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Strategies For Improving Access To Mental Health Services In SCHIP Programs

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Children and adolescents experience substantial barriers to obtaining needed mental health services. Fewer than half of children with identified mental health problems get treatment, services, or support. Only one in five get treatment from a mental health worker with special training to work with children.¹ One out of every ten children or adolescents has a serious mental health problem, and another 10 percent have mild to moderate problems.² Yet, access to health insurance does not by itself insure access to needed mental health services. Effective administration of mental health benefits is also essential.

Management of mental health services for children enrolled in a State Children's Health Insurance Program (SCHIP) program differs from state to state and even within states as many serve enrollees through multiple delivery systems. This *Issue Brief* examines strategies and challenges faced by three state SCHIP programs operating in 2006: North Carolina, Rhode Island, and Utah. These states were chosen because they represent different types of SCHIP programs and different types of delivery systems. Each state reports upon successful approaches to managing the delivery of mental health services for the SCHIP population.

National Academy for State Health Policy (NASHP) staff developed this brief in order to highlight opportunities for programmatic improvement in the delivery of mental health services for all SCHIP children. The information used to prepare this brief was collected from state websites and telephone interviews with state staff. Representatives from each of the three states also reviewed a draft of this brief.

Integrating Mental and Physical Systems of Care

Integration of care between mental health services and physical health services is critical for the health and well being of children. SCHIP programs employ many strategies to promote coordination and collaboration between these health systems. Implementing these strategies can require significant resource commitment, including the creation of community partnerships and assembling public and private resources.³ In this brief we examine strategies used to promote coordination and collaboration.

Table 1. Strategies for integrating mental health services.

State	SCHIP Program Type	Delivery System	Strategies for Integration
North Carolina	Combination S-SCHIP and M-SCHIP (as of January 1, 2006)	Managed Care	Shifting children from a separate SCHIP program to Medicaid SCHIP Expansion program Integration work group Implementing demonstration projects that place mental health clinicians in medical home setting (co-location models)
Rhode Island	Combination S-SCHIP and M-SCHIP	Managed Care with fee-for-service wrap-around	Utilizes contracting and purchasing strategies with MCOs which are tracked, monitored, and rewarded.
Utah	Separate S-SCHIP	Managed Care	Specialized mental health coordination units offer clinical case management services for all SCHIP children who access mental health services.

Source: NASHP staff research

CASE STUDY: NORTH CAROLINA

As of April 2006, there were 107,665 children in the North Carolina's Separate SCHIP program. From January to April 2006, 515 children received behavioral health services. The per member per month (PMPM) for SCHIP children is currently \$196.59.

Until January 1, 2006, North Carolina had operated only a separate SCHIP program, but as of that date, the State established a Medicaid expansion program—thus creating a combination program.

Overview of North Carolina's SCHIP Program

The S-SCHIP program serves all children under age 19 from families with incomes at or below 200 percent of the federal poverty level (FPL) who do not qualify for Medicaid (or the Medicaid Expansion program). The M-SCHIP program serves all children under age six from families with incomes below 200 percent of the FPL who do not otherwise qualify for Medicaid.

S-SCHIP participants obtain all services, including mental health and substance abuse services, through a managed care delivery system. North Carolina Health Choice (NCHC), the state's contracted managed care organization (MCO), purchases mental health management services from Value Options.

M-SCHIP enrollees may access the delivery system used by the state's Medicaid program which consists of a both an MCO option and a Primary Care Case Management (PCCM)/Fee-for-Service model for the provision of all services, including mental health and substance abuse services.

Mental Health Services Covered by the Separate SCHIP Program

North Carolina provides all children who participate in its S-SCHIP program with a benefit package that is actuarially equivalent to that provided by the State Employees Health Plan. The state has created an enhanced mental health benefit for children with special health care needs in the S-SCHIP program. This enhanced benefit includes community support, day treatment, intensive in-home services, multi-systemic therapy, mobile crisis, diagnostic assessments, as well as level II, III and IV residential and group homes options. Children with chronic mental illness are considered special needs children and, after physician certification, can access the enhanced mental health benefits.

Mental Health Services Covered by the Medicaid Expansion SCHIP Program

Behavioral health services covered in the M-SCHIP program are identical to those covered in the Medicaid program. All enrollees of the M-SCHIP program receive the full Medicaid benefit package that North Carolina must maintain under Medicaid law.

