The State of Care Coordination Under Medicaid Managed Care: Three States’ Experiences Serving Children with Mental Illness

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EXECUTIVE SUMMARY

Since its inception in the early 1980s, the movement to serve children with mental illness in community-based, “real-life” settings, rather than in isolating specialty mental health programs or institutions, has continued to grow. To be served well in the community, however, these children must have someone to coordinate the services they receive across the range of settings in which they potentially might interact, such as the schools, child welfare system, juvenile justice system, public mental health system, and Medicaid program. The surge in managed care designs for Medicaid programs that began during the 1990s held great promise for children with mental illness who were enrolled in Medicaid, because managed care was intended to promote the integration of service systems, improve access to services and providers, and provide the coordination of care that had been lacking under fee-for-service.

In this paper, we sought to answer one key question: Has managed care helped state Medicaid programs provide care coordination services for children with mental illness? To answer this question, we examined the issues affecting care coordination for children with mental illness who are enrolled in Medicaid managed care programs in Hawaii, Maryland, and Tennessee. The report’s findings are based on qualitative data obtained primarily from telephone interviews that we conducted between July and October 2002 with key stakeholders in each state, including state officials, representatives from managed care organizations and behavioral health organizations, providers, and advocates.

Our review of the evidence from the Medicaid managed care programs in the three states has produced the following key findings:

- All of the programs used the introduction of managed care to initiate care coordination services for children with mental illness. This change was significant for the many children with mental illness enrolled in the three states’ Medicaid programs (and for their families), because care coordination services historically were lacking under fee-for-service Medicaid.

- Despite the success of including care coordination as a covered benefit, the programs have failed to structure financial incentives in a way that promotes the provision of care coordination, or that ensures its continuity. Consequently, the volume of care coordination sometimes is inadequate, and the system is not error-free.

- Children with acute mental illness or with severe emotional disturbance who are enrolled in the states’ Medicaid managed care programs are the children most likely to receive care coordination services.

- The three states have adopted different designs to deliver care coordination services in Medicaid, but regardless of the design, usually only mental health services are coordinated. For example, there is little or no coordination with primary care providers or with services that other state agencies provide. The plans employ care coordinators who can link the mental health care coordination services to the plans’ physical health care services, but their efforts have been hampered by the failure of
the agencies responsible for mental health care coordination to communicate necessary information. Thus, Medicaid managed care does not provide comprehensive care coordination.

- Because of the designs adopted, multiple agencies are responsible for providing care coordination to children with mental illness who are enrolled in the Medicaid managed care programs. However, the lack of coordination among agencies is a persistent and largely unaddressed problem. The states have acknowledged the need for better interagency coordination and communication, but they have done little to improve the situation. Representatives from various state agencies believe the problem may be explained chiefly by the agencies' refusal to breach the confidentiality of minors. Although preserving the confidentiality of children is a critical issue, the states could develop consent forms to reassure parents that information about their children would be shared only with those who must have it in order to coordinate care.

- The programs in all three states have difficulty retaining care coordinators. Most care coordinators are inexperienced, recent college graduates who receive low pay and who typically leave the job within the first two years. Care coordinators and their patients, especially those in Maryland and Tennessee, would benefit from more regularly scheduled training courses.

- Maryland and Tennessee conduct only limited monitoring of their care coordination systems, primarily in the form of process monitoring; they do not yet monitor outcomes, although Tennessee has recently begun analysis of outcomes data. Their limited data collection activities severely hamper their monitoring and enforcement efforts. Hawaii's Medicaid agency does not monitor care coordination services, but two other state agencies responsible for providing care coordination services recently have established an extensive monitoring system that shows great promise.

- Legal challenges have had a significant impact on expanding access to care coordination for children with mental illness. Challenges in Hawaii and Tennessee were successful in establishing new laws specifying the care that the state is required to provide to children enrolled in Medicaid (in Tennessee), and, more specifically, to all children who need mental health treatment in order to benefit from their education (in Hawaii). In both instances, the courts decided clearly in favor of expanding services to these groups. To date, Hawaii has been more successful in implementing the terms of its consent decree, but it began planning its implementation four years earlier than did Tennessee.

We have derived important lessons from our analysis of the three states' programs. The following lessons are the ones we believe are key:

- Introducing care coordination services in Medicaid managed care requires both internal coordination and external coordination. Because care coordination must cover services in addition to those provided through Medicaid, Medicaid agencies must develop internal agreements with their contractors responsible for care coordination, and they must develop external agreements or understandings with all
the other state agencies that serve children. In the three study states, unclear expectations about different agencies’ responsibilities sometimes translated into poor access for individual children caught in interagency gridlock.

- At the same time, the introduction of care coordination can initiate a dialogue among state agencies about the children they serve in common. For example, Hawaii has established a working group of high-level policymakers to determine how to improve the system of care through better agency coordination, although this group has not yet been successful in its efforts. Under a court order, Tennessee’s agencies entered into an agreement that specifies the responsibilities of each agency with regard to children they jointly serve. Efforts such as these are key to improving external coordination.

- States must ensure that processes for addressing coordination issues are workable. Even if agreements about interagency coordination have been established, the failure of processes for handling coordination issues may impede children’s access to care coordination.

- Covering care coordination services in Medicaid managed care programs will not happen overnight. The infrastructure for care coordination has to be developed, but this process takes time, especially when other demands of program implementation, such as enrolling members, contracting with providers, and establishing data systems, are more pressing. Even Hawaii and Tennessee, which are under court order to improve care coordination services, have not yet implemented all the necessary system changes.

- Confidentiality issues act as barriers to care coordination and are difficult to overcome. None of the three programs in this study had anticipated this barrier, and none of them has been able overcome the conflict between patient confidentiality and care coordination. Preserving patient confidentiality, especially of a minor, is paramount, but care coordination cannot be inclusive unless all the entities serving children have been informed about the children’s care needs. Policymakers in the study states appear to be reluctant to develop and use consent forms that would resolve the problem. Thus, it is unclear what methods states should use to address confidentiality issues.

- Finally, the experiences of the three states have shown that no single model of care coordination is superior; states must implement the model of care coordination that they can support and sustain in the long run. Moreover, regardless of how services are delivered, monitoring the outcomes of the model chosen is critical for understanding how well it works.

Care coordination services meet critical needs for children with mental illness, as well as for their families. However, we found that designing effective ways to deliver the service is complicated and requires a multifaceted approach, given the multiple players involved. States that plan to design their own care coordination programs may benefit from the conclusions of this research, and they may be able to use the lessons we have learned to guide their own efforts in this important area.
I. INTRODUCTION

Mental health disorders affect a large proportion of children in the United States. Estimates indicate that 20 percent of all children have a diagnosable mental, emotional, or behavioral disorder; 9 to 13 percent of children aged 9 to 17 years have a serious emotional disturbance (SED) that causes a substantial functional impairment, and 5 to 9 percent of children in that age range have an SED that causes extreme functional impairment (Institute of Medicine 1989; and Friedman et al. 1998). Other studies have shown that children with mental illness often have problems in multiple life domains, including school, community, and home relationships; intellectual and educational performance; and social and adaptive behavior (Friedman et al. 1996; and Duchnowski et al. 2002).

Addressing the multifaceted needs of these children has been difficult because many entities have a role in meeting those needs, but they have failed to coordinate their various activities. For example, the schools, the child welfare system, the juvenile justice system, and the public mental health system, among others, are charged with serving children. Although a child with mental illness might be involved in all of these systems, mental health policy traditionally had been introverted, focusing more on how specialty mental health programs could increase resources, develop capacity, and improve services than on how to coordinate among these programs (English 2002).

However, a growing body of evidence suggests that treating children and adolescents in specialty mental health programs is isolating because the treatment takes place outside the context of "regular" home and school life, which may exacerbate the mental illness (Barker 1998; and English 2002). Thus, there has been a growing movement toward community-based interventions (Barker 1998; and English 2002). This shift in mental health policy toward serving children in their own "real-life" environments has transformed coordination of care among the many entities involved into a critical issue.

Medicaid, the health care insurer for poor and disabled children, funds the treatment of many of these children and thus is another entity that is involved at the state level. Medicaid spending on mental health care is enormous. For example, spending for children aged 6 to 14 years is estimated to be between $5.5 billion and $7.5 billion annually (Jeff Buck, Director for Organization and Financing, Center for Mental Health Services, Office of Managed Care, Substance Abuse and Mental Health Services Administration [SAMHSA], personal communication, September 17, 2002). Historically, however, traditional, fee-for-service Medicaid is a fragmented system that does not provide care coordination (Dickey 1997; and Talbott and Sharfstein 1986).

During the early 1990s, managed care was introduced as a new system of funding and delivering care for Medicaid recipients. Beginning in 1993, the federal government began approving a new generation of state Medicaid managed care programs under the auspices of Section 1115 demonstration programs that reformed state Medicaid programs (Brown et al.
Theoretically, managed care holds great promise for children with mental illness, because its goals are to promote the integration of service systems, improve access to both services and providers, and provide the coordination of care that has been lacking under fee-for-service.

Several barriers have complicated the provision of care coordination under managed care, however. First, because no infrastructure for providing care coordination existed, it was necessary to recruit, train, and retain care coordinators. Second, even though multiple agencies had roles in caring for children, the question of which entity would pay for care coordination had not been addressed. Was Medicaid managed care solely responsible for coordination? If not, should agencies share responsibility? If agencies were to share responsibility, should they share costs as well (or would they try to shift costs)? Third, some Medicaid managed care designs, such as those that carved mental health services for children out to a separate managed arrangement or fee-for-service arrangement, had the potential for introducing barriers to coordinating care. Finally, the ability of managed care organizations (MCOs) to provide care coordination for this group of children had not yet been tested.

To understand the issues affecting care coordination for children with mental illness who are enrolled in Medicaid managed care programs, it is first necessary to define “care coordination.” The literature reveals that the term often is poorly defined, and that many in the field use it interchangeably with “case management,” a term that also has multiple definitions in the literature (Austin 1983; Solomon 1992; and Intagliata 1992). Strolin (1995) does note that all definitions of case management have two things in common: (1) they refer to a set of core functions to be performed by the case manager; and (2) they indicate a common purpose—to mobilize, coordinate, and maintain an array of services and resources designed to meet the needs of individuals over time (Evans and Armstrong 2002).

“Care coordination” is thus one of the core functions of case management. It means to coordinate services for a child (or adult) in order to “link the various agencies, systems, and persons that may be involved with the care and support of the child and family” (Evans and Armstrong 2002). To do so, the case manager or care coordinator must establish and sustain a relationship with the child, the child’s family, and the child’s providers. Coordinators also must work with providers outside the entity in which they are located. In other words, they must coordinate both covered services and noncovered services; by contrast, case managers focus solely on covered services (Rosenbach and Young 2000). As Rosenbach and Young note, “Care coordination programs tend to use a broader social service model that considers a patient’s psychosocial context (such as housing needs, income, and social supports),” whereas case

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1Section 1115 demonstrations allow states to waive normal Medicaid rules, such as rules giving beneficiaries freedom of choice of providers and rules on eligibility (Brown et al. 2001). Before the 1990s, only one Medicaid Section 1115 demonstration, in Arizona, allowed comprehensive, mandatory managed care. As of September 2002, 16 states and one county had implemented these demonstrations; 3 more states had received approval for demonstrations, which were pending implementation; and three proposals were in the preapplication phase (Centers for Medicare & Medicaid Services 2002a).
management programs typically "rely on a medical model focused on a patient’s health care context." Case managers or care coordinators may also perform other functions. For example, in addition to coordinating a child’s care, a case manager or care coordinator who also is a clinical provider, such as a therapist or psychologist, might assess the child’s needs, determine which services are necessary, treat the child, and monitor and evaluate the child’s progress.

The Medicaid program similarly defines care coordination activities. Under Medicaid, care coordination services, including referrals and linkage to necessary medical, social, educational, or other services, are allowable activities under the rubric of case management services. Section 1915 of the Social Security Act defines case management services as “services which will assist individuals...in gaining access to needed medical, social, educational, and other services” (Section 1915(g)(2) of the Social Security Act). Federal law permits states to use Medicaid funds to support care coordination services for children with mental illness in either a fee-for-service or a managed care system.

Under fee-for-service Medicaid, a state can cover care coordination services for children with mental illness in a variety of ways. First, it can cover care coordination as a “Targeted Case Management” service, which enables states to reach out beyond the normal bounds of the Medicaid program, and to coordinate a broad range of activities and services to optimize the functioning of a Medicaid client (Centers for Medicare & Medicaid Services 2003a). The state can “target” a specific population with this service, such as children with SED. Second, instead of targeting this group, a state can elect to provide care coordination services whenever it deems the service to be medically necessary as the result of an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening (Fox and Wicks 1991). Third, a state can finance some care coordination activities under one of Medicaid’s treatment services benefits, such as rehabilitative services or the various independent practitioner services (Fox and Wicks 1991). This financing could be direct, such as by creating a new billing code for the service, or indirect, such as by wrapping payment for care coordination into payment for individual therapy. Fourth, case management services provided under an authorized home- and community-based services waiver (a type of waiver states can apply for to provide service alternatives to institutional care) can also be funded by Medicaid (Centers for Medicare & Medicaid Services 2003b). Finally, a state can cover care coordination under the “Administrative Case Management” rules, in which states can claim federal Medicaid funds to support the administrative activities associated with administering their Medicaid plans as they relate to care coordination (Center for Medicare & Medicaid Services 2003b). Under this method, a state would be able to contract with a state mental health agency to provide administrative services for children with SED, such as scheduling appointments for a child and/or assisting the child with transportation to the appointment (Fox and Wicks 1991). In each instance, the services are optional Medicaid benefits; in other words, a state may elect to provide case management and care coordination services in its Medicaid program, but it does not have to do so (Kaiser Commission on Medicaid and the Uninsured 2003).

