Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MANDATORY MANAGED CARE

Children's Access to Medicaid Mental Health Services

JUNE GIBBS BROWN
Inspector General

JANUARY 2000
OEI-04-97-00344

OFFICE OF INSPECTOR GENERAL

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

PURPOSE

To describe access to Medicaid mental health services under mandatory managed care for children with serious emotional disturbances.

BACKGROUND

States are increasingly converting their Medicaid programs from traditional fee for service models to managed care models. Nearly every State has implemented, or is planning to implement, mandatory managed care for Medicaid beneficiaries who require mental health services. These mandatory managed care contracts typically include services for both adults and children.

We did not specifically focus our inspection on provision of mental health care to children. However, while completing our inspection on Mandatory Managed Care - Changes in Medicaid Mental Health Services (OEI-04-97-00340), we observed specific problems with children's access to care. This report describes our specific observations related to access to mental health services by children with serious emotional disturbances.

We used a case study approach for reviewing mandatory mental health managed care programs in seven States. We integrated, compared, and summarized documentary and testimonial evidence obtained from State Medicaid managed care offices and mental health departments. We also interviewed managed care organization officials, mental health providers, and stakeholders for children's mental health. We did not validate the testimonial evidence, however, the views of program operators and stakeholders were generally similar and consistent with documentary evidence. Therefore, we believe their opinions provide useful insight into early managed care programs and the accessibility of services for children with serious emotional disturbances.

FINDINGS

Respondents said that providing mental health services to children with serious emotional disturbances can present unique challenges not typically found when delivering services to adults. These challenges are generally systemic in nature and have existed for years under traditional fee for service care.

Although conversion to managed care does offer State Medicaid programs opportunities to improve mental health services for children, respondents told us that conversion can also intensify existing problems. When implementing mandatory managed care systems, States should be aware of obstacles that can interfere with access to mental health services for children.

Access To Care Is Limited

- < Reductions of in-patient care for children was greater than that for adults.
- < Children's out-patient services lag behind those for adults.
- < First year managed care contracts included limited provisions for children.

Responsibility for Care Is Fragmented

- < Respondents were concerned about possible cost shifting.
- < Multiple State agencies have responsibility.

States Attempt to Improve Coordination and Access

- < States have negotiated interagency agreements and reported improved coordination, but access to care by children is still limited.

RECOMMENDATIONS

Children's mental health out-patient services have increased after implementation of mandatory managed care. However, children's access to mental health services is still limited, and the provision of care is fragmented. While attempts by some States to reduce fragmentation seem promising, most respondents agree more needs to be done. Accordingly, we recommend that HCFA encourage States to:

Specify services for children's mental health care in managed care contracts.

Children's services appeared to be an afterthought in State's first year managed care contracts. Providing more detailed specifications on services managed care organizations will provide will help ensure that children receive the specialized care they require.

Develop interagency agreements to promote coordination of children's mental health services.

Better coordination of care and improved services for children were reported in States where agencies have established such agreements. Establishing closer working relationships also reduced cost shifting concerns among agencies.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA concurred with our recommendation to encourage States to specify services for children's mental health care in managed care contracts. They prepared draft Interim Review Criteria for Children with Special Needs. States that mandatorily enroll children in capitated plans will be required to respond to the criteria as part of the waiver process.

Additionally, HCFA concurred with our recommendation to encourage States to develop interagency agreements to promote coordination of children's mental health services. HCFA plans to highlight the importance of such coordination in their imminent Report to Congress on special needs of vulnerable populations enrolled in Medicaid managed care.

SAMHSA commented that a number of our recommendations were useful, but expressed concern about drawing conclusions from what they believe is a study method that is not "scientific." We wish to emphasize that we used a case study method for our inspection. In describing our methodology we included a detailed explanation of the advantages and limitations of our case study approach. The limitations we point out are similar to those described by SAMHSA.

SAMHSA noted that the overall lack of consistent, detailed data was a possible major finding from our study. We agree. However, the problem is not limited to only children's programs. It is an issue we deal with explicitly in a companion report that addresses both children and adult mental health care. That report is titled *Mandatory Managed Care: Changes in Medicaid Mental Health Services* (OEI-04-97-00340).

