DOCUMENT RESUME

ED 464 466 EC 308 978

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TITLE The Impact of Managed Care on Efforts To Prevent Serious Emotional Disturbance in Young Children.
INSTITUTION University of South Florida, Tampa. Research and Training Center for Children's Mental Health.
SPONS AGENCY National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE 2000-00-00
NOTE 4p.; In: A System of Care for Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (13th, Tampa, FL, March 5-8, 2000).
CONTRACT H133B90022
AVAILABLE FROM For full text: http://rtckids.fmhi.usf.edu/conference_proceedings.htm.
PUB TYPE Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Administrative Problems; Delivery Systems; Economic Factors; *Emotional Disturbances; Financial Problems; Health Care Costs; *Health Insurance; *Health Maintenance Organizations; Health Services; Kindergarten Children; *Mental Health Programs; Performance Factors; *Prevention; Primary Education; Referral
IDENTIFIERS *Medicaid

ABSTRACT

This report explores the impact of managed care on providing preventative mental health services to young children at risk for serious emotional disturbances (SED). The study included a sample of kindergarten and 1st grade children (n=121) at-risk for SED that were identified in two public schools. Results of the study indicated that the move to managed care in provision of mental health services under Medicaid facilitated the provision of services in two ways for children at-risk for SED: (1) by emphasizing a community-based service provider network and provision of services in community-based facilities; and (2) by requiring the development of individualized service plans. Other than this, however, application of managed care to Medicaid acted as a barrier to the provision of mental health services for children at-risk for SED through eligibility requirements. Children eligible for targeted care management were required to have a SED as indicated by a defined mental disorder, be in, or at-risk for, residential placement, and need two therapeutic services in addition to case management. The move to managed care also acted as a barrier to prevention of SED through multiple cost and expenditure-oriented strategies, including decreasing the amount reimbursed for targeted case management and limiting services provided. (CR)

The Impact of Managed Care on Efforts to Prevent Serious Emotional Disturbance in Young Children

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Introduction

Project SUCCESS was designed to prevent serious emotional disturbance (SED) in young children. The project had an intervention package built on the principles of the Child and Adolescent Service System Program (CASSP; Stroul & Friedman, 1986) that included professionally recommended school-based mental health therapy and case management for high-risk children and their families. There was also an evaluation of the intervention that included an exploratory case study of the systemic facilitators of, and barriers to, the intervention package. This presentation focuses on this exploratory case study.

A statewide move toward managed care occurred during the implementation of Project SUCCESS. However, the mental health literature suggests a disagreement among professionals about the extent to which the principles of CASSP and managed care are compatible, especially regarding early identification and intervention and the role of families. Being exploratory, the case study was not designed to focus primarily on managed care, yet managed care quickly was found to have a great impact on prevention efforts.

Method

A sample of kindergarten and 1st grade children (N = 121) was identified in two public schools. Identification was based on passing one to three gates of the Systematic Screening for Behavior Disorders instrument (SSBD; Walker & Severson, 1992). Sixty-two percent were boys, 50% and 43% were Hispanic or African-American, respectively, and 85% received free or reduced lunches. Forty-seven percent spoke English at home, and the same proportion spoke Spanish. Sixty-three children were considered to have moderate risk and 28 to have high risk for SED. Thirty-nine (62%) of the children were identified as being at moderate risk and eighteen (64%) of those considered at high risk had externalizing problems. The intervention targeted the moderate and high risk children identified by the SSBD.

The design of the case study was a single case with embedded units of analysis (Yin, 1994). The major unit of analysis (the case) was defined as the system, or context, in which the project was implemented. Specifically, the case was defined as federal, state, and/or local policies, procedures and practices that might impact prevention efforts. The research questions were concerned with finding out what systemic/contextual factors promoted or inhibited full implementation of the intervention, and how those factors influenced project implementation.

Because little was known about what systemic factors might facilitate or impede efforts to prevent SED, a set of theoretical propositions about "best practice" in the prevention of SED was developed from the literature. These propositions suggested that areas of inquiry about systemic facilitators or barriers include, but are not limited to, the availability and accessibility of multiple services, eligibility criteria for Medicaid services, funding patterns, and mental health policies. Data collection focused on these areas, and included multiple interviews, observations, and review of documents. These data were used to develop empirically-based propositions about what factors acted as systemic facilitators and barriers and how they interacted; these propositions were "tested" the final two years of the project, as described below.

Data analysis involved noting patterns and themes, i.e., recurring regularities in the interviews, observations, and records. Each theme was corroborated by comparing data from interviews with data from records or observations, or by comparing data from one interview with that from another, independent interview. A given theme, or proposition, was revised when data from multiple sources were clearly inconsistent with the proposition as originally stated and modifications were required to fit the proposition to the data. All empirical propositions about system facilitators or barriers, and

their supporting data, were reviewed by the Project SUCCESS research staff, the principals of the participating schools, and the project's Advisory Panel (composed of professionals and parents). Suggested modifications in the propositions were made until all reviewers were satisfied that the final set of propositions fit the empirical data.