Strategies and Challenges to Integrate Systems of Care

Legislated Eligibility Shift

Effective January 1, 2006, the North Carolina legislature mandated the creation of an M-SCHIP program to serve all children below age six from families with incomes up to 200 percent of the Federal Poverty Level (FPL)—in effect changing the benefits provided to the younger children from that provided under the S-SCHIP program to that provided under the Medicaid program. State staff report that this legislative change of coverage and delivery system demonstrates how policymakers can and are mandating programmatic improvement. State staff reported that the legislature recognized the mental health care coordination benefit for children who are not special needs was less comprehensive in the S-SCHIP program than in the Medicaid program. North Carolina's delivery system change is an example of a strategy to create a continuum of support and care for the SCHIP and Medicaid populations beyond enhanced benefits for Children with Special Health Care Needs.

About SCHIP

The Balanced Budget Act of 1997 included the authorization of Title XXI of the Social Security Act, otherwise known as the State Children's Health Insurance Program (SCHIP). In creating SCHIP, Congress sought to assist state efforts to initiate and expand the provision of health benefits coverage to uninsured, low-income children.

States can provide SCHIP coverage to low-income children by using one of three options:

- Create a separate child health program (S-SCHIP),
- Expand eligibility for benefits under the state's Medicaid plan (M-SCHIP), or
- Implement both types of programs (combination).

All SCHIP programs are designed and administered by states within federal SCHIP rules. States have more flexibility in the design of S-SCHIP programs than M-SCHIP programs because S-SCHIP programs are bound by federal SCHIP rules while M-SCHIP programs are bound by both SCHIP and Medicaid rules.

Challenges remain for those experiencing a transition from M-SCHIP to S-SCHIP, as occurs at age 6 or after a family's income increases. The absence of comprehensive case management services in S-SCHIP is still viewed as a programmatic shortcoming. As a result, the "cliff effect" is delayed, but not dispelled. Cost of care—particularly for children requiring multiple mental health and medical care services—continues to be another significant challenge in the management of mental health services.

Integration work group

A behavioral health workgroup with representatives from the patient advocacy community, mental health providers, public health divisions, state health plan representatives, the Commission on Children with Special Health Care Needs, and SCHIP and Medicaid staff meet monthly to work on strategies to integrate mental health and physical care delivery systems and to support managed care principles in the delivery of mental health services for the SCHIP population. The Commission on Children with Special Health Care Needs takes the lead in making recommendations to the Department of Health and Human Services. One option that has been discussed is to enhance the mental health services that comprise the NCHC special needs package. The behavioral health work group reviewed service definitions and made recommendations of services to be adopted by NCHC.

The behavioral health work group also reviews and monitors the quality of mental health services for children with special health care needs and makes recommendations for improvement. For example, the work group recommended enhanced staff qualifications and services provided through Level III group homes that are now part of a rule effective April 3, 2006.

Demonstration projects placing mental health clinician in medical homes

North Carolina is taking active steps to address a recognized disconnect between the mental health and physical health services for its S-SCHIP population. In an effort to improve integration between the systems of care, Community Care of North Carolina is currently implementing a demonstration project in which four medical provider pilot sites in different counties will assess and evaluate methods of coordinating mental health services within a child's medical home. This model of co-location places licensed mental health professionals in pediatricians' offices. State and HealthChoice staff hopes that this will help bridge the current disconnect and improve the management of mental health services for children and families.

Findings from the pilot sites will be used to develop performance standards for both pediatricians and mental health professionals. HealthChoice staff efforts to inform SCHIP enrollees about the co-location pilots include use of coalitions and community organizations, public bulletins, and various communication materials. Evaluation of the demonstration sites will enable the state to refine the co-location strategy before implementing the model at a broader level.

CASE STUDY: RHODE ISLAND

As of April 2006, there were 75,000 children in the Rhode Island combination SCHIP/Medicaid program (RIte Care). Behavioral health services are provided both within the RIte Care managed care delivery system and the Medicaid fee-for-service delivery system.

Overview of Rhode Island's SCHIP Program

Rhode Island's Medicaid SCHIP Expansion program serves children ages 8 through 18 in families with incomes between 100 percent and 250 percent FPL and, under a Section 1115 SCHIP waiver, parents in families with incomes between 100 percent and 185 percent FPL. Families with incomes between 150 percent and 250 percent FPL must pay a monthly premium that ranges between \$61 and \$92 per month.

Under the Section 1115 SCHIP waiver, the S-SCHIP program also serves uninsured pregnant women in families with incomes of no more than 250 percent FPL who do not qualify for Medicaid due to excess income and, under S-SCHIP, uninsured unborn children from conception to birth from families with incomes of no more than 250 percent FPL who do not qualify for Medicaid for a reason other than excess income.