Additionally, SAMHSA expressed concern that we may not have adequately included the views of State mental health staff and stakeholders. As shown in our methodology, we considered input from such groups as highly important. To illustrate, we interviewed at least 37 State mental health staff and stakeholders.

We made several technical changes suggested by SAMHSA.

The full text of HCFA and SAMHSA comments are in Appendix B.

INTRODUCTION

PURPOSE

To describe access to Medicaid mental health services under mandatory managed care for children with serious emotional disturbances.

BACKGROUND

States are increasingly converting their Medicaid programs from traditional fee for service models to managed care models. As of June 1998, over 16.5 million Medicaid beneficiaries were participating in some type of managed care program. This represents over 53 percent of the Medicaid population.[1]

Nearly every State has implemented, or is planning to implement, mandatory managed care for Medicaid beneficiaries who require mental health services. As of July 1998, 36 States have implemented mandatory mental health managed care programs.[2] These mandatory managed care contracts typically including services for both adults and children.

We did not specifically focus our inspection on provision of mental health care to children. However, while completing our inspection on Mandatory Managed Care - Changes in Medicaid Mental Health Services (OEI-04-97-00340) we observed specific problems with children's access to care. This report describes our specific observations related to access to mental health services by children with serious emotional disturbances.

Medicaid Eligible Children

Children can qualify for Medicaid in several ways. Children are generally eligible for Medicaid benefits if they are under age 21 and their families' income is low. Additionally, most States extend eligibility to children who have qualified for the Supplemental Security Income Children's Program. States also generally include children that qualify under special home and community-based waivers.

Serious Emotional Disturbances

Children, up to age 18, who currently or any time in the past year have had a diagnosable mental, behavioral, or emotional disorder that results in functional impairment which substantially interferes with or limits the childs role or functioning in family, school, or community activities is defined as seriously emotionally disturbed.[3]

An estimated 1 in 10 children are reported to have a serious emotional disturbance at any given time.[4] In fact, the estimated prevalence rate of serious emotional disturbances for children is higher than the prevalence rate of serious mental illnesses for adults – about 9 percent for children verses about 6 percent for adults.[5]

Some of the more commonly recognized disabling types of mental illnesses that effect both adults and children includes schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder. Children with serious emotional disturbances may also be commonly diagnosed with attention deficit disorder, autism, pervasive development disorder, or Tourette's syndrome.

METHODOLOGY

State Selection

We reviewed mental health managed care programs for seven States. They were Arizona, Massachusetts, North Carolina, Utah, Washington, Iowa, and Colorado. We selected all States (five) that had been under a mandatory managed care program for persons with serious mental illnesses for at least three years as of April 1997.[6] We selected the remaining two States, Iowa and Colorado, at the request of HCFA. Although Iowa and Colorado had only been under managed care for about 2 years at the time of our inspection,[7] HCFA staff said they were generally recognized as having innovative programs.

All of the States surveyed, except North Carolina, included both adults and children in their mandatory managed care mental health contracts. North Carolina only contracted for the mental health care for children.[8] For comparison purposes, we provided a general description of each selected State program in Appendix A.

Document Review

At each selected State, we reviewed key Medicaid and mental health program documentation showing program implementation, status, and access to care for children with serious emotional disturbances. To illustrate, we analyzed the first year managed care contract for each selected State. We also analyzed requests for proposals, managed care waiver requests, State progress reports, internal and external studies and reviews on program operations, beneficiary satisfaction survey results, complaint and grievance reports, in-patient and out-patient care data and reports, mental health program costs, and records on beneficiary utilization.

We also conducted an Internet search to review managed care research involving children with serious emotional disturbances. Finally, we reviewed professional journals, studies and publications on State Medicaid programs and mental illnesses.

Interviews

We interviewed 23 Medicaid managed care and mental health staff members in our survey States. From those officials, we obtained an understanding of how individual States implemented and operated Medicaid mandatory mental health programs. Finally, we obtained the views of State Medicaid and mental health staff on program changes for children with serious emotional disturbances.