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2The passage of the Consolidated Omnibus Reconciliation Act of 1986 allowed states for the first time to provide case management as a distinct service under Medicaid without obtaining a waiver from the federal government (Centers for Medicare & Medicaid Services 2003c).
However, because there are challenges to providing case management and care coordination services to beneficiaries in fee-for-service Medicaid programs, some states were unable to provide these services when operating their fee-for-service programs. First, as noted, these benefits are optional, and, because Medicaid is a federal–state partnership, states had to be able to finance their portion of the benefit in order to provide it. Limited state budgets often precluded such arrangements. Second, few mechanisms existed under fee-for-service Medicaid to support care coordination activities. Many states had no infrastructure for providing this service. Moreover, under the administrative case management rules, only states or local public agency staff could furnish the care coordination services; a state was not permitted to use private sector providers (Fox and Wicks 1991). Third, to provide some types of care coordination, such as under the targeted case management rules, states had to obtain federal approval, a sometimes-lengthy process.

Providing care coordination in a managed care design for Medicaid has its challenges as well. However, Medicaid managed care programs have different incentives than do fee-for-service Medicaid programs, and those incentives make providing care coordination services a higher priority. Many states implemented their managed care programs to save money, and it is thought that providing such services as care coordination and case management save money because they can avoid more costly care, such as hospitalizations (U.S. General Accounting Office 1993). Moreover, managed care designs were adopted in part because they were a more comprehensive approach to care, and states hoped to provide services that would meet beneficiaries’ medical and social needs; this goal had the effect of making the provision of care coordination services a higher priority. Finally, care coordination was easier for states to implement under managed care than under fee-for-service because the burden of providing the service could be shifted to the contractor (the managed care organization or behavioral health organization). In the early to mid-1990s, when many states began implementing their Medicaid managed care programs, states could simply require their contracted plans (or providers, under a primary care case management program) to provide case management and care coordination services to beneficiaries. By the late 1990s, the federal government mandated the need for care coordination services for Medicaid beneficiaries in its final rule implementing the Balanced Budget Act of 1997, which now requires MCOs to ensure coordination of care (Federal Register 2002). Thus, Medicaid managed care programs hold greater promise for children and youths with mental illness who need care coordination services compared to fee-for-service programs.

In this paper, we seek to answer one key question: Has managed care helped state Medicaid programs provide care coordination services for children with mental illness? The paper builds on existing Medicaid managed care research conducted as part of two separate evaluations, both sponsored by the Centers for Medicare & Medicaid Services (CMS) and SAMHSA. The first evaluation, completed in 2001, examined the Medicaid managed care programs operating under Section 1115 demonstrations in Hawaii, Maryland, Oklahoma, Rhode Island, and Tennessee.³

³That evaluation was conducted under contract #500-94-0047. The Assistant Secretary for Planning and Evaluation sponsored it as well.
The second evaluation is ongoing and is examining the same types of programs, but in Kentucky, New York, Minnesota, and Vermont.\(^4\)

We draw conclusions about our key study question based on an assessment of the following aspects of Medicaid managed care and care coordination in three states:

- What is the Medicaid managed mental health program structure for children?
- Who receives care coordination, and who provides it?
- What training do care coordinators receive?
- Do entities responsible for care coordination work together?
- Do all children receive the care coordination services they need?
- How is the system monitored?

\(^4\)This evaluation is being conducted under contract #500-95-0040. The Los Angeles County Section 1115 demonstration, which was the fifth site evaluated under this contract, does not include a managed care intervention, and so was not considered for this analysis.
II. METHODS

To provide context for our discussion of the states’ programs presented in detail in the next three chapters, we briefly review the components of the methodological process we used in our study. We begin by discussing our method for selecting sites for study. We then describe how we developed protocols and conducted the interviews. We conclude the chapter with an overview of the data analysis, which lays out the structure of the remaining chapters in the report.

A. SITE SELECTION

SAMHSA was interested in understanding whether, and how, care coordination exists for children with mental illness who are enrolled in Medicaid managed care programs. Because of the rich history of research on the nine study states mentioned in Chapter I, it was most practical to select sites for study from among that group. Only five of the nine states—Hawaii, Maryland, Oklahoma, Rhode Island, and Tennessee—had implemented and maintained Medicaid managed care programs for children’s mental health care. For a variety of reasons, we decided to focus in this report on Hawaii, Maryland, and Tennessee. We selected these states for their diverse geography, varying program sizes, court rulings affecting care coordination (in Hawaii and Tennessee), and unusual program design (in Maryland). In Maryland, primary mental health services are part of managed care, but all other mental health services are carved out to a specialty mental health system. Maryland’s system reimburses on a fee-for-service basis but contains managed care elements, such as preauthorization for services. We initially had planned to consider a wide variety of program designs when selecting states, but the programs looked relatively similar; four of the five operate a mental health carve-out in their Medicaid managed care programs.¹

B. PROTOCOL DEVELOPMENT AND INTERVIEWS

We developed semistructured interview protocols that focused on a variety of areas germane to care coordination for children with mental illness who are enrolled in Medicaid managed care programs. The protocols covered such topics as:

- System structure, both of the managed care program and of the care coordination arrangements
- Contractual requirements with respect to care coordination

¹Oklahoma is the only state that does not directly carve out mental health services, but the MCOs it uses do carve out these services. In addition, unlike the other states, Oklahoma does not operate a statewide Medicaid managed care program. Rather, Medicaid recipients in rural areas receive mental health benefits entirely through fee-for-service arrangements.
• Whether requirements for receiving care coordination differed for children designated as having a more acute mental illness, such as SED, and for children with less-acute mental illness

• The way that care coordination works in practice

• Who the care coordinators are, and how they are trained

• Monitoring of care coordination

• Confidentiality issues surrounding coordinating a child’s care among different entities

• The degree of accessibility of care coordination and mental health services for children

• Whether cost-shifting is an issue

• Advice for other states

We identified the key state stakeholders whom we would have to contact in each state. As shown in Table II.1, the members of this group included key staff from state Medicaid organizations, state mental health departments, state education departments, the state juvenile justice system and state children’s departments; and representatives from participating MCOs, participating behavioral health organizations (BHOs), advocates, and providers. We conducted the semistructured discussions with these stakeholders from July through October of 2002.

We also reviewed the data collected between 1995 and 1999 for the larger evaluation of the three states and, where applicable, incorporated this information into the study. These data consisted of information collected during site visit interviews with key informants, during supplementary telephone interviews with key state informants to obtain updated information, from survey data, and from transcripts of focus group discussions with providers serving mental health and substance abuse populations.

C. ANALYSIS

We used the data to develop a comprehensive description of the structure of each state’s mental health services for children, as well as an assessment of how well care coordination is working in Hawaii (Chapter III), Maryland (Chapter IV), and Tennessee (Chapter V). We then drew conclusions and lessons learned from this research (Chapter VI).

2A Note About Terminology. States use different terms to describe the same thing. For example, in Tennessee, the people conducting care coordination are called “case managers”; in Hawaii, they are “care coordinators.” To factually report the situation in each state, we use the term that the state uses to describe the people who coordinate care.
<table>
<thead>
<tr>
<th>Table II.1 Number and Types of Individuals Interviewed, by State</th>
</tr>
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<tbody>
<tr>
<td></td>
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<tr>
<td><strong>Total Number of Individuals Who</strong></td>
</tr>
<tr>
<td><strong>Participated in Discussions</strong></td>
</tr>
<tr>
<td>Hawaii</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td><strong>Discussant Types</strong></td>
</tr>
<tr>
<td>Medicaid Administrators</td>
</tr>
<tr>
<td>Mental Health Department/Children’s Mental Health Department Administrators</td>
</tr>
<tr>
<td>Substance Abuse Department Administrators</td>
</tr>
<tr>
<td>Department of Children’s Services Administrators</td>
</tr>
<tr>
<td>Department of Juvenile Justice Administrators</td>
</tr>
<tr>
<td>Department of Education, Policy and Program Administrators</td>
</tr>
<tr>
<td>Special Education Administrators</td>
</tr>
<tr>
<td>Child Protective Services Administrators</td>
</tr>
<tr>
<td>Advocates for Children with Mental Illness or for Those with Behavioral Illness</td>
</tr>
<tr>
<td>Behavioral Health Providers For Children Participating in Medicaid Managed Care Program, Including Care Coordinators</td>
</tr>
<tr>
<td>Behavioral Health Organization Administrators</td>
</tr>
<tr>
<td>Managed Care Organization Administrators</td>
</tr>
</tbody>
</table>
III. MEDICAID MANAGED CARE AND CARE COORDINATION: STRUCTURE AND DELIVERY IN HAWAII

Assessing whether the Medicaid managed care designs adopted by the three study states have helped to provide care coordination for children with mental illness who are enrolled in the programs requires a thorough understanding of each state’s Medicaid managed care program, the way that each program provides behavioral health benefits, the way that other state entities responsible for children interact with the managed care program, and the locus of responsibility for care coordination. Chapter III presents this background material as it relates to Hawaii. Similar information for Maryland and Tennessee is found in Chapters IV and V, respectively.

A. PROGRAM STRUCTURE FOR CHILDREN’S MENTAL HEALTH CARE

Hawaii implemented managed care in its Medicaid program in 1994 to offset rising Medicaid costs (which had been increasing an average of 18.4 percent per year between 1988 and 1994), to resolve access problems in its fee-for-service program, and to expand coverage to some uninsured Hawaiians (Brown et al. 2001; and Liska et al. 1996). QUEST, as Hawaii’s Medicaid managed care program is called, introduced mandatory managed care, which requires that all welfare- and poverty-related eligible groups enroll in health maintenance organizations (HMOs) (Brown et al. 2001).1

Med-QUEST, an agency in the state’s Department of Human Services (DHS) that was created when QUEST was implemented, administers the program. For children enrolled in QUEST, behavioral health care—that is, both mental health and substance abuse treatment—is a covered benefit, just as physical health care services are covered. However, as a result of a federal consent decree concerning behavioral health care in Hawaii, the entity responsible for providing that service has changed over time.

Under the original design for QUEST, HMOs provided behavioral health benefits to all children except those categorized as having SED. Children with SED received those benefits through a separate managed behavioral health carve-out administered by the Child and

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1Hawaii also included spend-down medically needy children and adults but excluded both supplemental security income (SSI)-related and medically needy aged and disabled beneficiaries and poverty-related aged and disabled beneficiaries (Brown et al. 2001). Spend-down medically needy adults and children are adults and children who meet all Medicaid eligibility rules with the exception of rules about income. A state’s inclusion of this group in its Medicaid program enables these individuals to “spend down” to Medicaid eligibility by incurring medical or remedial care expenses (or both) that offset their excess income, thereby reducing the excess income to a level below the maximum allowed by that state’s Medicaid plan (Centers for Medicare & Medicaid Services 2002b).
Adolescent Mental Health Division (CAMHD) of the state’s Department of Health (DOH). After a child was designated as having SED, reevaluations were required every 3, 6, or 12 months, depending on the evaluating psychiatrist’s prescription. Table III.1 lists the requirements for receiving the SED designation.

Table III.1. Definition of SED in Hawaii’s QUEST Program

<table>
<thead>
<tr>
<th>Issue</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Can Refer a Child for Assessment?</td>
<td>Plans, parents, or CAMHD</td>
</tr>
<tr>
<td>Who Conducts Assessment?</td>
<td>Two state-employed psychiatrists</td>
</tr>
<tr>
<td>What Are the Required Conditions for SED Status?</td>
<td>A mental health diagnosis; a score of 120+ on the Child and Adolescent Functional Assessment Scale (an instrument that assesses various measures of the child’s functioning); illness present for six months; and disorder expected to persist into foreseeable future</td>
</tr>
<tr>
<td>Reevaluations</td>
<td>Conducted by psychiatrist every 3, 6, or 12 months</td>
</tr>
</tbody>
</table>


Children included in the SED carve-out were eligible to receive a comprehensive array of services consisting of case management (including care coordination) and medication management, in addition to unlimited inpatient and outpatient services (Vogel 2001). A much less expansive array of services was available to non-SED children through the HMOs. Table III.2 lists the services available to SED children and to non-SED children in the QUEST program.

In 1993, during QUEST’s planning stage, a group of families filed suit against the state’s Department of Education (DOE), DOH, and then-Governor Cayetano, alleging that collaboration to provide educational and health services for children who needed mental health treatment in order to benefit from their education was inefficient. In 1994, state officials acknowledged that Hawaii had failed to provide necessary services to children who were entitled to, but were not receiving, special education and related mental health services, and an out-of-court settlement was reached and approved by the court (State of Hawaii Department of Health 2002). The Felix Consent Decree, as the settlement is known, required DOE and DOH to establish a system of care for this class of children by June 30, 2000, that would satisfy the Individuals with Disabilities Act and Section 504 of the Rehabilitation Act, and that would embody the principles of the Child and Adolescent Service System Program (State of Hawaii Department of Health

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2In 1997, a private behavioral health organization, Community Care Services, was given the contract for SED children; in 1999, the contract was returned to CAMHD (Aileen Hiramatsu, Administrator, QUEST program, personal communication, October 19, 1998; and Joyce Ingraham-Chin, Director, Community Care Services, personal communication, October 20, 1998).
Table III.2. Covered Behavioral Health Services for Children in Hawaii’s QUEST Program

<table>
<thead>
<tr>
<th>Inpatient Services</th>
<th>Children Without SED</th>
<th>Children with SED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient psychiatric and detoxification services, including room and board, diagnostic services, and physician and other practitioner services</td>
<td>Inpatient psychiatric and detoxification services, including room and board, diagnostic services, and physician and other practitioner services</td>
</tr>
<tr>
<td></td>
<td>Maximum of 30 days per year</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>Maximum of 24 hours per year</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Other Services</td>
<td>Day treatment, subject to a two-for-one exchange for inpatient days; ambulatory and crisis services; methadone treatment; diagnostic and laboratory services; prescription drugs</td>
<td>Case management, care coordination, evaluation, and assessment services; medication management; ambulatory and crisis services; methadone treatment; diagnostic and laboratory services; physician and therapeutic services; prescription drugs</td>
</tr>
<tr>
<td></td>
<td>Unlimited, except for day treatment services</td>
<td></td>
</tr>
</tbody>
</table>


The principles of the Child and Adolescent Service System Program are based on a system of care approach that has three critical elements: (1) the needs and preferences of the child and the child’s family drive the mental health service system’s efforts, which are addressed through a strengths-based approach; (2) the locus and management of services occur within a multiagency collaborative environment and are grounded in a strong community base; and (3) the services, participating agencies, and programs generated are responsive to cultural context and characteristics (Duchnowski et al. 2002).

