follows. On average a child enrolled in the HCBS Waiver program is a 10 year-old White male (40% White, 23% African American, 24% Hispanic and 12% Other Race; 73% male). More than half (52%) lived in a single parent household while 30% lived in a two parent family. On average these children demonstrated functional impairment in 3 out of 5 areas assessed. Upon enrollment, providers identified an average of 10 symptoms and problem behaviors from a list of 25. More than half (56%) are in special education settings and 82% experienced at least one hospitalization prior to enrollment.

Family stressors were prevalent. Unstable relationships were reported among adults in 54% of the households. Poverty was indicated as a stressor on the family's situation in 51% of the cases. In almost half of all households ICCs reported the presence of mental illness for at least one adult household member (49%). In addition, at least one adult was a survivor of an abusive situation in a substantial number of households (44%). In about one third of families, evidence of domestic violence (36%) and chronic unemployment (34%) were identified as stressors.

At six months, providers reported on levels of unmet need in nine life domains as a guide for the development of action plans. Figure 2 presents these data for the first 19 children for whom these data were available. The areas of greatest need were emotional and psychological, which on average fell between moderate and severe need. Unmet need in the area of family life,

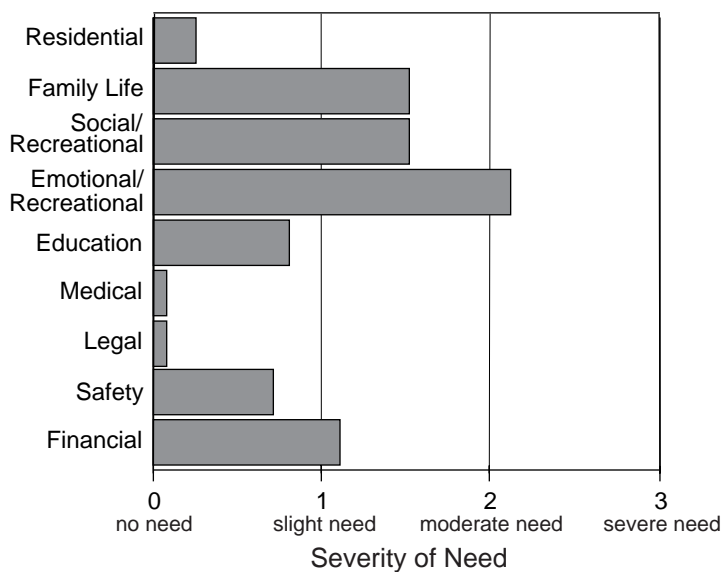
social and recreational and financial fell between slight and moderate need levels, on average.

Figure 3 presents changes in functional impairment and symptomatology at 6 months for the first 19 children assessed. The data show shifts in a positive direction over the first six months, with the average number of symptoms decreasing from 9.2 to 8.5, and the average number of areas of impairment dropping from 3.33 to 2.67.

Discussion

Implementation of the Home and Community Based Services Waiver is an opportunity for New York State to learn about the best complement of services and supports for the target population. This information will guide the development of managed care plans for children with serious emotional disturbance. Overall, preliminary findings are

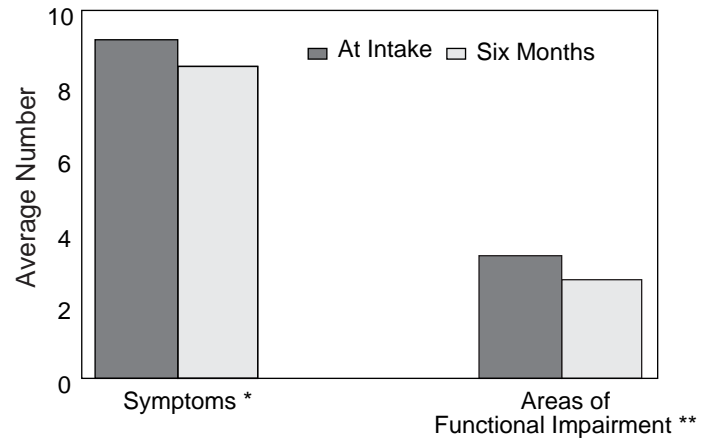
Figure 2
New York State Home and Community Based Services Waiver
Severity of Unmet Need in Nine Key Life Domains *
(n = 19)