Also, we interviewed 16 managed care officials and mental health care providers, as well as 21 mental health stakeholders [9] in our survey States. We obtained the views of both groups on program operations and children's mental health services. We were particularly interested in their views on the accessibility to services for children after States converted to a mandatory managed care system. We selected managed care officials, mental health providers, and stakeholders based on recommendations from State Medicaid staff.

Advantages and General Limitations

We used a case study approach to analyze the access to services of children with serious emotional disturbances under mandatory managed care. The advantage of this approach was that it allowed us to get the benefit of first-hand experiences from State officials, managed care representatives, mental health providers, and stakeholders. Our methods have general limitations in that the States or sites selected may not be typical, and we did not verify all testimonial information they provided to us. The information is also limited, because it reflects operations that occurred over a 2 to 3-year period starting with each State's first year contract. We are aware that State Medicaid managed care systems have continued to evolve with each new contract and waiver, and that program structure in our surveyed States may be quite different today from their initial managed care contracts.

The differences in program data reported by States, and the general lack of available children's data limits our ability to generalize across State programs. Each State Medicaid program collects and reports data differently. To illustrate, one State distinguished between services provided to children with serious emotional disturbances and children with less serious problems, while another State did not. Another State did not distinguish between care provided to adults and children when providing utilization data.

We integrated, compared, and summarized documentary and testimonial evidence obtained from State Medicaid managed care offices and mental health departments. We also interviewed managed care officials, mental health providers, and stakeholders for children's mental health. We did not validate the testimonial evidence, however, the views of program operators and stakeholders were generally similar and consistent with documentary evidence. Therefore, we believe their opinions provide useful insight into early managed care programs and access for children with serious emotional disturbances.

Companion Reports

This report is our third on mandatory managed care and Medicaid mental health services.

The first report is titled Mandatory Managed Care - Changes in Medicaid Mental Health Services (OEI-04-97-00340) It provides an early look at the changes that mandatory managed care had on State Medicaid mental health services for persons with serious mental illnesses. The report highlights program changes that affected both adults and children.

The second report is titled Mandatory Managed Care - Early Lessons Learned by Medicaid Mental Health Programs (OEI-04-97-00343). It highlights common program characteristics and implementation practices as guidance to other States that plan to convert to mandatory managed care.

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We did our field work between May 1997 and July 1997. While conditions regarding mental health services in managed care settings may have changed since then, our report reflects conditions and patterns of care in the first few years of converting fee for service programs to managed care. Wherever possible we have updated our background information. We conducted the inspection in accordance with Quality Standards for Inspections issued by the President's Council on Integrity and Efficiency**.**

FINDINGS

Respondents said that providing mental health services to children with serious emotional disturbances can present unique challenges not typically found when delivering services to adults. These challenges are generally systemic in nature and have existed for years under traditional fee for service care.

Although conversion to managed care does offer State Medicaid programs opportunities to improve mental health services for children, respondents told us that conversion can also intensify existing problems. States should be aware of the obstacles that can interfere with access to mental health services for children when implementing mandatory managed care systems.

Access To Care Is Limited

Reductions of In-patient Care for Children was Greater Than That for Adults

Utilization of in-patient services have generally decreased under managed care for all populations. However, the reduction of in-patient services for children has been the most dramatic. For example, one State reported that children utilizing in-patient care was down almost 40 percent, as compared to a decrease of 2 percent by adults for the same period. Another State reported a 30 percent decrease in psychiatric hospital admissions for children, as compared to a decrease of about 6 percent by adults during the same period.

Because detailed data was almost non-existent, we could not determine the actual extent to which access to needed in-patient services had been decreased. Generally, the only available data was satisfaction surveys and grievance files, but they generally did not reveal the large decrease of in-patient care as a problem. However, the results of the data may not be reliable indicators on accessibility of in-patient care.

Stakeholders in five of the seven surveyed States believed that managed care organizations were making it more difficult for children to be admitted into psychiatric hospitals. They said while in-patient care was often difficult under fee for service, the new managed care organizations implemented even more narrow criteria for hospital admission. Due to the more restrictive admission criteria, stakeholders said that children must go too far into a crisis situation before hospitalization is authorized. Stakeholders complained that approval and denial of hospitalization is often based only on what the clinicians observe during their evaluation. They said the clinicians do not consider what the parents and others observed in the hours or days proceeding their evaluation.