Although DOH and DOE implemented some aspects of the Felix Consent Decree on schedule, full implementation missed the court’s appointed deadline by one year. Under the new system, effective July 1, 2001, DOE provides mental health services for “low-end”-needs Felix children (defined as children who need only some non-intensive behavioral health supports to benefit from their education), and CAMHD provides mental health services for “high-end”-needs Felix children (defined as children who need more intensive mental health treatment to benefit

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3The Child and Adolescent Service System Program provided the conceptual framework for an integrated system of care for children receiving services from a variety of agencies (Duchnowski et al. 2002). This program, developed under funding from the National Institute of Mental Health in 1984, was the first to recognize the need for integration of public sector programs.
from their education).\textsuperscript{4} Whether a child qualifies as low-end or high-end is determined at the school level by the child’s Individualized Education Plan, which a school-based team consisting of a school psychologist, a school-based care coordinator, teachers, the child, and the child’s parents creates. Each team member contributes to the plan, which, by law, must include a statement of the child’s present level of functioning, annual goals, short-term objectives, services to be provided, starting date for provision of services, services provided, duration of services provided, and criteria for evaluating the services (P.L. 94-142; and Epstein and Walker 2002). Parents are required to attend at least one team meeting to receive an explanation of the plan, and they also must sign off on it.

The change in responsibilities at DOH and DOE has affected QUEST-enrolled children who fall into the Felix category. SED children no longer are carved out from the HMOs for behavioral health services. Instead, the carve-out now covers all QUEST children who also are Felix-class children, as determined by DOE, and who receive services from CAMHD; in other words, the carve-out now covers all high-end QUEST-enrolled children (Aileen Hiramatsu, personal communication, July 17, 2002).

CAMHD now serves any QUEST child who has acute mental health problems (“high-end” needs), and the QUEST determination process presented in Table III.1 is not used because the referral now originates in the schools, rather than through Medicaid.\textsuperscript{5} CAMHD thus serves as a de facto behavioral health organization for QUEST-enrolled children with acute mental illness (that is, those categorized as high-end needs children by DOE). CAMHD provides care by contracting with a variety of private service providers on a fee-for-service basis. It also operates seven Family Guidance Centers throughout the state (four on Oahu, and one each on the islands of Hawaii, Kauai, and Maui), which provide only care coordination services. Although this arrangement has been in place since July 2001, as of fall 2002, no written contract between the Med-QUEST agency and CAMHD had been established specifying the services to be provided to these children (Aileen Hiramatsu, personal communication, October 29, 2002). According to Med-QUEST’s administrator, the two agencies are in the process of creating a memorandum of understanding that would detail the services to be provided and the capitation rate. Establishing the capitation rate has held up the agreement, and the lack of good encounter data on the children using the services has hampered efforts to establish an actuarially sound rate. Once a written understanding is in place, CAMHD will be paid retroactively by Med-QUEST for the services that it has provided since 2001 (Aileen Hiramatsu, personal communication, July 17, 2002).

\textsuperscript{4}This design for treating Felix-class children is the final one. Hawaii initially had implemented an interim system in which CAMHD provided behavioral health services for low-end and high-end children.

\textsuperscript{5}Medicaid still uses a score of 120 on the Child and Adolescent Functional Assessment Scale in its fee-for-service Medicaid program (children eligible through SSI-disability), but not for children in managed care (Mary Brogan, CAMHD Performance Manager, personal communication, July 11, 2002).
CAMHD representatives reported that 400 to 500 of the children they serve in this new arrangement are QUEST beneficiaries (Mary Brogan, personal communication, July 11, 2002).\(^6\)

Low-end children who are enrolled in QUEST are not actually carved out of their HMO for mental health services. However, because DOE is responsible for their mental health services, the department essentially created a carve-out for the services. At this time, DOE does not receive Medicaid reimbursement for the services, but it is assessing whether it would be cost-effective for it to become a Medicaid provider.\(^7\)

Under this new service arrangement, DOE and CAMHD are responsible for providing all behavioral health services that the child’s Individualized Education Plan indicates are necessary with the exception of prescription drugs and inpatient services, which only high-end-needs children require, and which the HMOs provide (Aileen Hiramatsu, personal communication, July 17, 2002).\(^8\) According to HMO staff, because HMOs require one of their own participating psychiatrists to prescribe certain psychiatric drugs (for example, selective serotonin reuptake inhibitors), problems sometimes arise when a CAMHD provider is not a participating HMO provider but prescribes a drug of this type. In these cases, the HMOs work with CAMHD to ensure that the appropriate drug is prescribed. In addition, CAMHD and the HMOs’ staff reported that the two providers sometimes disagree about lengths of stay for some inpatient admissions, with HMOs authorizing a shorter length of stay than CAMHD had requested.

This new design specifies that prescription drugs and inpatient services are the only mental health services that HMOs must provide for Felix-class children. In actuality, however, HMOs may provide other services, especially for low-end-needs children who receive their services through DOE. According to HMO staff, this situation has arisen because the HMOs and DOE have failed to establish a working relationship. (DOE staff confirm this explanation.) Although the HMOs receive a monthly list identifying their enrollees whom CAMHD is serving, DOE does not provide similar notification about low-end children. Similarly, CAMHD—but not DOE—has assigned a central contact in its office whom HMO staff may contact about treatment

\(^6\)Medicaid officials disputed this assertion, stating that CAMHD served about 150 QUEST children—essentially the same number as had been classified as having SED in the QUEST program (Aileen Hiramatsu, personal communication, July 17, 2002). Neither CAMHD nor the Med-QUEST agency had information to support their assertions. Because the Med-QUEST agency has not reached an agreement with CAMHD over the capitation rate and services for these children, CAMHD has not been paid for any services since the new carve-out was implemented on July 1, 2001. Thus, it is impossible to assess which estimate is correct.

\(^7\)The University of Massachusetts is conducting this cost-effectiveness study, which should be completed in 2003 (Debra Farmer, Director for Special Education, DOE, personal communication, October 21, 2002). The Med-QUEST agency confirmed that it was holding discussions with DOE about the issue (Aileen Hiramatsu, personal communication, July 17, 2002).

\(^8\)Behavioral health services include substance abuse treatment, if a child’s Individualized Education Plan calls for that service (Aileen Hiramatsu, personal communication, July 17, 2002).
and coordination issues. Thus, an HMO might serve a low-end Felix-class child who also is receiving school-based services through DOE. Unless the child or a parent mentions the school services, the HMO’s providers have no way of knowing that two different systems are providing services (and, perhaps, even duplicative services).

According to HMO and state representatives, HMOs occasionally serve a high-end child who should be served by CAMHD. This situation might occur if the child is identified as a high-end Felix-class child after an HMO has begun providing services. The child is transferred to CAMHD after having been identified as a high-end-needs child, and the HMO can bill Medicaid above the capitation rate for the behavioral health services that it provided before the transfer occurred.

B. CARE COORDINATION FOR CHILDREN WITH MENTAL ILLNESS

The fact that three entities—DOE, CAMHD, and the HMOs—are involved in providing health care to children with mental illness leads to the question, do children with mental illness receive care coordination? After speaking with key stakeholders in Hawaii, we conclude that these children appear to be receiving some care coordination, and that high-end children clearly receive more care coordination services than do low-end children. However, communication problems as well as structural problems with the care coordination system itself mean that DOE and CAMHD typically coordinate only the child’s behavioral health care—coordination with a physical health care provider, such as a primary care provider or other specialist, rarely is provided.

1. Who Receives Care Coordination, and Who Provides It?

HMOs participating in QUEST must provide care coordination to their enrollees as a basic benefit, but the plans decide how they will provide this service (Aileen Hiramatsu, personal communication, October 29, 2002). Typically, HMOs provide care coordination to children with chronic illness; having SED would qualify, but children with SED are now considered high-end Felix children and are carved out of the HMOs to CAMHD for their mental health care. Because the Felix Consent Decree also mandated care coordination, both CAMHD and DOE provide care coordination services for the Felix children they serve. These children are not subjected to an “identification process” to determine which ones should receive care coordination services; rather, all Felix children are supposed to receive these services. Figure III.1 shows which agencies provide care coordination services to which children.

Although there are different models of care coordination, CAMHD, DOE, and, to some extent, Med-QUEST HMOs use the “service broker” model (Weil 1985; and Evans and Armstrong 2002). In this model, the care coordinator is a professional who is not a direct service provider. The care coordinator takes direction from the other professionals treating the child, keeps all stakeholders informed, schedules appointments, and helps the child to obtain necessary services.
High-end Felix children in the CAMHD system are assigned a care coordinator at their local Family Guidance Center. Family Guidance Center care coordinators must have at least a bachelor’s degree in psychology or in a related field. Their mandate is to coordinate a child’s mental health care services with every other entity that has contact with the child, so each coordinator must develop a coordinated service plan to cover all the entities a child might encounter, such as a child welfare officer, the schools, probation officers, early intervention services, the QUEST HMO, and the primary care provider. The care coordinator’s salary is low, and many respondents interviewed report that turnover is high. In addition, advocates reported problems with caseload turnover: care coordinators sometimes seemingly arbitrarily have given their patient caseloads to another coordinator. This type of switching fosters distrust, according to advocates, because children who have confided in one care coordinator subsequently are dropped and must establish a relationship with someone new.

DOE uses a variation of the service-broker model for low-end children in which it employs two people to fulfill the service broker’s role. The “care coordinator” is responsible for informing all involved parties about the child in question. This individual typically is the child’s teacher; however, the child’s parent may fulfill this role. The student’s Individualized Education Plan identifies the care coordinator, so everyone involved knows who the main point of contact is. The “student services coordinator” is responsible for procuring all services delineated in the Individualized Education Plan. Student services coordinators must be a “teacher-type”; most of them previously were special education teachers, regular education teachers, educational evaluators, or counselors (Debra Farmer, Director for Special Education, State of Hawaii Department of Education, personal communication, October 21, 2002). Each school is assigned

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9In 2002, Hawaii passed a law classifying all care coordinators as civil service workers (Mary Brogan, personal communication, July 11, 2002). It is possible that civil service requirements may affect eligibility for the care coordinator position.
only one or two student services coordinators, (depending on the size of the school), but every teacher in a school may function as a care coordinator.

HMOs’ care coordinators have various titles, but they usually are called “case managers.” Although standards vary from plan to plan, the minimum requirements for someone in this position typically include a bachelor’s degree in a health-related field, licensure as a health professional (such as a licensed nurse or certification in case management), and previous experience as a case manager for a health or human services agency. HMO staff whom we interviewed reported that most of their case managers were nurses, and that many of them held advanced degrees. Primary care providers also play a role in the care coordination process by linking patients to plan care coordinators and by providing referrals to other plan services.

HMOs’ care coordinators typically take on a case management role that is broader than the role of DOE’s and CAMHD’s care coordinators. Because they are medical professionals, in addition to linking children and their families with the providers of needed care, they are able to conduct assessments, develop service plans, and monitor and evaluate services delivered over time. We discuss the interaction of these care coordinators in detail in Section B.3.

2. What Training Do Care Coordinators Receive?

Within the system of care for Felix-class children, CAMHD offers and conducts “Cross-Systems Training” for CAMHD and DOE care coordinators, who are required to attend the training programs offered in this system annually. The classes are broken down into four broad categories, covering training in (1) disruptive behavior, (2) internalizing disorders, (3) assessment, and (4) other areas. They also are open to other system participants, such as clinical directors of Family Guidance Centers; CAMHD office administrators; DOE principals and vice principals; school counselors; student services coordinators; family court probation officers; and participants from provider agencies, such as paraprofessionals, mental health professionals, psychiatrists, and the provider agencies’ trainers, who can discuss the material with other provider staff. CAMHD is providing six classes for care coordinators for the period from September 2002 through February 2003.

After DOE became responsible for low-end children, in 2001, it began conducting in-house training for student services coordinators. In addition, the University of Hawaii offered an optional for-credit course covering the professional duties of the student services coordinator. This optional course was in high demand because DOE staff who earned continuing education

\[10\] CAMHD also offers additional training programs solely for CAMHD Family Guidance Center staff, including its care coordinators.

credits were able to move up the pay scale. DOE representatives lauded the course for helping the student services coordinators both to “take ownership” of their positions and to unite with DOE administrative staff in their new mission. Finally, Hawaii Families as Allies, which is a grassroots, parent-run advocacy organization, provides informative workshop training for all DOE employees on a variety of issues relevant to children with behavioral illnesses. The workshops have covered such topics as the impact of having a SED child in the classroom, understanding attention deficit hyperactivity disorder, and understanding obsessive-compulsive disorder (Vicky Followell, Co-Executive Director, Hawaii Families as Allies, personal communication, July 22, 2002).