* (six month assessment)

valuable in determining whether the targeted population is enrolled in the program. Data on functional impairment, symptomatology and history of hospitalization suggest that in fact the appropriate children have been enrolled. Six month data assessing unmet life domain needs suggests that providers are using an individualized care framework to structure service delivery. Finally, 6 month outcome data for the initial cohort are encouraging in that changes are positive. As data collection continues, the evaluation strategy should continue to yield valuable feedback on the effectiveness of the program in successfully serving children and families.

Figure 3
New York State Home and Community Based Services Waiver
Symptomatology and Areas of Functional Impairment
At Intake and Six Months
(n = 19)



* Out of 25 behaviors/symptoms

** Out of 5 areas of functional impairment

Service and Assessment of a Heterogeneous Population with Capitated Funds

Introduction

This summary highlights The Woodbourne Center's *Bridges* program, a short term treatment program for children of three cohort groups, namely, those receiving respite services, hospital prevention and hospital step-down services. In conjunction with its funding agencies, Baltimore Mental Health Systems and Family Preservation Initiative, Woodbourne designed Bridges as a capitated, three-tiered model within which children could move fluidly between Residential, Community Group Home, and Treatment Foster Care units (see Table 1). Serving an extremely high risk population with a history of abuse, multiple placements, and psychiatric hospitalization, Bridges offers a menu of therapeutic and practical family, child, and school-based intervention, comprehensive assessments, and longitudinal outcome monitoring at a cost-savings. Research findings have been utilized in developing differential treatment options by risk factors and cohort group membership.

Since its inception in 1994, 89 children have been served in one or more levels of the multi-faceted "Bridges" program. As shown in Table 2, respite services accounted for 75% of the reasons for admission, followed by hospital step-down (14%), and hospital prevention (10%). The average length of stay was 56 days, with the vast majority of all clients being discharged within 90 days. Although most clients' needs were met within one level of the program, 14% of the admissions in Fiscal Year 1996 moved between two levels of service during their course of treatment. This latter group had a slightly longer average length of stay (84 days).

Carole Bausell, Ed.D.

Director, Center for Research & Evaluation

*The Woodbourne Center
1301 Woodbourne Avenue
Baltimore, MD 21239
410/433-1000
Fax: 410/433-5834
www.woodbourne.com*

Patricia K. Cronin, L.C.S.W.-C.

Executive Vice President/COO

*The Woodbourne Center
1301 Woodbourne Avenue
Baltimore, MD 21239
410/433-1000
Fax: 410/433-1459
www.woodbourne.com*

Howard Olshansky, L.C.S.W.-C.

Vice President of Programs

*The Woodbourne Center
2041 E. Fayette Street
Baltimore, MD 21231
410/563-6400
Fax: 410/563-3120
www.woodbourne.com*

Bonnie Peet, R.N., MSN

Director of Child & Adolescent Services

*Baltimore Mental Health Systems
201 E. Baltimore Street, Suite 1340
Baltimore, MD 21202
410-827-2647
Fax: 410-837-2672*

Bridges Outcomes

Outcomes for the Bridges population as a whole were regarded as extremely positive in that 70% of the group were discharged to a parent, relative, or foster home. This percentage increased over the 30 days following discharge to 86%, and at six months was only slightly lower at 77% (see Table 3). The remainder of the population required a wide range of therapeutic or restrictive living environments ranging from treatment foster care to residential treatment.

An in-depth analysis of outcome by cohort group revealed that, as expected, less positive results were obtained with the hospital prevention and hospital step-down cases. A full 70% of the children who came to Bridges directly from psychiatric hospitals still require some type of therapeutic living environment upon discharge, however only 20% had to be readmitted to a hospital (resulting in a 80% decline in re-admission rate). The hospital prevention cohort achieved better results in that a full two thirds of this group was residing in a least restrictive home environment six months post-discharge.