Further, stakeholders in all States were concerned that children were being removed from psychiatric hospitals too quickly. They generally believe however, that out-patient care provides a better treatment environment for children and that in-patient care was relied upon too heavily under the fee for service system.

Controlling access to expensive in-patient services and substituting less expensive out-patient services is a standard managed care practice. It reduces managed care costs. It is also generally regarded by Medicaid staff as being a more effective and appropriate treatment than in-patient care. This is particularly true for children because family involvement can play an important role in treatment plans.

Children's Out-patient Services Lag Behind Those for Adults

State Medicaid representatives and stakeholders told us that under fee for service, children's access to mental health out-patient services was below that for adults. Under mandatory managed care, State representatives noted that the gap between adults and children's care still exists despite the addition of several new alternative out-patient children's services such as: respite care, family support services, in-home treatment, and school based programs.

All State Medicaid representatives reported that out-patient programs have expanded under mandatory managed care. However, the number of children that access services are still generally below the level of access for adults. For example, one State reported that the percentage of adult enrollees accessing out-patient services was over twice that for children (123.7 per 1000 vs 54.8 per 1000). Another State reported that about 6 percent of eligible adults accessed out-patient services, while only about 3 percent for eligible children accessed out-patient services.

Part of the problem stemmed from the lack of available services. To illustrate, prior to managed care, some State Community Mental Health Centers did not even offer children mental health services. Further, when implementing mandatory managed care States generally implemented program improvements in the adult system before expanding them to the children's system. Finally, under mandatory managed care, States generally did not emphasize children's programs in their first year managed care contracts.

First Year Managed Care Contracts Included Limited Provisions for Children

In the six States that provided mandatory managed mental health care to both adults and children, State first year contract request for proposals included few provisions that specifically addressed children's care issues. Typically, care for children was addressed by adding the contract language "and children" to care areas generally designed for adults, and by included a short paragraph stating that managed care organizations will provide services to children.

Responsibility for Care Is Fragmented

Respondents Concerned About Potential Cost Shifting

Medicaid representatives in five of the seven surveyed States expressed a concern that placing mental health services under a capitated (flat fee) payment arrangement would increase the incentive for managed care organizations to shift care to other State agencies, such as the juvenile justice, child welfare, or education system, in order to reduce costs. They said that when multiple State agencies provide overlapping services to the same population, and such agencies have their own independent budgets, cost shifting is a strong possibility. Several State representatives told us that it was not uncommon for one agency to accuse another of "dumping" children on their agency, especially those children requiring long-term care.

We did not specifically determine an adverse impact on children resulting from cost shifting. However, several State representatives said it could happen. To illustrate, State child welfare agencies often provide mental health treatment under Medicaid fee for service to children they have placed in residential treatment centers. In that State, the State Medicaid representatives expressed concern that managed care organizations would attempt to refer children to the residential treatment centers to reduce their in-patient psychiatric care costs. Medicaid staff in another State were so concerned about the likelihood of cost shifting that they convened a monthly committee to review the issue.

The data in one State tended to collaborate the concerns about cost shifting. The data showed that the number of placements in residential treatment centers increased about 5 percent over what was expected under fee for service prior to conversion to managed care. However, the data was inadequate to determine the causes of the increase.

Multiple State Agencies have Responsibility

A variety of State and Federal children's programs have evolved over the years. In our survey States a minimum of five agencies were responsible for providing various levels of mental health services to children. These programs include the health system, education system, social services, substance abuse, and juvenile justice system. Children with serious emotional disturbances have complex needs, and could require services from one or all of the State programs. However, no one program or system has the responsibility and expertise to coordinate or meet all the needs of the mentally ill, particularly when that person is a child.