HMOs vary in the types of training they provide for their care coordinators. Each plan conducts ongoing training, and each one also may use outside trainers from time to time to enhance its own continuing education efforts.

3. Do Entities Responsible for Care Coordination Work Together?

The Med-QUEST agency’s agreement with CAMHD requires CAMHD to coordinate care with the QUEST plans. Because CAMHD and the HMOs must communicate, respondents agreed that coordination between these entities is effective to some degree; at a minimum, the HMO is informed when one of its enrollees receives treatment. Even so, multiple respondents indicated that CAMHD’s care coordination is restricted almost entirely to the behavioral health services it provides. It also appears that coordination between CAMHD and HMOs is most evident when the HMO pays for the services (that is, for prescription drugs and inpatient services). Despite the ways that the CAMHD system is structured to facilitate communication and coordination with Medicaid managed care (in particular, the monthly list of enrollees who are receiving services through CAMHD and the central contact person at CAMHD), HMO staff reported that coordination still is difficult to achieve. Although they are able to learn the identity of a child’s CAMHD care coordinator, obtaining information from that individual on a regular basis is challenging. Furthermore, HMO staff also reported that the HMOs feel the responsibility for coordinating the care in these instances still remains with CAMHD; although the HMOs’ care coordinators review any progress notes forwarded to them by CAMHD and notify the primary care provider that a child is receiving treatment, the child is under CAMHD’s care, and CAMHD purportedly releases too little information on the treatment provided to enable the HMO to determine the child’s coordination needs.

DOE coordinates the services it provides. However, Hawaii has not required DOE and Med-QUEST to establish agreements about coordinating services with HMOs or primary care providers, and DOE has chosen not to initiate any such agreements on its own. Thus, the coordinated services and providers within DOE operate in a vacuum, outside the Medicaid program.

12 Hawaii Families as Allies also provides these courses to the general public through a contract with CAMHD (Vicky Followell, personal communication, July 22, 2002).
In addition to a lack of care coordination among the entities providing health services, coordinating care with other state agencies is also problematic. In some cases, for example, family court judges adjudicating child cases have dictated the level and type of services for a child even though other professionals would be better suited to evaluate the child’s needs. CAMHD staff also reported that they have encountered problems when trying to coordinate care with the child welfare agency. For example, CAMHD sometimes is asked to conduct an out-of-home placement for a Felix-class child who is in the foster care system (essentially performing foster care placement) even though CAMHD’s staff believes the child needs some other service.

The root of the communication problems among DOE, CAMHD, and the HMOs stems from the confidentiality issues surrounding children’s health records and health status. Several interviewed officials commented that state agencies have not been willing to share information because they are afraid they may breach the confidentiality rights of a minor, nor have they been willing to ask parents to release this information in order to better coordinate the child’s care. Furthermore, coordination issues have given rise to territorial issues concerning which state government agencies have responsibility for particular areas. Agencies are not always willing to cede power, even if passing on responsibility would be in the best interests of the children. As Table III.3 shows, the issue of overlapping and competing responsibilities for children’s issues applies to all the agencies serving children in Hawaii.

### Table III.3. Hawaiian Agencies Concerned with Children’s Issues

<table>
<thead>
<tr>
<th>Children’s Issue</th>
<th>Agency Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Med-QUEST (Department of Human Services)</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>Child and Adolescent Mental Health Division (Department of Health)</td>
</tr>
<tr>
<td></td>
<td>Department of Education</td>
</tr>
<tr>
<td></td>
<td>Med-QUEST (Department of Human Services)</td>
</tr>
<tr>
<td>Education</td>
<td>Department of Education</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Alcohol and Drug Abuse Division (Department of Health)</td>
</tr>
<tr>
<td>Child Welfare(^a)</td>
<td>Child Welfare Agency (Department of Human Services)</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>Office of Youth Services (^b) (Department of Human Services)</td>
</tr>
<tr>
<td></td>
<td>Juvenile Intake Branch (Family Court system)</td>
</tr>
<tr>
<td></td>
<td>Children and Youth Services Branch (Family Court system)</td>
</tr>
<tr>
<td></td>
<td>Detention Services Branch (Family Court system)</td>
</tr>
<tr>
<td></td>
<td>Crime Prevention and Justice Assistance Division (Department of the Attorney General)</td>
</tr>
</tbody>
</table>

\(^a\)Abuse and neglect issues, foster care, and adoption.

\(^b\)Services for youths at-risk for incarceration.
What is Hawaii doing to change this situation? Are there other actions that Hawaii can take to change it? The state recognizes that care coordination for children with mental illness does not operate smoothly, and it is actively seeking solutions to the problem. For example, for all Felix-class children, the various agencies serving children have agreed to participate in team meetings in which representatives from every state agency that has any interaction with the children try to resolve care coordination problems. (Representatives of HMOs do not attend these meetings.) The state also has established a “Policy Academy” of high-level state policymakers from the relevant agencies (DOE, DOH, DHS, the family courts, and the judicial system) that has been given a mandate to try to remove barriers to coordination.

At the same time, Hawaii recognizes that agencies generally are reluctant to share any information on children in their care that may adversely affect the confidentiality of the children’s records, and that, in the absence of open communication, it will not be able to make any progress toward removing barriers. The parties involved admit that both confidentiality issues and “turf” issues may be too big for the state to overcome.

4. Do All Children Receive the Care Coordination Services They Need?

QUEST plans believe that all of their members who need care coordination services are receiving them. The plans work with their primary care providers to provide EPSDT services for children, as required by federal law. In addition, they give the physicians feedback on the physicians’ performance in such areas as number of children receiving annual examinations, delivering immunizations on schedule, and so on. The plans’ care coordinators follow up on cases in need of care coordination, such as children with chronic illness. They admit that some children may not always receive all the coordination that is supposed to take place between the plans and CAMHD or DOE, but they also believe the responsibility for coordination lies with CAMHD and DOE, which are the primary providers. QUEST-enrolled children with mental illness seem to receive care coordination services from DOE and CAMHD, but respondents agreed that care coordination provided by these agencies is limited to coordination of the children’s behavioral health needs only.

However, it appears that some children in Hawaii do not receive the care coordination services that they need. According to those whom we interviewed, children with mental illness who are not in contact with the established systems of care are not receiving care coordination. In fact, it is likely that children in this group, which includes homeless children and “home/hospital children,” are not receiving any services. About 7 percent of Hawaii’s population is homeless (and another 17 percent is at risk for homelessness), compared with 0.3 percent of the population of the United States as a whole (Market Trends Pacific, Inc. 1999; and Burt et al. 1999). If we extrapolate national estimates of child homelessness to Hawaii, it would appear that one-quarter of the state’s homeless population—or about 20,000 children—probably is homeless. Typically, homeless people in Hawaii resist intervention, especially government intervention, because their homeless state embarrasses them, they fear the government might try to place their children in foster care, and they distrust authority, among other reasons (Debra Farmer, October 21, 2002).

Some DOE and CAMHD staff are assigned to seek out parents who are homeless. Their goal is to garner the parents’ trust, and to convince them to enroll their children in school or in
treatment, if necessary. These staff members report that the battle is an uphill and lengthy one because parents usually trust government workers only after repeated visits and guarantees that their children will not be removed to foster care. The fact that this population is highly mobile and often hard to find further increases the difficulty of the task.

Home/hospital children are children who receive their school instruction at home from public school personnel. According to DOE, a high percentage of children in the school system are members of this population, which includes any child with a medical verification of the need for the provision of educational instruction in the home or hospital setting, depending on the child’s location (State of Hawaii Department of Education 2003). Any child who will miss school for more than 2 weeks qualifies as a home/hospital child. While many home/hospital children might not be enrolled in QUEST, whether because they do not qualify for Medicaid or because they qualify for Medicaid under the SSI-related rules (a group that remains in Hawaii’s fee-for-service Medicaid program), the state believes some portion are QUEST enrollees. Although the department has not yet focused on how to conduct outreach to this group, DOE recently identified it as a target group in need of outreach and care coordination from the school-based behavioral health system (Debra Farmer, personal communication, October 21, 2002).

5. How Is the System Monitored?

At this time, the Med-QUEST agency is concerned primarily with whether children have access to good services. It monitors the services the HMOs and CAMHD provide (and will monitor DOE’s services if it enters into an agreement with that department), such as whether licensed professionals are used, how often children with various diagnoses receive services, and so on. According to Med-QUEST’s administrators, the agency does not monitor whether CAMHD and the HMOs coordinate care. However, the administrators also reported that, after the agency has determined whether services provision is operating well, it might assess care coordination in the future.

Both CAMHD and DOE perform extensive, integrated monitoring of the care they provide (including care coordination services), as required by the consent decree (Debra Farmer, personal communication, October 21, 2002). They conduct three main types of monitoring:

1. Internal Reviews. Files are pulled for 10 percent of the Felix-class students at each school. Trained reviewers assess the files against a protocol to determine what the

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13 Prior to the implementation of the CAMHD and DOE care system for Felix-class children, the QUEST specialized behavioral health plan conducted this type of outreach to homeless members with SED. It no longer does so because it is no longer the contractor for services to children with SED.

14 The department did not have the data on the exact number of home/hospital children.

15 The HMOs conduct their own internal monitoring as part of their quality improvement efforts.
student outcomes have been since the Individualized Education Plan first was implemented.

2. **Compliance Monitoring.** Two Individualized Education Plans are pulled for every teacher in every school to assess whether the plans are in compliance with the elements that the standard specifies must be in a plan.

3. **Core Area Monitoring.** These analyses examine a number of core areas annually to assess the schools' performance in each area. In the 2002-2003 school year, the focus areas include all complaints and due process cases, cases in which children are suspended for longer than 10 days, whether the schools are following the 60-day timelines established in the Individualized Education Plans, cases in which children who should receive services have not received any services during the preceding 30 days, and home/hospital children.

C. **SUMMARY**

With the introduction of managed care in its Medicaid program, Hawaii began formally covering care coordination services for children with mental illness. Initially, HMOs provided mental health benefits for most children, but children with SED were carved out to a specialized behavioral health plan, which was administered by the state children's mental health agency. Although plans could use their discretion to determine which children received care coordination, typically only children with SED who were served by the carve-out received the service. However, a consent decree concerning children with behavioral health problems has expanded care coordination services to all children who have a mental illness and who are served by the state's school system.

According to those whom we interviewed, some aspects of the care coordination system, such as coordinators' training and monitoring conducted by the school system and by the children's mental health agency, work quite well. However, the system has not resolved all its problems. Three entities—the HMOs, the school system, and the state agency for children with mental illness—provide care coordination services, and communication and coordination among them generally is weak or nonexistent. In some cases, the high turnover among care coordinators working for the children's mental health agency has created distrust in the children and their families, as has the shifting of caseloads from one care coordinator to another in a seemingly arbitrary manner. Hawaii is actively seeking solutions to these and other problems, but it admits that such issues as the importance of preserving the confidentiality of minors and interagency turf issues continue to pose challenges.
IV. MEDICAID MANAGED CARE AND CARE COORDINATION: STRUCTURE AND DELIVERY IN MARYLAND

This chapter presents our assessment of whether the Medicaid managed care program in Maryland has been able to provide care coordination for children with mental illness who are enrolled in the program. The structure of the chapter follows the one we used in Chapter III. As in Chapter III, we begin by describing the state’s Medicaid behavioral health benefits. We then examine the way that other state entities responsible for children interact with the managed care program and describe the locus of responsibility for care coordination in Maryland.

A. PROGRAM STRUCTURE FOR CHILDREN’s MENTAL HEALTH CARE

Maryland implemented HealthChoice, its Section 1115 Medicaid managed care demonstration program, in 1998. The goals of the program are to curb rising Medicaid costs and to provide a “medical home” for Medicaid recipients, who frequently rely on institutional providers (such as emergency rooms) for their care. The HealthChoice program requires almost all Medicaid beneficiaries to enroll in an MCO (Gold et al. 1999).1 At this time, six MCOs provide medical care; substance abuse treatment; and primary mental health services, which HealthChoice defines as services, such as for the treatment of depression, anxiety, or attention deficit disorder, that licensed physicians are able to provide in the scope of their practice (Gold et al. 1999).

From the program’s inception, all other mental health services (“specialty” services) were carved out from managed care and placed into a fee-for-service public mental health system managed by the Mental Hygiene Administration, a division of Maryland’s Department of Health and Mental Hygiene.2 Maryland combined its budget for state mental health services and Medicaid dollars to fund the public mental health system, in effect creating a new public mental health system that people in HealthChoice and uninsured people are able to access.

The Mental Hygiene Administration contracts with Maryland Health Partners (MHP), an administrative services organization wholly owned by Magellan Behavioral Health Care, to administer the public mental health system (U.S. Department of Health and Human Services 2002a). In addition, it has delegated the responsibility for planning, managing, and monitoring public mental health services to 20 Core Services Agencies, which are local mental health

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1The exceptions to this requirement are dual eligibles, qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, short-term Medicaid beneficiaries, short-term Medicaid eligibles with “spend-down” status, institutionalized individuals, and individuals enrolled in other Medicaid waiver programs (Gold et al. 1999).

2The Mental Hygiene Administration is one of six administrations in the department’s Public Health Services Division. Two others are the Alcohol and Drug Abuse Administration and the Developmental Disabilities Administration.
authorities (State of Maryland, Department of Health and Mental Hygiene, Mental Hygiene Administration 2002). Although these agencies do not provide services directly, they contract with mental health providers, including community mental health centers, mental health case management agencies, private providers, and residential treatment facilities.

HealthChoice gives all enrollees access to the specialty mental health services available in the public mental health system either through self-referral or through the referral of their primary care provider. All enrollees are automatically preauthorized to receive as many as 12 outpatient specialty mental health visits per year. During the visits, the mental health provider must make a diagnosis and must obtain authorization for additional treatment.