Figure 1 depicts the progression in placements over time for each cohort group. The respite group required progressively fewer therapeutic or restrictive placements from the point of discharge (28%) to 30 days (17%) and finally six months post-discharge (11%). The hospital prevention group similarly decreased their usage of restrictive placements from discharge (57%) to the six month mark (33%). The hospital step-down group, however, only showed some short-term progress with regard to utilization of these placements from 70% at discharge to 30% 30 days after discharge, to 66% at the six month point.

Many findings were statistically significant, among them:

- Members of the hospital step-down group were in more restrictive settings at discharge than the respite group and in more restrictive settings than both the respite and prevention groups at 30 days post-discharge [$F(2,58) = 4.50, p < .05$];
- The less restrictive the placement at discharge, the less restrictive the placement six months later ($r = .84, p < .01$);
- Children admitted on psychotropic medication were in more restrictive placements 30 days post-discharge [$t = 2.55, (27) p < .05$];
- Children who were precipitously discharged from the program were more likely to have lived at some point with individuals with substance abuse issues ($r = .32, p = .01$) and to have suffered more types of victimization;
- Children who had been sexually abused were also more likely to have suffered physical abuse (chi-square = 15.30, ($df = 1$), $p < .01$) and neglect (chi-square = 7.20, $df = 1, p < .01$);
- There was a trend for the hospital prevention and hospital step-down group outcomes to improve at 30 days post-discharge but to worsen slightly at 6 months post-discharge, whereas the respite children experienced a constant improvement of outcomes over time.

Table 1
Single Versus Multiple Program Level Utilization

	Residential Unit	Community Group-Home Unit	Treatment Foster Care Unit
Single Program Level Utilization	60%	66%	95%
Multiple Program Level Utilization	40%	33%	5%
Overall Utilization	$n = 15$	$n = 15$	$n = 19$

Bridges 1996 Admissions

Service and Assessment of a Heterogeneous Population with Capitated Funds

Table 2
Primary Purpose of Admission
(n = 77)

	Frequency	Percent
Respite	58	75%
Hospital Prevention	8	10%
Hospital Step-down	11	14%

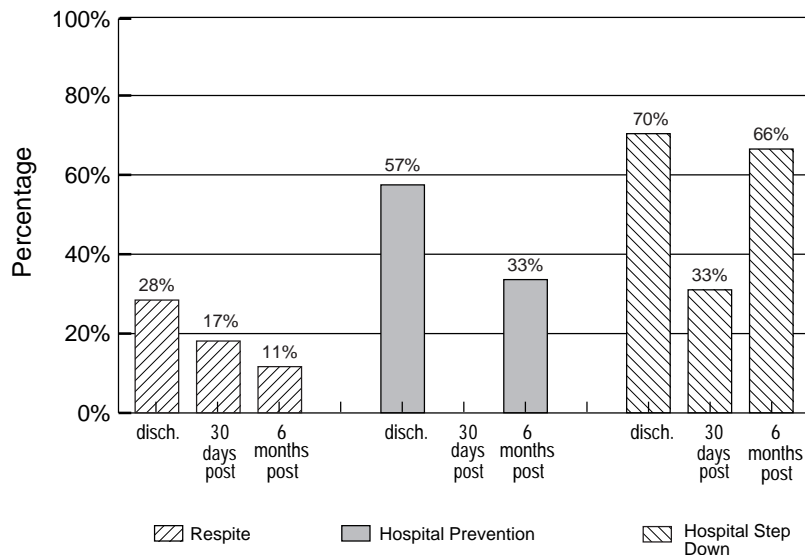
Woodbourne Center, Inc. - Bridges, August 1994 - February 1997

Table 3
Treatment Outcomes Over Time
Combined Cohort Groups

	Parent, Relative, Foster Home	Therapeutic or Restrictive Placement
At Discharge <i>n = 63</i>	70%	30%
30 Days Post-Discharge <i>n = 22</i>	86%	14%
6 Months Post-Discharge <i>n = 31</i>	77%	23%