Responsibilities for the different children's programs fall under different State agencies, all with different budgets and priorities. They tend to work independently which has caused a fragmented system of care for children. For example, State representatives told us that while State mental health agencies have program staff and resources to furnish mental health services

to children, they generally must wait for referrals from other agencies. State mental health agencies do not have daily contact with children that other agencies such as school and juvenile justice systems do. However, while the schools and juvenile justice systems have daily access to children, they do not typically have staff and resources to address their mental health needs. Also, if a State mental health agency observed social and developmental issues while providing mental health services to a child they typically had to refer the child back to the school system, or social services agency.

Without coordination of care among multiple State agencies, stakeholders said that children often become proverbial footballs, being passed back and forth between systems. They said that this passing back and forth between agencies typically results in children not receiving needed mental health care. Further, often just determining which agency is responsible for providing care is difficult, at best, because of the multiple physical and social needs of child with serious emotional disturbances.

States Attempt to Improve Coordination and Access

States have undertaken a variety of strategies to increase agency cooperation. Some of the State strategies are highlighted below.

> One State passed legislation requiring agencies to work together. This initiative has resulted in State law that requires the health, education, and court system to work together to provide better services to children.
>
> Two States are testing programs that establish one case manager and one agency to represent all children's service systems. The pilot programs are designed to minimize costs, increase access to available and needed services, and reduce duplication of multiple case coordination.

Other States have established voluntary agreements between children's agencies, and committees to assist with program integration.

In all cases where an interagency agreement or committee was established, stakeholders and State officials reported better coordination of care and improved services. However, State Medicaid staff said that coordination and access problems still exist, despite the interagency agreements.

RECOMMENDATION

Children's mental health out-patient services have increased after implementation of mandatory managed care. However, children's access to mental health services is still limited, and the provision of care is fragmented. While attempts by some States to reduce fragmentation seem promising, most respondents agree more needs to be done. Accordingly, we recommend that HCFA encourage States to:

Specify services for children's mental health care in managed care contracts. Children's services appeared to be an afterthought in State's first year managed care contracts. Providing more detailed specifications on services managed care organizations will provide will help ensure that children receive the specialized care they require.

Develop interagency agreements to promote coordination of children's mental health services. Better coordination of care and improved services for children were reported in States where agencies have established such agreements. Establishing closer working relationships also reduced cost shifting concerns among agencies.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA concurred with our recommendation to encourage States to specify services for children's mental health care in managed care contracts. They prepared draft Interim Review Criteria for Children with Special Needs. States that mandatorily enroll children in capitated plans will be required to respond to the criteria as part of the waiver process.

Additionally, HCFA concurred with our recommendation to encourage States to develop interagency agreements to promote coordination of children's mental health services. HCFA plans to highlight the importance of such coordination in their imminent Report to Congress on special needs of vulnerable populations enrolled in Medicaid managed care.

SAMHSA commented that a number of our recommendations were useful, but expressed concern about drawing conclusions from what they believe is a study method that is not "scientific." We wish to emphasize that we used a case study method for our inspection. In describing our methodology we included a detailed explanation of the advantages and limitations of our case study approach. The limitations, we point out, are similar to those described by SAMHSA. Our goal was to take advantage of the early experience of some States to guide implementation of other States who are using a managed care approach for mental health services. We are confident that our readers will interpret our findings in the context of the methodology which we described. SAMHSA's thoughtful comments will also help our readers avoid the pitfalls of over generalization.

SAMHSA noted that the overall lack of consistent, detailed data was a possible major finding from our study. We agree. However, the problem is not limited to only children's programs. It is an issue we deal with explicitly in a companion report that addresses both children and adult mental health care. That report is titled *Mandatory Managed Care: Changes in Medicaid Mental Health Services* (OEI-04-97-00340).

Additionally, SAMHSA expressed concern that we may not have adequately included the views of State mental health staff and stakeholders. As shown in our methodology, we considered input from such groups as highly important. To illustrate, we interviewed at least 37 State mental health staff and stakeholders.

We made several technical changes suggested by SAMHSA. For example, we clarified Appendix A to show services that were excluded from risk by managed care organizations during their first year contracts.

We present full text of HCFA and SAMHSA comments in Appendix B.