The specialty mental health services that the public mental health system provides treat such conditions as schizophrenia, psychoses, neurotic disorders, major depression, bipolar disorders, attention deficit disorder, and post-traumatic stress syndrome (Code of Maryland Regulations [COMAR] 10.09.70.10). These services are available to all HealthChoice enrollees authorized by MHP to receive care in the system, but certain services, such as respite services, mental health targeted case management (including care coordination services), psychiatric rehabilitation program services, and residential treatment services, are available only to a “priority population,” as shown in Table IV.1 (Maryland Health Partners 2000). The priority population consists of children younger than age 18 with SED and adults with serious and persistent mental illness (COMAR 10.09.45.01). Instead of using a specific assessment tool to classify children as having SED, Maryland defines children with SED as those having a DSM-IV diagnosis and a functional impairment that substantially interferes with their role or ability to function in the family, school, or community (COMAR 10.09.45.01). However, state mental health officials remarked that this definition is very broad and that it is not the definition of SED that limits access to services. Instead, they report that it is MHP’s use of medical necessity criteria and referral guidelines that limit access.

Three other agencies (the Department of Human Resources, the Department of Education, and the Department of Juvenile Justice) provide services to children with mental health and substance abuse problems. The Department of Human Resources oversees the care of children in out-of-home placements, such as foster care, kinship care, or adoption. It has its own case workers, who interact with each child receiving care. All children under the department’s care

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3There is one Core Services Agency for the city of Baltimore and one for each of Maryland’s counties with the exception of five rural counties (Caroline, Dorchester, Kent, Queen Anne’s, and Talbot) that share one Core Services Agency. Thus, there are 20 Core Services Agencies in total.

4Although preauthorization may be an effective mechanism to increase access to specialty mental health care, in a sense, it also may create a barrier to care coordination. Because enrollees are able to self-refer to specialty mental health services, their primary care provider may not be aware that they have sought treatment elsewhere. If the mental health provider does not communicate with the physician, the opportunity for coordination of care is lost. (However, enrollees whose condition can be treated successfully in 12 or fewer visits may not need care coordination services.)

5We do not discuss adults here because this report focuses on children.
Table IV.1. Covered Behavioral Health Services for Children in Maryland’s HealthChoice Program

<table>
<thead>
<tr>
<th>Inpatient Services</th>
<th>Children Without SED</th>
<th>Children with SED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>Covered, but not in managed care—remain in fee-for-service</td>
<td></td>
</tr>
<tr>
<td>Primary mental health services</td>
<td>Covered under managed care</td>
<td></td>
</tr>
<tr>
<td>Specialty mental health services</td>
<td>Partial hospitalization services, emergency room services, mobile treatment services, supported employment services, enhanced support services, home health psychiatric services, residential crisis services, occupational therapy services, interdisciplinary team treatment planning, outpatient mental health services, intensive outpatient treatment services, urgent care services, psychological testing services, hospital consultation services, and nursing home psychiatric consultations</td>
<td></td>
</tr>
<tr>
<td>Remain in fee-for-service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Outpatient Services</td>
<td>Not available</td>
<td>Residential treatment services, respite services, mental health targeted case management, psychiatric rehabilitation program services, and residential rehabilitation program services</td>
</tr>
</tbody>
</table>

are automatically eligible for the HealthChoice program and may receive care through the public mental health system. The Department of Education provides school-based mental health services through its Pupil Services Teams. The Department of Juvenile Justice provides services for children in its residential facilities. (Detained children lose their Medicaid eligibility.) Under a new agreement between the Department of Juvenile Justice and the Mental Hygiene Administration, all adolescents entering the juvenile justice system will be provided with mental health screening, assessment, and diagnostic and treatment services. Currently, only the screening portion of this plan has been implemented, but the three-year interagency agreement calls for the development of a plan, the details of which have not yet been defined, to provide and pay for mental health treatment services for adolescents in detention.

B. CARE COORDINATION FOR CHILDREN WITH MENTAL ILLNESS

Maryland has several mechanisms designed to coordinate care for children with mental health problems and for those with substance abuse problems. Unfortunately, our interviews found that virtually none of these mechanisms is functioning properly, and the ones that are functioning still have significant problems. In effect, therefore, children with mental illness who are enrolled in HealthChoice do not receive adequate care coordination.
1. Who Receives Care Coordination, and Who Provides It?

Children with mental illness who do not have SED qualify for care coordination through their MCO only if they have another high-risk or high-cost illness that the MCO is responsible for treating, such as a substance abuse problem, mental retardation, or developmental disability.

Children with SED who participate in HealthChoice can access care coordination services in two ways. First, providers (such as community mental health centers, residential treatment centers, and other private providers) are supposed to provide care coordination as part of the treatment they provide. Providers receive a higher payment rate for children under the public mental health system than for adults. In exchange for receiving a higher payment rate for children, Maryland requires the children’s mental health care providers to coordinate and manage their patients’ care. In particular, providers’ services should include “assistance in securing entitlements, coordination of services, and liaison with external services (somatic and mental health)” (Maryland Health Partners 2001a).

Second, MHP offers targeted case management, which should include care coordination services, as a covered service under the public mental health system. Targeted case management services are provided by a mental health case manager and are available only from designated mental health case management agencies that the Core Services Agencies have selected. Children with SED may be referred to targeted case management by an MHP care manager or by a Core Services Agency child and adolescent coordinator. The MHP care manager’s role is to “assist service providers in delivering an integrated community-based treatment program even though services may be delivered by several service providers and systems of care” (Maryland Health Partners 2001a). The MHP care manager acts as a gatekeeper, authorizing and coordinating mental health services within MHP. For example, the care manager may attend conferences or meetings with the school system or juvenile justice system to discuss and plan for a child’s care (Maryland Health Partners 2001a). Each Core Services Agency employs a child and adolescent coordinator to coordinate services for children with mental health needs, not for individual children with mental health needs, but for all children in the community. They develop plans at the county level and serve as a member of relevant committees. Figure IV.1 shows which entities provide care coordination to which children.

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6One such committee is the Local Coordinating Council, which develops and implements plans of care for residential placement or for alternatives to residential placement for children with special needs (who may or may not participate in HealthChoice) (COMAR 01.04.01.02). Maryland has 20 Local Coordinating Councils, which are sponsored by Maryland’s Office of Children, Youth and Families. A State Coordinating Council oversees the operations of all the local councils and monitors the provision of residential placement services to children with special needs. Each council consists of representatives of the Mental Hygiene Administration, Department of Juvenile Justice, Developmental Disabilities Administration, Alcohol and Drug Abuse Administration, local board of education, local health department, local department of social services, local Core Services Agency, and the local management board. Like the Core Services Agencies and Local Coordinating Councils, Maryland has 20 local management boards, which receive funding through the Office of Children, Youth, and Families and are responsible for coordinating child and family services in their jurisdiction.
MHP has developed a series of communication tools and policies to facilitate communication between mental health providers and primary care providers. MHP has produced and distributed a videotape to the MCOs to help the physicians better understand the role of the public mental health system, the purpose of mental health screening, and how to make referrals to MHP (Maryland Health Partners 2001b). In addition, after MHP has authorized patients to receive services, it sends letters to the patients' physicians that list the treating provider's name, the type of services authorized, and the time period during which the authorization is effective. MCOs are required to submit lists of their enrollees electronically to MHP, and MHP periodically notifies the MCOs electronically which of their enrollees are receiving services through the public mental health system (Maryland Health Partners 2001b). MHP also expects mental health providers (with the enrollee's consent) to communicate additional information on the enrollee to the primary care provider. Finally, MHP is required to periodically review medical records for evidence of coordination of medical and mental health care.

Despite the presence of these services and tools, there are problems with the care coordination that MHP and the public mental health system provide. First, mental health case management agencies have difficulty retaining their case management staff. The average tenure for a mental health case manager is only about one year. Each case manager is responsible for only about 12 children, so heavy caseloads do not appear to be the cause of turnover. Although the case documentation system they use reportedly supports continuity of care from one case

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7Enrollees who have used their 12 preauthorized visits or who require a service, such as residential treatment services, that can be accessed only by the “priority” population, require authorization to receive services through MHP.
manager to the next, new case managers do face a learning curve that limits their effectiveness and productivity. Second, as reported by a manager of a mental health case management agency, MHP authorizes targeted case management services for six months, but it rarely grants a request to reauthorize this service. Case managers usually arrange for children to receive “psychiatric rehabilitation services,” which include in-home interventions, life-skills training, in-home behavioral modification, and after-school programs. However, MHP considers case management to be unnecessary for a child who receives psychiatric rehabilitation services (Maryland Health Partners 2001a). Thus, after the child has begun to receive these services, MHP does not permit the case manager to follow up to determine whether the services meet the child’s needs. It is possible that MHP assumes providers of psychiatric rehabilitation services will take on the role of care coordinator. However, there is no evidence that these providers receive any training in care coordination, nor do they have any incentive to refer a child to any other type of service provider.

MCOs do not have a care coordination role for children with SED (because services for children with SED are carved out to a separate system), but the MCOs’ special needs coordinators may act in this capacity by acting as a conduit to coordinate information between MHP and the MCOs.

Care coordination services for children with mental illness also are available through the Department of Education’s Pupil Services Teams, which have been in place at every public school in the state since 1988. The purpose of these teams, whose members are health personnel, mental health personnel, guidance counselors, administrators, and teachers, is to identify and meet students’ mental health, physical health, emotional, and social needs. The teams accomplish this goal by providing case management to individual students, and by planning and intervening to address the needs of specific groups of students. As far as we could determine, however, the teams’ care coordination activities do not cover care provided by HealthChoice MCOs.

A child who is involved in an out-of-home placement receives care coordination services from Department of Human Resources caseworkers. However, a respondent from the department reported that the caseworkers do not always follow up adequately with mental health providers. When a mental health provider develops a treatment plan for a child, the child’s Department of Human Resources caseworker is responsible for following up with the provider to understand both the elements of the plan and his or her role in helping to ensure that the plan is carried out. Because the Department of Human Resources last provided training on following up with mental health providers in 2000, the very high caseworker turnover rate means that few of the caseworkers currently working for the department have received this training.

2. What Training Do Care Coordinators Receive?

Case managers providing MHP-covered targeted case management must meet one of the following minimum education and training requirements: (1) a master’s degree in a mental health field, (2) a bachelor’s degree in a mental health field and one year of mental health experience, (3) a master’s degree in an unrelated field and one year of mental health experience,
or (4) a bachelor’s degree in an unrelated field and two years of mental health experience (COMAR 10.09.45.01). In addition, case managers must satisfactorily complete either a state-approved training program or an approved program developed by a mental health case management agency (COMAR 10.09.45.03). A representative of one of these agencies reported that most of the agency’s case managers have bachelor’s degrees.

The Mental Hygiene Administration trains the mental health case managers to follow the “brokerage model” of case management, which focuses on addressing an individual’s need for specific services. The MHP officials with whom we spoke indicated that the targeted case management services it covers were designed to assist adults with mental health problems in accessing housing and similar services. They conceded that children with mental health problems and adults with mental health problems have different needs, and that the brokerage model may be less effective when applied to these children. They also commented that it would be worthwhile to examine the use of a clinical case management model, which focuses on an individual’s overall needs for medical and mental health services, educational services, and social supports.

3. Do Entities Responsible for Care Coordination Work Together?

In our interviews, we found few examples of cooperation among the agencies responsible for coordinating the care of children with mental health needs; furthermore, limited financial and staffing resources exacerbate the coordination problems. In fact, the respondents whom we interviewed cited numerous examples of a lack of coordination. For example, they cited coordination problems among the different divisions of the Department of Health and Mental Hygiene, which apparently communicate and cooperate to only a limited extent. A high-level staff member at the Mental Hygiene Administration, the key state agency responsible for HealthChoice, believes that the administration has been better able to coordinate policies and services with agencies outside the Department of Health and Mental Hygiene than within it. This problem affects children with co-occurring disorders of mental illness and substance abuse problems or developmental disabilities, who are served through agencies in the Department of Health and Mental Hygiene other than the Mental Hygiene Administration. The staff member further commented that the administration has had difficulty providing services in HealthChoice for children who have been dually diagnosed with mental health and substance abuse problems, so much so that substance abuse services conceivably could be carved out to MHP. This staff member also noted that the department also has problems coordinating care for children who have both mental health problems and developmental disabilities.

Coordination problems also exist at the provider level. For example, although mental health providers are expected to provide care coordination services as part of the standard of care, respondents indicated that they often fail to do so. Respondents who were providers or

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8This section does not describe the training or qualifications for employment of the MCOs’ special needs coordinators because these staff are not the primary care coordinators for children with mental health needs. Children with mental health needs receive treatment through the public mental health system.
advocates believe that the public mental health system’s payment rates are too low, so that providers do not have an incentive to put any effort into care coordination—the providers have difficulty covering their costs, let alone provide care coordination in addition to treatment. Moreover, paying for care coordination in this manner, rather than establishing a separate payment for the service, disregards care coordination as an integral part of successful treatment (Blue Ribbon Task Force on Mental Health 2002).

Another payment issue that exacerbates efforts to coordinate care is that the public mental health system operates on a fee-for-services basis, but the mental health case management agencies receive a monthly fee for targeted case management. In order to bill for case management services, the agencies are required to provide two case management visits per month. However, the amount of the monthly fee is approximately equal to the cost of providing the two visits. Because mental health case management agencies do not have an incentive to provide any more than the two required visits, respondents indicated that they provide as few case management visits as possible, rather than the number of visits necessary to effectively implement a plan of care based on a child’s identified needs.