Woodbourne Center - Bridges, August 1994-February 1997

Figure 1
Short Term and Longitudinal Outcome of Clients
Requiring Therapeutic or Restrictive Placement
(at discharge, 30 days post discharge and 6 months post discharge)



Discussion

In conclusion, the ability to analyze Bridges data by different subgroups of its clientele has been especially promising in yielding research findings that can be translated into program enhancements or strategic plans. For example, it was found that the innovative three-tiered model was most utilized by those clients in the residential and group home components and least by those in treatment foster care. While outcomes for the program as a whole were positive and continue to improve after discharge, it was useful to learn that they were most positive for respite clients and less so for children exiting psychiatric hospitals or on psychotropic medications on admission. Clients from families with substance abuse issues were identified as needing new approaches just to insure treatment completion. The strategy of preventing expensive hospitalization proved to work extremely well and should probably be pursued more aggressively in the field. It would appear that once a child is hospitalized (as demonstrated by the hospital step-down group results), this experience is more likely to be followed by a cadre of relatively expensive and restrictive placement options.

Evaluating Capitated Services in Colorado: Family and Provider Perspectives

Introduction

As a result of House Bill 92-1306, Colorado Mental Health Services (MHS) implemented a Medicaid Mental Health Capitation and Managed Care Pilot program in 1995. This study was undertaken in 1996 as one of several evaluations to understand the impact of this reform on services for children and their families. The goal of the study was to gain knowledge from the pilot program in its early implementation that could inform the proposed subsequent statewide Medicaid Capitation Program beginning in January 1998. This summary provides selected findings regarding why respondents perceived the needs of children and families to be met or not met under the pilot program.

Method

A qualitative approach was used to capture the experiences of pilot program participants. The two sequential components of the study were: (a) family focus groups and (b) case studies. Three focus groups were conducted for the purpose of identifying themes regarding met and unmet service needs. The case study data helped investigators understand and document more comprehensively the initial focus group findings. In addition to the perspectives of parents and guardians, the case studies included interviews with mental health clinicians, and when possible, other human service providers.

Diane Patrick, MUA
CASSP Coordinator
Colorado Mental Health Services
3824 West Princeton Circle
Denver, CO 80236
303/762-4089
Fax: 303/762-4373
diane.patrick@state.co.us

Jean Demmler, Ph.D.
NASMHPD Research Institute
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
703/739-9333 x 36
Fax: 703/548-9517
jean.demmler@NASMHPD.org

William Bane, MSW
Program Administrator
Child & Family Services
Colorado Mental Health Services
3824 West Princeton Circle
Denver, CO 80236
303/762-4076
Fax: 303/762-4373
bill.bane@state.co.us

Participants/Sites

The study included four of the seven pilot capitation sites. These Mental Health Assessment and Service Agencies (MHASAs) were selected to represent the geographic characteristics of Colorado (urban and rural) and the architecture of managed care (public or public-private partnership; see Table 1).

The researchers encouraged participation from all segments of the client population. Therefore, invitations to the focus groups were mailed from MHS to all (or to systematically selected 50% or 33% samples) parents/guardians of children receiving services in the study sites in April 1996. Parents/guardians responded to the project director who made a list of potential participants. Final selection criteria emphasized culturally diverse groups with varying ages and severity of mental health problems among children represented. Twelve participants were invited to each group; nine family members or guardians actually attended.

Purposeful selection of case study participants (N= 24) allowed for representative examples of the met and unmet needs identified during focus groups. Potential problems with biased selection from either the providers or consumers of services were resolved in the following way. Twelve cases

that potentially represented instances of met or unmet needs were solicited from service providers, and 12 were obtained from families and advocates (see Table 1).

Analysis

Considering the results of content analyses of the focus group transcripts, a semi-structured data collection instrument guided the interviews of parents and providers in the 24 case studies. Each case study was classified, based on all information collected, as to whether the mental health treatment and support needs of each child and family were *well met*, *somewhat met* or *not well met*. Cases were then organized under these three ratings to examine why respondents considered needs met or not met.