APPENDIX A

Summary: First Year Medicaid Managed Care Mental Health Contracts

State	Start Date	Waiver Type	Type of MCO	Coverage	Initial Area Covered	
AZ	Jan 1992	1115	Non-profit, public sector, CMHCs*	Adults and Children	Statewide	
CO	Aug 1995	1915(b)	Most areas non-profit, public sector CMHCs. Two rural areas - partnership between public sector CMHCs and private, for-profit companies	Adults and Children	6 test areas. Excluded largest metro area	State hospital & drugs
IA	Mar 1995	1915(b)	one private for-profit company for whole State	Adults and Children	Statewide	State hospital & drugs
MA	Jan 1992	1915(b)	one private for-profit company for whole State	Adults and Children	Statewide	State hospital & drugs
NC	Jan 1994	1915(b)	Non-profit, public sector CMHCs	Children Only	11 counties, approx 25% of state	Outpatient care
UT	Jul 1991	1915(b)	non-profit, public sector CMHCs	Adults and Children	8 of 11 areas. 80% of Medicaid population	State Hospitals
WA	Jul 1993	1915(b)	Non-profit public sector system	Adults and Children	6 of 14 areas. 66% of Medicaid population	In-patient care

* Community Mental Health Centers

APPENDIX B

Agency Comments

Health Care Financing Administration (HCFA)
Substance Abuse and Mental Health Services Administration (SAMHSA)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 14 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Mandatory Managed Care: Changes in Medicaid Mental Health Services," (OEI-04-97-00340); "Mandatory Managed Care: Children's Access to Medicaid Mental Health Services," (OEI-04-97-00344); and, "Mandatory Managed Care: Early Lessons Learned by Medicaid Mental Health Programs," (OEI-04-97-00343)

Thank you for the opportunity to review and comment on the three draft reports on mental health services in mandatory Medicaid managed care programs. The reports examine changes in services, children's access to care, and early lessons learned. We appreciate the effort that went into these reports. The reports provide good, first-hand information on the changes to Medicaid mental health services resulting from mandatory managed care enrollment during the first years of these programs.

Medicaid managed care initiatives are designed to control escalating costs, expand coverage and access to services, and improve quality of care. States face the challenge of designing and monitoring mental health programs that provide Medicaid beneficiaries with the care that they need while reducing or containing growth in costs. States set standards in their contracts for determining appropriate levels of services, using broad definitions of medical necessity, and limiting the use of prior authorization requirements for access to outpatient care. Also, states generally expand the range of community-based mental health services covered, compared with fee-for-service programs. Most carve-out plans use several approaches to quality assurance, including conducting patient satisfaction surveys, establishing and monitoring standards, and having consumer committees.

Two of the three above-subject reports contain recommendations. Our specific comments to those recommendations are attached.

Attachment

IG	✓
EAIG	
PDIG	✓
DIG-AS	
DIG-EI	✓
DIG-OI	
DIG-MP	
OCIG	✓
ExecSec	
Date Sent	10-15

Comments of the Health Care Financing Administration on the Office of Inspector General Draft Report: "Mandatory Managed Care: Children's Access to Medicaid Mental Health Services," (OEI-04-97-00344)

OIG Recommendation

HCFA should encourage states to specify services for children's mental health care in managed care contracts.

HCFA Response

We concur. HCFA will emphasize to states the importance of managed care contracts defining clearly what mental health services must be provided to enrolled children. HCFA has prepared draft Interim Review Criteria for Children with Special Needs and states who mandatorily enroll children in capitated plans will respond to these criteria as part of their waiver application.

OIG Recommendation

HCFA should encourage states to develop interagency agreements to promote coordination of children's mental health services.