Problems with care coordination go beyond payment issues, however, extending to difficulties between the MCOs and MHP. Respondents indicated that the MCOs have had difficulty establishing communication between their special needs coordinators and MHP. Early in the public mental health system program, MCOs’ special needs coordinators would contact MHP to obtain information about their enrollees. The MCO respondents with whom we spoke believed that, because of confidentiality concerns, either the mental health providers or MHP (or both) were unwilling to share information unless the enrollee in question had signed a release form for each information request. This requirement severely limited the ability of the MCOs and their primary care providers to coordinate care. After more than a year of study, Maryland’s Attorney General ruled that the MCOs had a right to access information from MHP without first obtaining signed releases from patients. MHP subsequently developed a password system that the special needs coordinators were to use when requesting information. The password system has not been smoothly implemented, however, and the special needs coordinators still find it difficult to obtain information from MHP. Although the MCOs, MHP, and the Mental Hygiene Administration have put considerable effort into improving communication, confidentiality concerns have proved to be a major barrier to communication.

Four years after implementation of the HealthChoice program, data exchange between MHP and the MCOs still is insufficient, according to multiple respondents. To address this problem, MHP and the MCOs hold monthly meetings to discuss data issues, but progress has been slow; the extent of data sharing between these entities in 2002 remains about the same as it had been in 1999. In addition, FirstHealth, the pharmaceutical benefits manager for the public mental health system, does not contribute information about prescriptions filled for psychiatric medications into the datafile that the MCOs access. As a result, the MCOs cannot inform their primary care providers about the psychiatric medications their patients are taking. To obtain this information, the primary care providers would have to contact the mental health provider directly, but little, if any, contact between these providers seems to take place.

The MCOs (including their primary care providers and special needs coordinators) and MHP (including its mental health providers and case managers) have other care coordination
problems as well. Although Maryland’s Code of Regulations requires that these entities communicate with each other, our interviews revealed that, in practice, they do not appear to do so. In addition, several respondents were of the opinion that primary care providers, mental health providers, and case managers are not particularly interested in coordinating care between the medical and mental health systems because none of them has any incentive to seek the information necessary to coordinate care.

Despite these problems, several initiatives indicate that agencies may be more willing to work together. First, under a new agreement, MHP now provides mental health services to children in Maryland’s foster care system. To facilitate the provision of this service, MHP has trained all foster care workers on how to access mental health services. Second, the Mental Hygiene Administration is working with the Department of Juvenile Justice to identify children with mental health needs who are in the juvenile justice system. Although the Department of Juvenile Justice is paying for the screening costs, the public mental health system will have to pay for the cost of the children’s care. Third, the Mental Hygiene Administration and the Maryland Coalition of Families for Children’s Mental Health are working on a joint initiative to develop a “blueprint” for children’s mental health. This plan will propose changes in the public mental health system to improve the care available to all children who need mental health services, especially those enrolled in HealthChoice.

4. Do All Children Receive the Care Coordination Services They Need?

It appears that access problems limit the availability of care coordination services for certain groups of children with mental illness. For example, some children with mental health needs also require services to address their mental retardation, developmental disabilities, or substance abuse problems. Others may have been the victims of physical or sexual abuse or the perpetrators of such abuse. Respondents believed that care coordination services are available for these children, but that access to providers may be limited in some of the more rural parts of the state. They agreed that targeted case management services would be available to children in this population who met the requirements of the SED classification. Furthermore, the carve out of mental health services into a separately administered fee-for-service system has hindered the coordination of care for children with dual diagnoses, because treatment is delivered in two separate systems.

5. How Is the System Monitored?

The structure of the public mental health system requires that system monitoring take place, but few details are available on what is measured, and little data exists to document this measurement. The Core Services Agencies are required to monitor MHP’s compliance with its contract, and to report this information to the Mental Hygiene Administration. The Mental Hygiene Administration, in turn, is required to monitor the performance of the Core Services Agencies. The Mental Hygiene Administration declined to provide us with either data on the number of children with SED receiving case management services through the public mental health system or any information on the effect of these services on the children’s satisfaction or outcomes of care. One respondent indicated that the Mental Hygiene Administration does not
have adequate staffing resources to perform data analyses or to generate monitoring reports and summaries.

MHP has assessed consumer satisfaction with the public mental health system and has documented these outcomes in several reports, the two most recent of which were released in 2000 (Oliver and Johnson 2000a and 2000b). None of its reports, which were based on surveys of adults and children (through an adult proxy) who were using the system's services, asked direct questions about coordination of care or about case management services. However, one survey asked the adult caregivers of children receiving services whether their child had any unmet mental health needs (Oliver and Johnson 2000a). Thirty-nine percent of the survey's respondents felt that their child had an unmet need for medication, counseling, help obtaining insurance coverage, transportation, in-school services, health services for behavioral problems, or help accessing services.\(^9\) Care coordination has the potential to address many of those unmet needs. In an appropriately implemented care coordination system, a care coordinator's initial assessment would identify and document an individual's unmet needs. The care coordinator would then develop a plan of care and would arrange for the provision of services to address the needs. Finally, the care coordinator would monitor the individual's progress to ensure that services were being delivered as planned, and that the individual's condition and functioning were improving.

C. SUMMARY

HealthChoice, Maryland's Medicaid managed care program, has carved out specialty mental health services to a fee-for-service public mental health system, but that system has placed little emphasis on care coordination for children with mental illness. Although targeted case management is a covered benefit available to children with SED, respondents indicated that the way in which this service is delivered and the rules governing its reimbursement appear to severely limit its effectiveness. It may have been unrealistic to structure provider payment rates with the expectation that providers would devote a portion of their payment to providing care coordination. Furthermore, mechanisms to improve communication and to facilitate data exchange among providers have been poorly designed and implemented. A few new initiatives seem to indicate that state agencies have become more willing to work together to improve services for children with mental health needs. However, these initiatives require high-level interest and significant financial support in order to sustain them over periods of political transition and slow economic growth.

\(^9\)It is important to note that this survey includes children who receive care through the public mental health system, but who are not Medicaid beneficiaries. These children may have more unmet needs because they do not have access to the same non-mental health services as the Medicaid population does.
V. MEDICAID MANAGED CARE AND CARE COORDINATION: STRUCTURE AND DELIVERY IN TENNESSEE

In this chapter, as in Chapters III and IV, we assess whether the managed care design implemented in Tennessee's Medicaid program has helped to provide care coordination for children with mental illness who are enrolled in Medicaid managed care. In this chapter, we provide background on the structure of behavioral health services in Tennessee's Medicaid managed care program and then examine how care coordination services are provided for children with mental illness.

A. PROGRAM STRUCTURE FOR CHILDREN'S MENTAL HEALTH CARE

TennCare, Tennessee's Medicaid managed care program, began operating in 1994 with the goal of providing health care benefits to Medicaid beneficiaries, people without health insurance, and people whose medical conditions made them uninsurable (U.S. Department of Health and Human Services 2002b).\textsuperscript{1,2} During the program's first two years, MCOs provided all acute care mental health and substance abuse services, and the care of children with SED and of adults with serious and persistent mental illness was carved out to fee-for-service providers. However, after two years, Tennessee implemented the TennCare Partners program, which carved out all mental health and substance abuse treatment services for all TennCare enrollees to managed BHOs; the expectation was that BHOs would be better able to serve enrollees in need of mental health or substance abuse treatment (Hoag 2001). To fund TennCare Partners, the state combined some TennCare funds with all state mental health funds.

The TennCare Bureau, a state agency in the Department of Finance and Administration, always has had administrative responsibility for TennCare. However, the Tennessee Department of Mental Health and Developmental Disabilities, as the lead state agency for mental health policy and program funding, recently has been given a program oversight role. For example, although the TennCare Bureau approves all contract provisions, that department now contracts with the BHOs for the TennCare Partners program (Dougherty and Boughtin 2002). A memorandum of understanding between the two agencies, implemented in 2000, has helped to clarify each agency's role in TennCare Partners (Dougherty and Boughtin 2002).

\textsuperscript{1}Enrollment in TennCare was mandatory for all Medicaid beneficiaries, including elderly, blind, disabled, and dually eligible Medicare/Medicaid enrollees. Qualified Medicare beneficiaries, qualified disabled working individuals, and state low-income Medicare beneficiaries were the only Medicaid participants who were exempt from mandatory enrollment (Wooldridge et al. 1996).

\textsuperscript{2}Enrollment by people who were uninsured or uninsurable (people in the expansion group) was not limited by income; however, expansion-group members with family income above the federal poverty level had to share in the costs of their coverage (Wooldridge et al. 1996).
Under the TennCare Partners program, two BHOs provide services and receive monthly capitation payments for each enrollee. The BHOs' provider networks include all five state-operated regional mental health institutes, the community mental health centers, and a variety of other mental health practitioners, including many in private practice.

When TennCare Partners was implemented, enrollees were divided into two groups consisting of "basic" participants and "priority" participants, and providers received a higher capitation rate for enrollees in the priority group. Priority participants were children with SED and adults with serious and/or persistent mental illness (the latter are not discussed in this report, however). Table V.1 presents Tennessee's requirements for qualification for an SED designation.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral for Assessment</td>
<td>By plans, providers, or family members</td>
</tr>
<tr>
<td>Assessment</td>
<td>By staff of case management agencies, community mental health centers, or regional mental health institutes</td>
</tr>
<tr>
<td>Required Conditions for SED Status</td>
<td>TPG 2 assessment, which requires a valid DSM-IV diagnosis, excluding substance abuse disorders (DSM-IV ranges 291.00-292.90 and 305.90), developmental disorders (DSM-IV ranges 299.00-299.80, and 315.00-319.00), or V-codes (DSM-IV V15.81-V71.09) and at least one GAF score &lt;51 in the last six months</td>
</tr>
<tr>
<td>Reevaluations</td>
<td>Every six months</td>
</tr>
</tbody>
</table>

**Source:** Vogel 2001; and Bill Fletcher, Director, Research and Analysis, Office of Managed Care, Tennessee Department of Mental Health and Developmental Disabilities, personal communication, March 14, 2003.

GAF = Global Assessment of Functioning, an interviewer-rated instrument that enables a trained professional to assess the severity of a child's mental illness; TPG = Target Population Group.

The basic benefit package provided standard episodic care services, whereas the priority package provided an expanded group of services to enrollees who were the most severely ill. Thus, such services as 24-hour residential treatment, psychiatric rehabilitation, and mental health case management were available only to priority participants.

3Magellan Behavioral Health owns Tennessee Behavioral Health, Inc. and 50 percent of Premier Behavioral Health Systems of Tennessee (Paul Miller, TennCare Partners Program Director, personal communication, July 9, 2002).
Tennessee's Department of Children's Services provides services to children who are in the custody of the state or are at risk for being placed into custody because of delinquency or family abuse or neglect. Many of these children need mental health care. Historically, the department conducted its own case management activities and operated its own network of health care providers. However, as of October 1, 2001, TennCare has required the BHOs to provide mental health case management services for children in the department's custody.

In 1998, parents and guardians of TennCare-enrolled children filed a class action complaint in U.S. District Court against TennCare, the Tennessee Department of Health (the home of the TennCare Bureau at that time), and the Department of Children's Services. *John B. v. Menke* charged that officials of the agencies were responsible for, but failed to provide, EPSDT services and necessary medical and mental health services to children in state custody or at risk for entering state custody, as required by Medicaid.

Under a consent decree resulting from the complaint, the entities responsible for health, education, and social services now are required to coordinate their activities (United States District Court for the Middle District of Tennessee at Nashville 1998). In addition, the consent decree states that Tennessee must implement clinical case management services that (1) address the needs of children, and (2) are not used as a tool for prior authorization.

The consent decree specified several administrative and policy changes. For example, the requirement that a child must have received a designation of SED in order to receive "enhanced" mental health benefits has been eliminated. (TennCare has retained the SED/non-SED classifications for data tracking and reporting purposes. As of July 30, 2002, 4.2 percent of the 620,838 children younger than age 18 who were enrolled in TennCare were classified as having SED [Bill Fletcher, personal communication, March 14, 2003].) Now, all children are entitled to receive any medically necessary mental health service (United States District Court for the Middle District of Tennessee at Nashville 1998). The state now pays BHOs a single capitation rate that is slightly higher than the rate the BHOs received for providing care to "basic" participants, but this change in the payment structure has not resulted in lower payments to providers overall. Table V.2 reflects the current benefit structure.

![Table V.2. Covered Behavioral Health Services for Children in the TennCare Partners Program](image)

<table>
<thead>
<tr>
<th>Inpatient Services</th>
<th>Children Without SED</th>
<th>Children with SED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available as medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Available as medically necessary</td>
<td></td>
</tr>
<tr>
<td>Other Services</td>
<td>Psychiatric pharmacy and pharmacy-related laboratory services, transportation for enrollees lacking accessible transportation, specialized crisis services, mental health case management services, 24-hour residential treatment, housing/residential care, specialized outpatient and symptom management, psychiatric rehabilitation</td>
<td>All available as medically necessary</td>
</tr>
</tbody>
</table>
B. CARE COORDINATION FOR CHILDREN WITH MENTAL ILLNESS

Consistent with the conclusions of the court, most of the respondents we interviewed confirmed that while policy-level mechanisms to coordinate care do exist, their presence does not ensure coordination at the service-delivery level. For example, since the inception of the TennCare Partners program, the BHOs have required the community mental health agencies with which they contract to adhere to the guidelines of the BHOs' "Supervised System of Care," a system that defines a formal communication process among providers. In addition, each community mental health agency must develop a quality monitoring plan to monitor and evaluate the services it provides. However, the majority of respondents we interviewed believed that these policy-level mechanisms do little to ensure meaningful communication among providers to coordinate care for individual children.