Results

The study resulted in the identification of three major areas influencing whether needs were perceived as met or unmet in the Capitation Program: (a) multi-system framework, (a) empowerment of parents and guardians, and (c) quality services.

Multi-system framework

In keeping with the system of care framework that advocates integrated approaches to services (Stroul & Friedman, 1986), the multi-system perspective emphasizes the importance of school-based services, day treatment, and case management functions. Respondents in this study viewed school-based services positively because they were accessible and minimized transportation difficulties. When needs were perceived as well met, availability of school-based services was one reason given. In an instance where needs were not well met, both the parent and teacher of a child terminated from unsuccessful clinic-based treatment believed therapy could have been effective if provided at the school.

**Table 1
CASSP Capitation Study Sites**

	Urban	Rural
Public	Behavioral Health Care Inc (BHI)	Weld Mental Health Center
	Focus Group Held 8 Case Studies	Focus Group Held 4 Case Studies
Public-Private Partnership	Pikes Peak (Colorado Health Networks)	West Slope (Colorado Health Networks)
	Focus Group Held 8 Case Studies	No Focus Group 4 Case Studies

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According to some respondents, integration of therapy and education, and the year-round availability of day treatment favorably impacted the treatment of some children. Conversely, some respondents expressed concern about the lack of day treatment services in rural areas, and the premature discharge of children from day treatment by school districts.

Case management and service coordination are central aspects of an effective system of care (Friesen & Poertner, 1995). Study participants concurred with this idea in their perceptions of needs being met or not met. In several instances, a mental health provider coordinated family, child welfare, and mental health services to adequately support a child's placement.

Parents often spoke of frustrations in dealing with multiple agencies. For them "the system" was one entity that includes child welfare, juvenile justice, the schools, and mental health. Results suggest that frustration with one agency can override positive experiences with others. Several parents stressed the need for a "hub" or "single door" that would allow them to access all the services they need.

Empowerment of Parents and Guardians

Families must serve significant roles in children's mental health services (Koroloff, Friesen, Reilly, & Rinkin, 1996). Consistent with such views, findings in this area highlighted the importance of partnerships of care; parent and family support, education, and advocacy; clarity regarding mental health benefits under managed care; and culturally appropriate services. Partnerships between families and service providers appeared to have many facets. Individualized and flexible treatment, in addition to an array of services, was felt to be essential. Parents reported that they appreciated being listened to and having their

suggestions acted upon. A grandmother, who felt fully involved in her grandchild's treatment, commented, "They ask my advice sometimes... they listen to my questions and opinions."

The data suggested that a partnership of care between the family and provider was probably the most important factor in the family's view that needs were met. Some parents reported needing more services than were provided, but perceived their needs as met because of the working relationship that existed with a service provider. When services were appropriately winding down, families noted that the ability to periodically contact a therapist provided an important "life line" to services.

Families noted the need for more education regarding medications and mental health symptoms. They also pointed out that this information is essential for all caregivers (for example, schools and Head Start programs), and that symptoms were often erroneously described as bad behaviors, causing labeling and other negative effects for the child. Parents noted the positive benefits of family advocates and support groups. Most parents in the focus groups valued the experience of coming together in this way, and wanted more of such opportunities.

Parents generally lacked knowledge or appeared misinformed about mental health benefits under the capitation program. For example, some believed that there was a limit of ten sessions. Some were not aware there had been a change from the fee-for-service system.

Although the cultural competence of services did not emerge as a major issue, several parents found this to be important. For example, a Spanish-speaking parent expressed a need for a therapist with whom she could communicate and who would understand her culture.