Mental Health Services Covered by the SCHIP Program

Service coverage in the M-SCHIP and S-SCHIP program are identical to coverage in the Medicaid program. All enrollees of the Medicaid expansion, the SCHIP waiver, and the S-SCHIP programs receive the full Medicaid benefit package, including the full package of mental health services, which are provided in-plan (a managed care delivery system for all health care) and out-of-plan (fee-for-service wrap-around).

Strategies for Integrating Systems of Care

Managed Care Options

Rhode Island requires SCHIP-eligible low-income pregnant women, families, and children to enroll into comprehensive Managed Care Organizations (MCOs). Those enrolled in MCOs are required to obtain basic mental health and substance abuse services, such as inpatient and outpatient treatment, from their MCO (in-plan services). These include medically necessary behavioral health services, which are covered with no artificial limits on them. Fee-for-service behavioral health wrap-around benefits, such as residential treatment for adolescent and Community Intensive Services are provided out-of-plan and also without artificial limits.

Additionally, Children with Special Health Care Needs (CSHCN) are voluntarily enrolled into Neighborhood Health Plan of Rhode Island beginning September 2003, as were children in substitute care (foster children) beginning in December 2000. Case management services are provided for each member based on a screening process which determines their level of necessary coordination. All mental health services are monitored contractually through performance standards and incentives.

Contracting and Prudent Purchasing Standards

Generally, as state, county, and local agencies have come to realize the potential value of contracting with MCOs, many have developed specific goals for improving their systems through managed care. Rhode Island staff report that by defining broad access and outcome measures as part of contracting standards, the MCOs are accountable to define how they will meet required continuum of care principles, including the benefits and mechanisms by which MCOs will report upon these standards. For example, a current RIte Care health plan recently proposed pre-paying for emergency psychiatric slots as a means by which to assure access to these necessary services.

One report says “a well-designed managed care system can best achieve these goals when purchasers and MCOs clearly understand the needs of the population served, the unique requirements imposed by the fiscal and political environment, and the most effective managed care practices.”⁴ To meet these conditions, Rhode Island purchasers use the contract development process and the ongoing contract expectations to maximize control over the design, award, operations, and outcomes of the managed care system for its Medicaid/SCHIP population

For more information, access Rhode Island’s report entitled, *Rhode Island’s Strategy for Assessing and Improving the Quality of Managed Care services under RItE Care* at www.dhs.ri.gov/dhs/reports/strategy-final.pdf. This report examines various quality assessment and improvement activities for low income populations.

Tracking, Monitoring, and Rewarding Performance

An additional layer of the prudent purchasing strategy is Rhode Island’s requirement for participating health plans to employ Health plan Employer Data and Information Set (HEDIS) and HEDIS-like methodology in the provision of data as part of a performance incentive program. Staff reports monitoring requirements which include; ‘follow-up visits within 30 days after inpatient hospitalizations,’ as well as the well-visit requirements. These principles are utilized to capture quality and access in the management of behavioral health service delivery. Financial incentives are awarded annually based on the degree to which each health plan meets these and other standards.

CASE STUDY: UTAH

As of April 2006, there were 28,146 children in the state’s separate SCHIP program.; 1,289 children received behavioral health services. An overall per member per month is \$112.98 with \$4.33 capitated for mental health services.

Overview of Utah’s SCHIP Program

Utah operates an S-SCHIP program that serves uninsured children through age 18 from families with incomes of no more than 200 percent FPL who do not qualify for Medicaid. (This state does not operate an M-SCHIP program.) Families participating in the S-SCHIP program may be required to pay a quarterly premium up to \$25 depending on family income:

- Families with incomes of 101-150 percent FPL pay of \$13 per family per quarter, and
- Families with incomes of 151-200 percent FPL pay of \$25 per family per quarter.

All S-SCHIP program participants are required to join a managed care organization (MCO), except SCHIP participants who live in rural areas have a carve out option if an MCO provider is not within a 30 mile radius. The state contracts with Molina Healthcare and the Public Employees Health Plan for the provision for all services, including mental health and substance abuse services.

Mental Health Services Covered by the S-SCHIP Program

Utah provides all children enrolled in its S-SCHIP program with a benefit package that is at least actuarially equivalent to the benefit plan provided to state employees.

Strategies for Integrating Systems of Care

Clinical case management services within Managed Care Organizations

Utah utilizes its contracts with its two MCOs in order to manage mental health services for the SCHIP population. Specialized units within each plan authorize and coordinate services per guidelines provided by the MCO and the contracts with the state.