1. Who Receives Care Coordination, and Who Provides It?

As mandated by the courts, all children enrolled in TennCare Partners are entitled to receive any medically necessary mental health service. In TennCare Partners, care coordination falls under the case management service, which is a covered benefit; the program covers three types of case management services for children: (1) mental health case management, (2) continuous treatment teams, and (3) comprehensive child and family therapy (see Figure V.1).

Mental health case management, the least intensive level, is designed for children with multiple needs who require services from more than one agency, and for children with one or more risk factors, such as a history of inadequate parenting, a history of child abuse or neglect, or living in poverty. The majority of children receiving case management receive this level of care. Either the community mental health centers or two mental health case management agencies, located in Nashville and Memphis, provide the service; BHO preauthorization is not required. Children receiving mental health case management usually are referred by outpatient therapists and inpatient facilities, although some referrals may originate with the children's families. The contractually required caseload is an average of 1 case manager to 30 (Tennessee Department of Mental Health and Developmental Disabilities 2001). As of October 2001, 6,204 children under age 18 were receiving mental health case management services (Bill Fletcher, personal communication, March 14, 2003).

Continuous treatment teams consist of community mental health center psychologists, psychiatric nurses, and case managers. A continuous treatment team is an intensive service requiring BHO preauthorization. It is provided to children who are at imminent risk for out-of-home placement, including placement to a psychiatric hospital, or who have multiple care needs from multiple agencies, and it often includes a medical component. Children are enrolled in a continuous treatment team for an average of six to eight months. TennCare Partners does not mandate limits on caseloads for this service, which average approximately one caseworker for every five children (John Page, Senior Vice President for Children, Youth, and Family Services,
Comprehensive child and family therapy is the most intensive type of case management service provided to children who are at imminent risk for out-of-home placement or who have multiple, complex care needs. Youth Villages is the state’s only authorized provider of this service, and BHO preauthorization is required. Children are enrolled in this type of case management for an average of three to four months. As with the continuous treatment team service, caseloads are not stipulated; caseloads average 1 caseworker for every 10 children (Barbara Grunow, Director, Youth Villages, Nashville, personal communication, January 14, 2003). In April 2002, 153 children were receiving this service (Ellen Wilbur, personal communication, July 18, 2002).

4Centerstone is a nonprofit behavioral health corporation that operates six community mental health centers and treatment facilities in Tennessee.
State officials described three mechanisms which they believe help to coordinate care for children with mental illness. First, the contracts between the Department of Mental Health and Developmental Disabilities and the BHOs require the BHOs’ and MCOs’ providers to coordinate their services through case management, and to ensure continuity of care. Second, mental health providers are required to fax a form to their patients’ primary care providers that communicates the patients’ diagnosis, medications, and treatment plan. Finally, communication between the mental health providers and all other providers of medical, mental health, or other services is supposed to be documented in the progress notes of patients’ medical records. The BHOs monitor compliance with the latter two processes during their annual on-site visits to provider offices.

However, respondents whom we interviewed indicated that the care coordination provided by the more intensive levels of case management (continuous treatment teams and comprehensive child and family therapy) appear to be more effective than the care coordination provided by the least intensive level (mental health case management), largely because the case managers for the former levels are more experienced and have lower caseloads. They also identified four factors that prevent case managers, especially those providing mental health case management, from effectively coordinating care for children with mental health needs. First, because case management now is offered on the basis of medical necessity, providers appear to be reluctant to refer children with less-acute mental illnesses for that service. Second, few community mental health centers have made care coordination a priority. As a result, according to the respondents, these centers may not train case managers adequately, and they may not evaluate the case managers’ performance on the basis of their ability to coordinate care across providers. The respondents also reported that mental health case managers coordinate services and communication among providers within their own community mental health centers effectively, but that they are unable (or unwilling) to coordinate care with outside providers or agencies.

Third, as discussed in detail in the next section, respondents believed that case managers do not have the background or experience to perform their role effectively. Finally, they also believed that caseload limits were not enforced, leading to overwhelmingly high caseloads.

2. What Training Do Care Coordinators Receive?

Although case managers are required to have a bachelor’s degree in a “related” field, respondents indicated that the requirement is interpreted very broadly. Furthermore, most case

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5Section 3.4.3.3 of Amendment 3 of the current BHO contract states that the BHO should expect primary care physicians from the MCOs to contact them for consultation about any covered mental health or substance abuse condition or service. In addition, primary care physicians are encouraged to refer to the BHO for coordination of the treatment of any covered mental health or substance abuse condition and service when those services can be provided by mental health professionals (Tennessee Department of Mental Health and Developmental Disabilities 2002).
managers are recent college graduates who have little or no case management experience, nor do they understand the service needs of children with mental health problems.

The Department of Mental Health and Developmental Disabilities sets the requirements for case manager training in its contracts with the BHOs, and community mental health centers or the case management agencies (with which the centers can contract to provide the service) provide the training. Within 60 days after the start of their employment, case managers are required to demonstrate competence in 24 areas of knowledge (such as crisis intervention and resolution, assessment of support systems, and service planning and monitoring). The BHOs have established a system to monitor this requirement.

The caseload for mental health case management is supposed to be no more than 30 clients per case manager. Some respondents indicated that caseloads are often substantially higher than this limit. One BHO representative with whom we spoke indicated that they rigorously enforce the caseload limit, but that some community mental health agencies try to circumvent the limits. Respondents indicated that case manager burnout and turnover are serious problems caused in part by caseloads substantially larger than the limit. According to some respondents, the average tenure for case managers is less than one year.

Given their limited experience and training, respondents believed that case managers are likely to have difficulty understanding the requirements of their job and the needs of their clients. Similarly, high caseloads would prevent them from devoting the time and attention necessary to manage the complex needs of children with acute mental illnesses or SED. To compound these problems, low salaries make it difficult for agencies to attract more-qualified candidates and provide no motivation for case managers to remain in their positions for the long term. Together, these factors greatly limit the effectiveness of mental health case management services, including care coordination, in TennCare.

3. Do Entities Responsible for Care Coordination Work Together?

As a result of the consent decree, TennCare entered into agreements with the Departments of Mental Health and Developmental Disabilities, Children’s Services, and Education that specify each agency’s responsibilities with respect to children they serve jointly. Coordination was further formalized by the creation of a new office, the Deputy to the Governor for Health Policy, that is responsible for the Children’s Health Initiative; this program is charged with coordinating EPSDT compliance, and with adjudicating disagreements among the agencies, as specified in the consent decree.

However, the respondents we interviewed believed that cooperation has been an elusive goal and the attempts of the consent decree to force cooperation have not been wholly successful. The defendants filed a motion requesting that the enforcement of the agreement be stayed, and that the agreement be modified. In January 2001, the plaintiffs (parents and guardians of TennCare-enrolled children) filed a motion requesting that the state be found in contempt for failing to carry out the agreement. In the case (John B. v. Menke), the court stated that, although Tennessee appears to recognize the need for coordination among agencies, the office of the Deputy to the Governor for Health Policy is powerless to coordinate care because it does not
have the authority to control the actions of the BHOs or the MCOs (United States District Court for the Middle District of Tennessee at Nashville 2001). Many respondents believed that, while care coordination has improved, there is still a considerable amount of work to be done to ensure that all children receive the care they need. Moreover, the court also found the case management provided under TennCare to be insufficient and many of the most severely ill children to lack case managers. Because referral to this service is easily accessed, the finding seems to indicate either that many providers and families are unaware of the availability of case management services or that other factors prevent the providers and families from obtaining these services.

In response to its findings in John B. v. Menke, the court called for the appointment of a Special Master charged with both mediating among the parties and drafting an EPSDT-compliance plan for providing medical and mental health services to TennCare enrollees and other Medicaid-eligible people younger than age 21. The Special Master was appointed in February 2002, and the court will hold periodic hearings to monitor the progress of the agreement’s implementation (Gordon Bonnyman, Managing Attorney, Tennessee Justice Center, personal communication, November 8, 2002).

The lack of cooperation among agencies manifests itself in many ways. For example, respondents reported that mental health case managers do not usually interact with the school system, and are seldom involved in developing Individualized Education Plans for special needs students. While one mental health center is known to actively places case managers in the schools, several respondents stated that this approach is not the norm. Some respondents indicated that mental health case managers are not given information during training about resources available outside their community mental health centers that might benefit children with mental health needs. In addition, the mental health case managers usually do not become involved with the juvenile justice system unless they are specifically asked to do so. Children under the care of the Department of Children’s Services have a second case manager, to coordinate the child’s interactions with the court system. While having two case managers is promoted by the Department of Mental Health and Developmental Disabilities, since many of the functions of these case managers are distinct, several respondents indicated that considerable overlap in responsibilities exists between these two coordinators, and moreover, that communication between the two departments’ case managers is often poor.

Despite this lack of cooperation, certain signs suggest that care coordination may improve. First, in a new initiative, the Bureau of Alcohol and Drug Abuse Services is conducting cross-training of its staff with staff from the Department of Mental Health and Developmental Disabilities. Cross-training to familiarize staff from one area with the policies and procedures of the other is intended to better equip these staff to provide consumers with accurate information, and to direct the consumers to appropriate services. In addition, respondents cited a number of pilot projects, some funded by the Substance Abuse and Mental Health Services Administration, that seem to be successfully coordinating care and providing children with services. For example, one of these pilot projects uses family services coordinators, who are parents of children with SED, to create a Child and Family Team to identify needs and implement plans of care for children with SED. The goal of the program is to keep these children in their family homes or to return them to their homes. However, neither the TennCare Bureau nor the other state departments responsible for children in Tennessee have determined how they might incorporate these pilot projects into the TennCare program.
4. Do All Children Receive the Care Coordination Services They Need?

Access problems appear to limit care coordination services for certain segments of the target population, primarily those with a dual diagnosis. These children have mental health needs in addition to having a diagnosis of mental retardation, developmental disabilities, or alcohol/drug dependence. They also may have been the victims of physical or sexual abuse or the perpetrators of such abuse. Because few providers in Tennessee are qualified to provide services for dually diagnosed children, and because many rural areas of the state have few providers available, respondents agreed that finding treatment services for these children is a higher priority than is care coordination. They also believed that treatment services for children with mental health needs and mental retardation are the most difficult to find because the state has so few providers of the services. According to respondents, it is still quite common for the families of these children to relinquish custody in order to secure care for them.

Children who are dually diagnosed with mental illness and a substance abuse problem are faced with the problem that substance abuse services are extremely limited under TennCare. Obtaining care is complicated by what respondents cited as TennCare’s requirement that services be authorized for the treatment of one condition only. Thus, if a child has both mental health needs and a substance abuse problem, a provider might refer the child for treatment on the basis of a mental health diagnosis and subsequently attempt to arrange for substance abuse treatment services while the child is participating in the program. However, after the child’s mental health problem has been treated successfully, the program is no longer authorized to provide substance abuse treatment, even if the child still has a substance abuse problem.

For dually diagnosed children, the availability of care coordination under available case management services varies by provider. Respondents cited examples of providers that offer both mental health treatment and substance abuse treatment in one program and also include case management services, as well as examples of providers that offer no case management services.

5. How Is the System Monitored?

At the start of the TennCare Partners program, there was little data monitoring to ensure that the care provided was coordinated and that all providers had the information they needed to effectively care for their patients, according to those we interviewed. Recently, however, more data are being collected and analyzed. The BHOs are contractually required to monitor coordination of mental health treatment with primary care providers. With respect to mental health case management, the Department of Mental Health and Developmental Disabilities now monitors both process and outcomes measures. In addition, the Department of Mental Health and Developmental Disabilities has begun to analyze service utilization data collected from the TennCare Partners program to determine whether the agencies are providing care coordination. However, many of the respondents we interviewed did not believe that this data has been used to improve case management services.
C. SUMMARY

TennCare, Tennessee's Medicaid managed care program, carves out all mental health and substance abuse services to the TennCare Partners program, which contracts with two managed behavioral health care organizations. A 1998 class action complaint charged that state officials were responsible for providing EPSDT, medical, and mental health services to children who were in the custody of the state or who were at risk for entering into state custody, as required by Medicaid, but that they had failed to do so. The ensuing consent decree brought about several changes in the way that mental health services are provided, including the elimination of the requirement of a diagnosis of SED to access services. Now, all children are provided with case management services, as medically necessary, and they may receive one of the following three types of case management: (1) mental health case management, (2) continuous treatment teams, or (3) comprehensive child and family therapy. However, care coordination in mental health case management (the level of services that is used the most) does not seem to extend beyond mental health services. In addition, the consent decree had called for other reforms, but none of these has been implemented. The result is that care coordination for children with mental health needs, but especially for those with SED, is difficult to access and does a poor job of providing necessary services.
VI. CONCLUSIONS AND LESSONS LEARNED

In this paper, we set out to answer one key question: has managed care helped state Medicaid programs provide care coordination services for children with mental illness? Our review of Medicaid managed care programs in Hawaii, Maryland, and Tennessee found that the programs used the introduction of managed care to initiate care coordination services for children with mental illness. This change was a significant one for the many children with mental illness enrolled in the three states’ Medicaid programs (and for their families), because fee-for-service Medicaid historically did not cover the service.

Given this achievement, have the Medicaid managed care programs provided care coordination services successfully? Here the answer is ambiguous: clearly, there is a difference between including a service as a covered benefit and providing access to the service. In this chapter, we draw conclusions about care coordination in the Medicaid managed care programs we reviewed, using the assessment questions established in Chapter I to organize these conclusions. In addition, we draw lessons learned about care coordination from those programs.