Quality Services

The philosophy of wraparound services promotes use of a broad array of resources (VanDenBerg & Grealish, 1996). Congruent with this view, study participants saw 24-hour care, crisis intervention, in-home services, psychiatric services, and continuity of care as essential components of quality care. They believed that twenty-four hour care did not have to be in-patient. Study participants expressed dissatisfaction with the process of obtaining in-patient care and the results of this service. One parent expressed her frustration, stating:

I called the cops. The crisis team, finally the crisis team listens and puts (my son) in (the hospital). He was in the hospital for about four weeks, (then) they let him out. He was as sick as when he went in, as when they let him out.

Some respondents indicated the need for 24-hour supports or alternatives to hospitalization in certain instances such as terminating medications. In one such case, inpatient care may have been denied with no 24-hour alternative offered.

Immediate access to a family's own service provider was often successful in averting crisis situations. For the most part, however, crises typically involved calling the police when a situation had escalated to an emergency. Parents reported their concerns were often dismissed, and they resented being asked to persevere in a time of crisis. The dialogue from one focus group underscores this point:

Person 1: *(The mental health therapists) want to keep spaces available for these emergencies. And so you get dismissed all over the place. And you have blood running out your nose and trickling down your mouth... and it's not the individual therapist or doctor, or whatever's fault... it's the whole system.*

Person 2: *Yeah*

Person 3: *You keep telling them, and they don't seem to hear what you're saying.*

Person 1: *As long as they think you can hold on another day...*

Person 4: *Or another month!*

Generally, respondents viewed in-home services positively because they allowed parent involvement in the care of the child. For instance, parents with other young children often faced difficulties transporting the family to the mental health center; in-home services eliminated this barrier. Family preservation services provided by the mental health center reportedly helped one family keep a child out of the hospital and at home following inpatient care.

Parents were able to be good medication monitors when they had access to psychiatric assessment and consultation. More often than not, however, parents had grave concerns noting that psychiatrists do not spend enough time with the child for adequate psychiatric or medication evaluations. Furthermore, "assembly line" prescriptions, which involved using one medication after another, were perceived as problematic by several parents.

Continuity of care was impacted by multiple factors. Families found changing providers as a result of capitation to be frustrating and disruptive. The use of waivers, a mechanism in the capitation program that allows consumers to request permission to retain a clinician outside of the provider network, was mentioned only once by study participants. Some parents reported paying treatment costs out of pocket in order to keep the services they desired. Parents identified a lack of coordination among mental health and physical health care providers. Finally, several parents reported multiple changes of the mental health center providers over short periods of time.

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Discussion

The finding that there has been some success in meeting the needs of children and their families during the first year of Medicaid Capitation is hopeful. More importantly, the perceptions of families and service providers document a vision of an improved system of public mental health care that is informing planners and providers as the capitation program expands beyond the pilot phase.

The family and provider perspectives captured in this study informed the expansion of managed care in a number of ways. First, MHS staff reviewed the final report from this project and incorporated key findings into the request for proposals (RFP) for the capitation program expansion. Also, the RFP included a copy of the study report. Second, study staff made numerous presentations on the study to various groups in the state, including the state's Child and Adolescent Service System Program (CASSP) Advisory Council and Mental Health Planning and Advisory Council. This resulted in productive discussions about shaping the future of the capitation programs.

A number of important messages emerged from this study. First, using qualitative methods is a key research strategy in exploring managed care in children's mental health. Since little previous research exists in this area, identification of key concepts and issues is an important step. The inquiry emphasized the key components of a managed care system, such as integrated and accessible services that are responsive to child and family needs, and informed and involved families. Moreover, this effort underlined the need for consumer-focused evaluations such as these in order to shape the future of managed care and capitated approaches.

Further investigations should examine family and provider perspectives relative to the specific outcomes of services in managed care environments. Such studies may also require the use of a comparison group in a fee-for-service system. Although the current study included parents and other caregivers of children, it did not include the children themselves. Future studies should focus on how they, as consumers, view capitated services. Additional investigations should more fully explore, in the context of a capitated system, the three key issues that resulted from this study: integrated services, family empowerment, and the necessary array of quality services. Each of these areas is certainly worthy of their own study. Finally, since this study occurred early in the capitation program, it will be important to conduct it in later stages to determine if themes change or remain the same.

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