- Intermountain, a mental health management contractor for the state, provides services for the Public Employees Health Plan SCHIP product. These services include utilization management and "gateway services," which are assessments and referrals to appropriate providers. Utilization management is completed on a regional level with clinical staff in provider hospitals. Clinicians include Registered Nurses (RNs) and Licensed Clinical Social Workers (LCSWs). As part of the service delivery team they communicate with medical providers regularly regarding care and needed information. Initial gateway services are provided by non-licensed support staff with specific orientation on provider services and availability. Any questions regarding level of care or provider type are referred to the utilization management staff for further assistance.
- Along the same lines, Behavioral Health Strategies (BHS) of Utah provides a highly coordinated two-tiered mental health benefit package for the Molina Healthcare SCHIP members in an effort to ensure prompt access to appropriate and quality mental health care services. At the first level is the Family Assistance Program where assessments and brief problem resolution counseling services are offered. All members are given the phone number to this level of service as the contact to access any level of mental health services. This number is staffed 24 hours a day 7 days a week for either scheduling an appointment for non-urgent services or to coordinate a crisis intervention. Services at this Family Assistance Program level of care are provided by licensed mental health professionals and are generally available within a few days of calling for an appointment. When the first level of preventive care is not sufficient to treat the member's mental health needs, the Family Assistance Program counselor contacts the Behavioral Health Strategies case manager, also a licensed mental health professional, to coordinate a referral to a BHS network mental health provider and to coordinate care with the medical provider as well. This second level referral may be to a hospital, a psychiatrist, a counselor, or any other level of services or combination of services that would be appropriate to meet the needs of the member and that falls within the benefit design of SCHIP. This BHS case manager contacts the appropriate provider and member and coordinates the referral to ensure that a prompt appointment is scheduled. The BHS case manager then stays in touch with the provider to continue to coordinate care to ensure that the member receives quality appropriate services to resolve the presenting mental health symptoms.

State staff reports that both health plans' strategies have proven quite effective in improving the integration of medical care and mental health services in Utah.

ABCD II Initiative

Utah participates in NASHP's Assuring Better Child Health and Development (ABCD) II Program, sponsored by the Commonwealth Fund, and designed to strengthen primary health care services and systems that support the healthy mental development of young children, ages 0-3. State staff report that

although ABCD is specific to the Medicaid program, as is true in all participating states, providers who serve Medicaid children and families often provide services to SCHIP children and families as well. Therefore, utilizing a learning collaborative approach whereby medical providers are trained to use standardized, validated tools to screen children as part of the well child visit, improves identification of children in need of additional services in both the Medicaid and the SCHIP programs.

A contract with the Utah Pediatric Partnership to Improve Health Quality (UPIQ) outlines a three year plan; year one, screening infants convened in October 2004; year two, screening toddlers convened in May 2005; and year three, screening for maternal depression, which is in the planning stages, will be convened in September 2006. To date, over 20 practices statewide have participated in the learning collaboratives.

Provider Network Development

State staff report that transition from Medicaid or other private health plans to the S-SCHIP program has the potential to affect the continuity of care for beneficiaries—mostly a result of differing provider networks. To develop a solution to this challenge, SCHIP administrators convened representatives from the pre-paid mental health plans and mental health provider community. They agreed to allow SCHIP families to stay with current providers even if the provider is not part of the new plan's network.

Provider network expansion and compromise, however, does not alleviate the financial burden for families whose child quickly exceeds current mental health service limits. While the specialized units within each health plan work to improve integration and efficiency between systems of care and to improve overall service delivery, state staff report a need to revisit service limitations in the SCHIP program.

CONCLUSION

While each state we examined reports that completely integrated mental health and physical care systems are not yet fully realized, staff in each state cite integration as an important overall goal for children enrolled in their SCHIP programs.

In summary, the efforts in these three states' SCHIP programs draw upon various evidence-based administrative strategies in an effort to integrate systems of care by improving coordination and collaboration between mental and physical health services.

Notes

¹ American Psychological Association, Public Policy Office 750 First Street, NE, Washington, DC, 20002-4242

² American Psychological Association, Public Policy Office 750 First Street, NE, Washington, DC, 20002-4242

³ Hornberger, Steve, Martin, Teri, and Collins, Julie. *Integrating Systems of Care: Improving Quality of Care for the Most Vulnerable Children and Families*, Child Welfare League of America Press, Washington, DC 2006.

⁴ *Contracting for Public Mental Health Services Opinions of Managed Behavioral Health Care Organizations*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Office of Managed Care, prepared by the Lewin Group under the project direction of Terry Savelle and Gail K. Robinson.

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