A. CONCLUSIONS

1. What Is the Medicaid Managed Mental Health Program Structure for Children?

The three study states have adopted different structures for providing mental health benefits in their Medicaid managed care programs. Hawaii and Maryland give responsibility to the contracted HMOs, but children with more-severe needs are treated through carve-out arrangements. The program structures differ in that Hawaii’s carve out is to a managed system operated by another state agency, whereas Maryland’s is to a privately administered fee-for-service system. In both instances, other agencies are involved as well. In Hawaii, the state’s school system is also responsible for care coordination services for children with mental illness; in Maryland, local case management service agencies are responsible, as are providers. Tennessee directly carves out all mental health services for children to specialized BHos.

Despite structural differences in the provision of mental health benefits, we found that the states have used managed care designs for Medicaid to cover care coordination effectively. Historically, fee-for-service Medicaid did not cover care coordination, so the only care coordinators were either the families themselves, who often felt burdened and overwhelmed, or their providers, if they were willing to assume that role. Introducing a new system of care into Medicaid enabled the states to include new benefits they believed were necessary, such as care coordination and other case management services.

This is not to say that the volume of care coordination provided for children with mental illness is adequate, or that it works flawlessly in the three Medicaid managed care programs. The financial incentives are not structured to promote the provision of care coordination, or to ensure its continuity. Even during the mid-1990s, when state budgets were less constrained than they are today, the states wanted to pay a minimum capitation payment, and to receive a maximum amount of services from the MCOs and BHos. With the exception of Maryland, the
states' inability to risk adjust capitation rates—so that the rates reflect individual enrollees' health risks—means that the plans receive the same amount of money for a child with SED as they do for a child with no health problems (Brown et al. 2001). On average, states and plans expect that the costs per child will level out so that the money saved on a healthy child can be used to provide for services to treat a sick one. However, given that the infrastructure for care coordination had to be developed (as was the case in other states [Rosenbach and Young 2000]), it is likely that the capitation rates in the study states did not support these start-up costs. Thus, it also is likely that plans started from a deficit situation as they attempted to provide care coordination. Moreover, as others have documented, capitation rates have remained fairly low over time, and, in all three states, the plans' and care coordination agencies' payment rates for therapists, nurses, case managers, and care coordinators who provide care coordination have remained low as well (Brown et al. 2001). Even in Maryland, where rates supposedly are structured to include care coordination, providers reported that the rate barely covers treatment, leaving nothing to support care coordination activities.

Despite these shortcomings, advocates and others cited the states' efforts to provide care coordination as critical for advancing the care of children with mental illness, particularly in community settings. In two states, legal challenges have had a significant impact on expanding access to care coordination for children with mental illness. Challenges in Hawaii and Tennessee were successful in establishing new laws specifying the care that the state is required to provide to children enrolled in Medicaid (in Tennessee), and, more specifically, to all children who must have necessary mental health treatment in order to benefit from their education (in Hawaii). In both instances, the courts decided clearly in favor of expanding services to these groups. To date, Hawaii has been more successful at implementing the terms of its consent decree, but it began planning its implementation four years earlier than did Tennessee.

Although legal challenges are time-consuming and expensive, these two cases are ones in which allies—children's advocates and parents of children with mental illness—were able to convince the court system to acknowledge their needs. Would stakeholders in these cases recommend court actions to stakeholders in other states? Overwhelmingly in Hawaii, those with whom we spoke reported that they would recommend court actions to stakeholders in other states, as long as it could be documented that the states had failed to provide services as obligated by federal law. Respondents in Tennessee were less eager to recommend court action, in part because the John B. v. Menke case was decided five years ago, but there still has been little progress toward care coordination.

2. Who Receives Care Coordination, and Who Provides It?

In all three states, children with acute mental illness or SED who are enrolled in the Medicaid managed care programs are the ones most likely to receive care coordination services. In Hawaii, children identified by the state's educational system as having any mental illness receive care coordination services. Respondents in Tennessee noted that all children are eligible for any medically necessary service in the state's program, but respondents indicated that only those with SED receive this service. Maryland offers the service only to children with SED.
A variety of designs have been developed to deliver care coordination services in the three programs. In Hawaii, where treatment for children with acute mental illness enrolled in Medicaid managed care is carved out to the state's mental health agency for children, care coordination is provided under that agency's auspices. For children with less-acute mental illness who are identified through the educational system, DOE provides two care coordinators—one coordinator to keep everyone informed, and one to procure all the services that the child needs. The care coordinators employed by HMOs in the state also play a role by serving as the link between the mental health care coordination a child might receive outside the HMO and the physical health care services that the plan provides. In Maryland, local mental health care management agencies provide care coordination under Medicaid. In Maryland, as in Hawaii, the Medicaid plans' care coordinators do not directly provide care coordination services for children (who are carved out for that service), but they try to coordinate information between the two entities. In Tennessee's program, care coordination for children with mental illness is provided by either community mental health centers or two other designated agencies in the state.

Regardless of the design adopted, we found that usually only mental health services are coordinated. For example, there is little or no coordination with primary care providers or with services that other state agencies provide in all three states. Although plans employ care coordinators who can link the mental health care coordination services to the plans' physical health care services, a lack of communication from those responsible for mental health care coordination hampers this effort. Thus, Medicaid managed care is not providing comprehensive care coordination.

3. What Training Do Care Coordinators Receive?

The states either designated an agency to provide training for care coordinators (Hawaii and Maryland) or established the minimum requirements that care coordinator training must entail (Tennessee, with training provided by contracted providers). Respondents indicated that care coordinators in both Maryland and Tennessee receive only minimal training, whereas training in Hawaii is more intensive and more highly structured. Care coordinators and their patients would benefit from more regularly scheduled training courses. In addition, states or other responsible entities should monitor that care coordinators have attended all required training sessions.

Because there are no financial incentives to provide care coordination, the same situation exists in each state: care coordinators are most likely to be recent college graduates and inexperienced, and they typically leave the job within the first two years. Unless or until states place a higher priority on this service and are willing to pay to make it a priority, the situation is likely to remain unchanged.

4. Do Entities Responsible for Care Coordination Work Together?

Because of the designs adopted, multiple agencies are responsible for providing care coordination to children with mental illness who are enrolled in the Medicaid managed care programs. However, a lack of interagency coordination is a persistent and still largely unaddressed problem. The states have acknowledged the need for better coordination and
communication among the agencies that serve these children, but they have done little to improve the situation. In Hawaii’s program, in which DOE, CAMHD, and Med-QUEST HMOs provide care coordination services for children enrolled in Medicaid managed care, little coordination takes place at the agency level, despite several years of work by high-level policymakers to craft an agreement among the three entities. A similar situation exists in Maryland. In Tennessee, the agencies responsible for serving the children have been placed under court order to coordinate their care, and a new agency was created within the Governor’s office to ensure that coordination occurs as mandated. However, the state is fighting this mandate, having filed a motion to stay this agreement and to modify it. The lack of communication and coordination among the key state agencies that serve children has hampered the ability of one or more groups to provide “complete” care coordination.

Various state agency representatives blame these problems chiefly on their inability to breach the confidentiality of minors. Although we agree that preserving the confidentiality of the children served is a critical issue, it is possible to develop consent forms to reassure parents that the information would not be shared beyond those who need to have it in order to coordinate care. Furthermore, we believe that parents would be highly likely to sign consent documents if they knew that sharing their child’s medical history could enhance their child’s treatment (for example, by enabling a primary care provider to assess whether prescribed medications might interact and produce adverse reactions).

5. Do All Children Receive the Care Coordination Services They Need?

A diagnosis of mental illness does not ensure that a child will receive care coordination services. As we have shown, two of the three study states (Maryland and Tennessee) are most likely to offer care coordination only to the most acutely ill children. Although Tennessee abolished the requirement that only SED children receive care coordination, it replaced the policy with a medical necessity criterion. In practice, therefore, the state has not expanded the population that is eligible to receive the service. Hawaii’s system of care coordination is disjointed, but the state has made efforts to ensure that every child with a mental health problem receives the available care coordination services (which are restricted to coordinating mental health services).

In addition to children with less-acute problems, in each state, certain groups of children with mental illness diagnoses have limited access to care coordination services. For example, in Maryland and Tennessee, because the supply of providers specializing in treating children with dual diagnoses (such as mental illness and mental retardation or mental illness and substance abuse) is limited, these children have reduced access to providers who can treat and coordinate all their needs. According to respondents in Tennessee, the state currently places a higher priority on providing this population with basic treatment services than on coordinating care. Because care coordinators are not available in some rural areas of Maryland, the inability of certain groups to access care coordination services typically is a function of the groups’ geographic location. In Hawaii, schools provide most care coordination services. Consequently, neither the large population of homeless children who do not attend school nor the population of children who receive instruction outside the school grounds (such as children receiving education services at home) are able to access care coordination services.
6. How Is the System Monitored?

_Maryland and Tennessee conduct only limited monitoring of care coordination systems._

The monitoring that these states do conduct consists primarily of process monitoring—that is, assessing compliance with established contract terms for caseloads, contacts per case manager, and the like. It appears that Maryland has not focused on outcomes, while Tennessee has only recently begun analyzing outcomes data.

At this time, the Medicaid agency in Hawaii does not monitor care coordination between the plans and the agency responsible for coordinating care for children with mental illness. However, the school system and children’s mental health agency, which together provide most care coordination services for these children, recently have established an extensive monitoring system. Three types of monitoring are in place, process and outcomes measures are examined annually, feedback is provided, and corrective actions are required when problems are identified. This relatively new system shows great promise for monitoring the care coordination system.

The states’ limited data collection activities severely hamper monitoring and enforcement efforts, especially in Maryland and Tennessee. For example, although Maryland contractually requires performance data to be reported, state officials were unable to provide us with basic statistics on the number of children receiving care coordination services. Officials in Tennessee admitted that they have been collecting service utilization data for at least two years, but have just begun analyzing this information. Given that Tennessee’s Medicaid managed care program has been operating for nearly 10 years, this news is extremely discouraging.

B. LESSONS LEARNED

This analysis of care coordination in the Medicaid managed care programs of three states is not representative of all state Medicaid managed care programs. Even so, however, it offers useful lessons for states, policymakers, and stakeholders about efforts to implement or expand care coordination services for children with mental illness.

First, _the introduction of care coordination services in Medicaid managed care requires both internal coordination and external coordination._ Providing care coordination services is complicated. Carve-out designs dominate the field of behavioral health care, yet they inhibit coordination because physical health care and behavioral health care are provided in two separate systems. This study has shown that care coordination for children enrolled in Medicaid involves every service and system with which the children might be involved. Because care coordination must cover services in addition to those provided through Medicaid, Medicaid agencies must develop both internal agreements with their contractors responsible for care coordination and external agreements or understandings with all the other state agencies that serve children. We found that the three state Medicaid agencies did not fully anticipate the amount of communication and coordination required at the agency level in order to provide the care coordination service successfully. Unclear expectations about different agencies’ responsibilities sometimes translated into poor access for individual children caught in interagency gridlock.
At the same time, the introduction of care coordination can initiate a dialogue among state agencies about the children they serve in common. Hawaii, which has not yet accomplished its goal, has established a working group of high-level policymakers to determine how they might improve the system of care. Under a court order, Tennessee’s agencies entered into an agreement that specifies the responsibilities of each agency with regard to children they jointly serve. Efforts such as these are key to improving external coordination problems.

States must ensure that processes for addressing coordination issues are workable. Even if agreements about interagency coordination have been established, the failure of processes for handling coordination issues may impede children’s access to care coordination. For example, in Maryland, an elaborate process was developed to enable the MCOs and MHP (the entity responsible for mental health care) to share data about clients. To date, however, MHP still has difficulty convincing the MCOs to contribute data to the system. Moreover, because the system has not obtained any pharmaceutical data, primary care providers are unable to assess whether multiple providers have prescribed medications for a patient. Tennessee’s BHOs implemented a “Supervised System of Care,” defining the processes for providers to communicate with each other and with the BHOs, but these communication policies reportedly do not work at the service delivery level. Also, Tennessee created a new agency to implement the terms of its consent decree, but that agency is powerless to promote coordination because it has no authority over the MCOs or BHOs participating in the Medicaid program.

Other states will learn from this study that covering care coordination services in Medicaid managed care programs will not happen overnight. The infrastructure for care coordination has to be developed, but this process takes time, especially when other demands of program implementation, such as enrolling members, contracting with providers, and establishing data systems, are more pressing. Even in the two states under court order to improve care coordination services, some of the required system changes have not occurred.

States also must recognize that confidentiality issues act as barriers to care coordination and are difficult to overcome. None of the three programs in this study had anticipated this barrier, and none of them has been able overcome the conflict between patient confidentiality and care coordination. Preserving patient confidentiality, especially of a minor, is paramount, but care coordination cannot be inclusive unless all the entities serving children have been informed about the children’s care needs. Policymakers in the study states appear to be reluctant to develop and use consent forms that would resolve the problem. Thus, it is unclear how states will be able to overcome confidentiality issues.

Finally, the experiences of the three states have shown that no single model of care coordination is superior. Indeed, states must implement the model of care coordination that they can support and sustain in the long run. For example, a system like Hawaii’s, in which multiple state agencies are responsible for care coordination services, requires many staff and financial resources to implement, operate, and maintain. At the same time, this model spreads the resource demands among several agencies, thereby reducing the impact on each individual agency. Maryland’s model of care coordination focuses on maintaining services planning and delivery at the local level, because the state believes that this model will improve the quality of the services. Regardless of how services are delivered, monitoring the outcomes of the model chosen is critical for understanding how well it works.
Care coordination services meet critical needs for children with mental illness as well as for their families. As we have shown, however, designing effective ways to deliver the service is complex and requires a multifaceted approach, given the multiple players involved. States that plan to design their own care coordination programs may benefit from the conclusions of this research, and they may be able to use the lessons we have learned to guide their own efforts in this important area.
REFERENCES


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