Results & Discussion

The state in which the project was located experienced a growth in Medicaid of 28% the decade prior to and during the project. Clearly, this growth surpassed the general revenue growth of 8.5% during the same period (Boothroyd, Armstrong, Massey, Kutash, & Shern, 1998). Thus, the state implemented a number of managed care strategies to reduce costs, including: 1) an emphasis on community-based care, 2) limits on the number of group and individual therapy sessions, 3) limits on family/professional contacts for explanations of examination results, 4) a review of patient treatment and billings associated with these plans (which were simultaneously expanded), 5) a reduction in the amount that could be reimbursed for case management, and 6) restrictions on eligibility requirements for case management services. Because most Project SUCCESS children were eligible for (but not necessarily enrolled in) Medicaid, and because the salaries of involved therapists and case manager(s) were paid for with Medicaid funds, these changes impacted the intervention as described below.

For reasons unrelated to managed care, these changes did not have a major impact on the provision of professionally recommended therapeutic services. In one school, the mental health provider pulled out of the school because not enough children were being served to justify the salary of the therapist. The issue here concerned the combination of low Medicaid enrollments and parent refusals for mental health services. At the other school, the Full Service School coordinator placed the Project SUCCESS children receiving therapy with university psychology students under a supervised internship at the school. This effectively bypassed Medicaid limitations on the number of allowed therapy sessions.

However, the managed care strategies related to tightened eligibility criteria for case management, reduced reimbursement for these services, and audits of the expanded service plans had a major impact on case management (the family-focused part of the intervention). A case manager originally hired to work with the families of the high-risk children was fired by the provider agency working with Project SUCCESS due to "problems with paperwork." Auditors required providers to return Medicaid funds to the State in the same proportion to inadequacies found in the expanded service plans; this was of concern to providers. Additionally, recently tightened eligibility requirements for case management focused on the concept of "medical necessity," requiring the *presence* (diagnosis) of a serious emotional disturbance, placement or potential placement in a residential institution, two services in addition to case management, and the recommendation of a psychiatrist or other physician. The provider interpreted these as requiring a DSM-IV diagnosis on Axis I (Clinical Disorders), and only seven of the 28 high risk children met such eligibility criteria. Also, reimbursement for case management was reduced, making it less viable for providers. Thus, another case manager was never hired for Project SUCCESS.

This study suggests that *prevention* of SED is not supported by a service delivery system based on managed care strategies. The final set of theoretical propositions (see Table 1), which reflect the findings of the case study, indicates that managed care may facilitate prevention by emphasizing community-based services and individualized service plans. However, it can act as a major barrier to services through strict eligibility requirements combined with reduced reimbursement for case management, which prevent at-risk children and their families from receiving such services. Further, it can act as a barrier when expanded individualized service plans are combined with utilization review; that is, an increased possibility for returning Medicaid funds due to paperwork problems does not encourage mental health providers to serve the larger population of at-risk children. Finally, it can act as a barrier to prevention and treatment when arbitrary limits are placed on provision of therapeutic services without reference to a given child's need or progress. In sum, managed care may indeed contain costs for mental health services for at-risk children at present, but it may also lead to increased costs in serving more children and youth with more problems, and more severe problems, in the future.

Table 1
Empirical Propositions Related to Impact of Managed Care on Prevention of SED

1. The move to managed care in provision of mental health services under Medicaid facilitates the provision of services in two ways for children at-risk for SED:
   A. Emphasizing a community-based service provider network and provision of services in community-based facilities, and
   B. Requiring the development of individualized service plans.
2. Other than this, however, application of managed care to Medicaid acts as a barrier to the provision of mental health services for children at-risk for SED through eligibility requirements, e.g., requiring that children eligible for "targeted" case management meet the following criteria to be certified:
   - Have a serious emotional disturbance as indicated by a defined mental disorder;
   - Be in, or at risk for, residential placement; and
   - Need two therapeutic services in addition to case management.
3. The move to managed care also acts as a barrier to prevention of SED through multiple cost and expenditure-oriented strategies, including:
   A. Requiring that providers of "targeted" case management must, among other criteria, have the capacity to manage (i.e., contain) utilization of such services and to conduct regular utilization reviews;
   B. Using strategies such as paperwork audits that may result in recoupment of Medicaid funds already paid to mental health providers as a service management/containment strategy;
   C. Decreasing the amount reimbursed for targeted case management; and
   D. Limiting services provided, i.e. individual therapy sessions, group therapy sessions, and consultation by therapists with family members to explain results of psychiatric testing.

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