HCFA Response

We concur. Coordination of all health services for all populations, but particularly for children's mental health services, is extremely important. The study's strong findings of the lack of such coordination in the states studied are alarming. In connection with our imminent Report to Congress on the special needs of vulnerable populations enrolled in Medicaid managed care, HCFA plans to highlight the importance of effective state-level coordination of all services to special needs populations.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

AUG 16 1999

TO: June Gibbs Brown
Inspector General

FROM: Administrator

SUBJECT: Draft Reports on Mental Health Services in Medicaid Managed Care Programs

Thank you for the opportunity to review and comment on the following three draft reports from your Office of Evaluations and Inspections:

- Mandatory Managed Care: Changes in Medicaid Mental Health Services (OEI-04-97-00340)
- Mandatory Managed Care: Early Lessons Learned by Medicaid Mental Health Programs (OEI-04-97-00343)
- Mandatory Managed Care: Children's Access to Medicaid Mental Health Services (OEI-04-97-00344)

These reports are based on case studies of seven states and their experiences with implementing mandatory managed care for Medicaid beneficiaries, with a particular focus on how it affects access to and quality of mental health services. Each report discusses its findings, and in some cases, recommendations, to States involved in implementing mandatory managed care for Medicaid-funded services.

While we very much appreciate the difficulty in conducting short term program evaluations, particularly in an environment of newly emerging, dynamic and complex health systems changes, and believe that a number of the report's recommendations are useful, we are concerned about the conclusions which the public, the Department, and the Congress may draw from these reports. Our concerns are summarized under the following general areas:

Findings and Recommendations. Generally speaking, the research upon which the reports are based is neither scientific nor comprehensive. The investigators, themselves, state that there is a great deal of variation among States in terms of how they have chosen and are choosing to implement changes to their Medicaid programs. In addition, the participating States have not had an opportunity to collect outcome data on the effectiveness of these services. While the lessons learned from these seven States' experiences are valuable to the ongoing implementation efforts of other States, we would hesitate to refer to some of these lessons as "findings" that may be construed as scientific data or to make general recommendations to the field based on these results.

Two findings in particular seem to lack a balanced perspective. The first finding, in the report on *Changes in Medicaid Mental Health Services* (page 9), is that managed care has expanded available services. This is a broad statement that, for a number of reasons, does not appear to be based on a sound evaluative approach.

First, the statement is based on documents from only four of seven states. Two of these were specifically chosen by the Health Care Financing Administration as having generally recognized innovative programs.

Second, the statement is based on the fact that out of a very small sample of programs, just over half reported increased utilization (ranging only from one to two percent) after conversion to managed care. One would presume this means that the overall penetration rate increased during some specific time period. It is not clear, however, if this is for all services or only a subset of services (e.g., outpatient services). Also, it seems doubtful that a one to two percent increase is statistically significant.

Third, even if penetration rates did increase in these four States it does not mean that Medicaid beneficiaries were receiving higher quality care and were experiencing improved outcomes from those services. The report notes that no State had working outcome measures in place.

Fourth, all seven States claimed dramatic declines in inpatient costs. One would assume this was the result of decreased utilizations. Two States said there was a reduction of 40 to 50 percent in available psychiatric beds. Commonly, according to State Medicaid staff, average length of stay was reduced by as much as 50 percent. Was this dramatic decline in inpatient utilization factored into the apparent increase in mental health services utilization?

Finally, it was noted that psychiatric hospital re-admission rates were generally higher under managed care, ranging from four to nine percent, and that stakeholders in several States expressed concern that lower average length of stays and increased re-admission rates may indicate that persons with serious mental illnesses are being released from in-patient care too quickly. This seems to be a noteworthy finding in and of itself.

The second troublesome finding, in the report on *Early Lessons Learned by Medicaid Mental Health Programs* (page 5), is that it is best to separate mental health services from other health services. We believe it is misleading to characterize this as a "finding." Finding generally refers to a conclusion reached after investigation or examination. For several reasons, this does not appear to be the case here.

First, all of the States studied were carve outs. There was no examination of integrated programs. While the seven States all may have indicated that such an arrangement worked well in terms of administration and implementation of a managed care arrangement, no comparison was conducted with other States that did not choose to carve out such services, nor is there any outcome data to indicate that such an arrangement resulted in more effective services. A more thorough comparative analysis would seem to be required in order to reach a reasonable basis for conclusion.

Second, while there certainly are benefits to carve-out programs, there is no balanced discussion of the potential problems of carve-out programs. For example, how do you integrate and coordinate care to meet both the physical and mental health care needs of the client and treat, in a comprehensive manner, persons with co-occurring mental health and substance abuse disorders?

Third, the report also states (page 1) that there was no attempt to "determine the effectiveness of the lessons learned reported by the States." Again, with this in mind, we do not believe it is appropriate to characterize this and other "lessons" as "findings." It tends to give them an air of authority that is not justified by the evidence.

New Services. In the report on *Changes in Medicaid Mental Health Services* (pages 9 and 10), the findings refer to new services or "innovative interventions" that have expanded the scope and flexibility of outpatient services. In addition, the report claims that these services or interventions would not or could not have been offered under the previous fee-for-service program.

We believe that these statements are misleading, at best. To our knowledge, providing services through a managed care arrangement does nothing to change the eligibility of a service or "intervention" for Medicaid reimbursement. At least two of the services identified, residential services and vocational services, generally are not coverable under Medicaid. It is possible that States may have obtained permission to offer an otherwise uncoverable service under an 1115 waiver. However, if that is the case, the reason should be attributed to the waiver, not to managed care. It is important that the OIG clarify these issues and independently determine that States are meeting applicable statutory and regulatory requirements. States should not be given the impression that managed care allows them to circumvent or ignore Medicaid limits on service coverage.

Data. In the report on *Children's Access to Medicaid Mental Health Services* (page 7), it is stated that "detailed data was almost nonexistent." Other parts of this report, however, cite statistics that assume that States do have such detailed data (e.g., changes in inpatient utilization). If States do not have detailed data, where do such statistics come from and how credible are they? Also, we would assume that the lack of detailed data is a serious handicap for state administrators and federal reviewers in their management and oversight responsibilities. If this is true, it would seem that this also should be a major finding of the report.

Involvement of State Mental Health Stakeholders. It is not clear to what extent State mental health staff and officials and mental health planning council members were involved in the interviews conducted as part of this study. The primary focus of the study at the State level appears to be on the State Medicaid agency. Although the investigators do make mention of including State mental health staff and stakeholders in the study, it is not evident to what degree this occurred. From a State systems perspective, we believe that it is critical that such important State stakeholders not only be included in such evaluations, but that State Medicaid agency staff be strongly encouraged to work in partnership with their State Mental Health Authorities to ensure access and quality services for those with serious mental illnesses.

Finally, on an editorial note, each of the reports contains an Appendix A, a chart entitled "Summary: First Year Medicaid Managed Care Mental Health Contracts." According to the chart, the State of North Carolina's 1915(b) waiver program excludes outpatient care from its covered mental health services. Based on the information available to us on North Carolina's waiver program, outpatient services are covered. We suggest that the OIG confirm this information for accuracy and make changes if necessary.

In summary then, SAMHSA would recommend that the OIG proceed cautiously in making general statements of findings or recommendations to States without consideration or mention of these important concerns and limitations.

If you have any questions on these comments or need additional information, please contact Robert Willcoxon, SAMHSA GAO liaison, on 443-4543.

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ENDNOTES

1. National Summary of Medicaid Managed Care Programs and Enrollment, Medicaid Managed care Enrollment Report, Health Care Financing Administration, June 30, 1998

2. State Profiles on Public Sector Managed Behavioral Health Care and Other Reforms. Managed Care Tracking System, Substance Abuse and Mental Health Services Administration, July 31, 1998

3. Federal Register, Volume 58, Number 96, May 20, 1993 page 29425

4. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1996

5. ibid

6. Oregon and Tennessee have been under managed care for a minimum of three years, but did not phase in their seriously mentally ill populations until January 1995 and July 1996 respectively.

7. Iowa implemented March 1995. Colorado implemented July 1995.

8. In February 1999, North Carolina requested to withdraw its 1915(b) waiver extension of the Carolina Alternatives Program. The State proposes to move all recipients back to a fee for service system on or before June 30, 1999.

9. For the purpose of this report, stakeholders include family members of children with serious emotional disturbances, and State and national mental health organizations representing children with serious emotional disturbances. The organizations include such groups as the National Alliance for the Mentally Ill, The America Psychiatric Association, and The Federation of Families for Children's Mental Health.