Financing the Delivery of Integrated Services for Children

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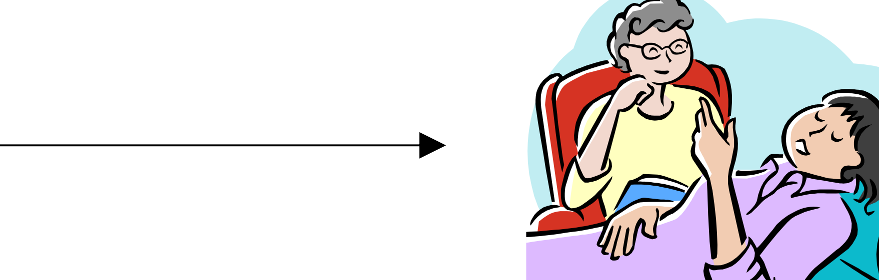
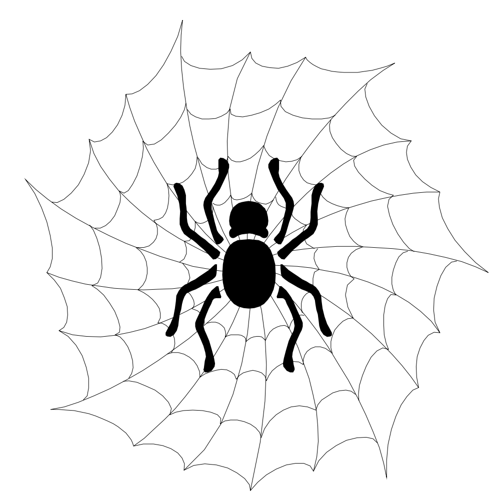
Need for Integrated Service Delivery

- Healthy children
  - Pediatrician/primary care
  - Schools
  - (Child welfare)/(Juvenile Justice)
- Chronically ill/special needs
  - Pediatrician/primary care
  - Specialty care
  - Schools
  - (Child welfare)/(Juvenile Justice)



Service Web



- Duplication
  - cost-shifting risk
- Coordination
  - multi-service use by SED children
    - 92% used MH services in 2+ systems
    - 19% used MH services in 4+ systems
- Redundancy
  - more chances to catch and treat
    - ½ children with MH problems are never treated

Evidence on Systems of Care

- MH – federal financing, demonstration programs, controlled experiments 1984+
- Cost
- Client/family satisfaction
- Mental health outcomes

Why don't systems live up to their promise?

- Diffusion of responsibility
- Failure to provide effective treatments in any setting
- Insufficient incentive to coordinate services

Lessons for Financing

- Locus of responsibility clearly established
- Reimbursement for provision of high quality services in areas of core competence
- Incentives to refer – and follow-up – in areas outside core competence

Opportunity

- Expansion of public health insurance systems
  - Medicaid
  - SCHIP

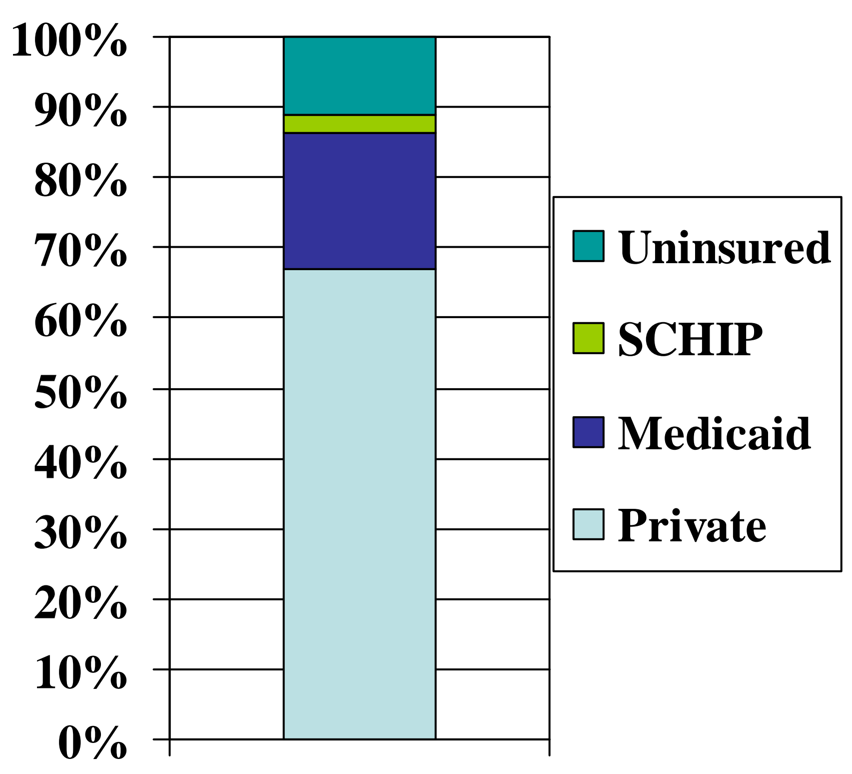
Reduce fragmentation

- Increased use of managed care in public insurance programs

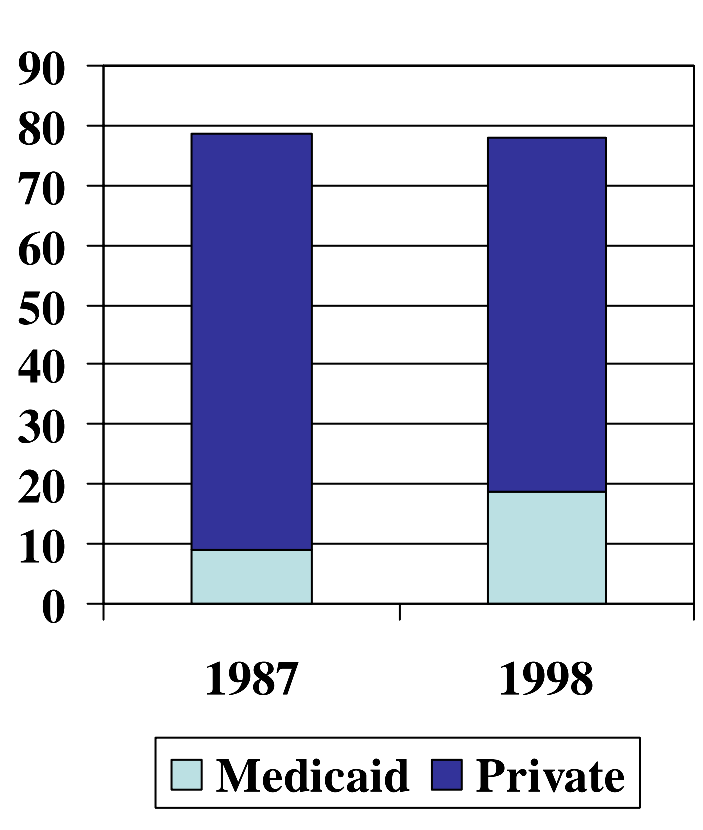
Contractual obligations

Concerns around primary care

Children’s Health Insurance



Especially for Special Needs Children



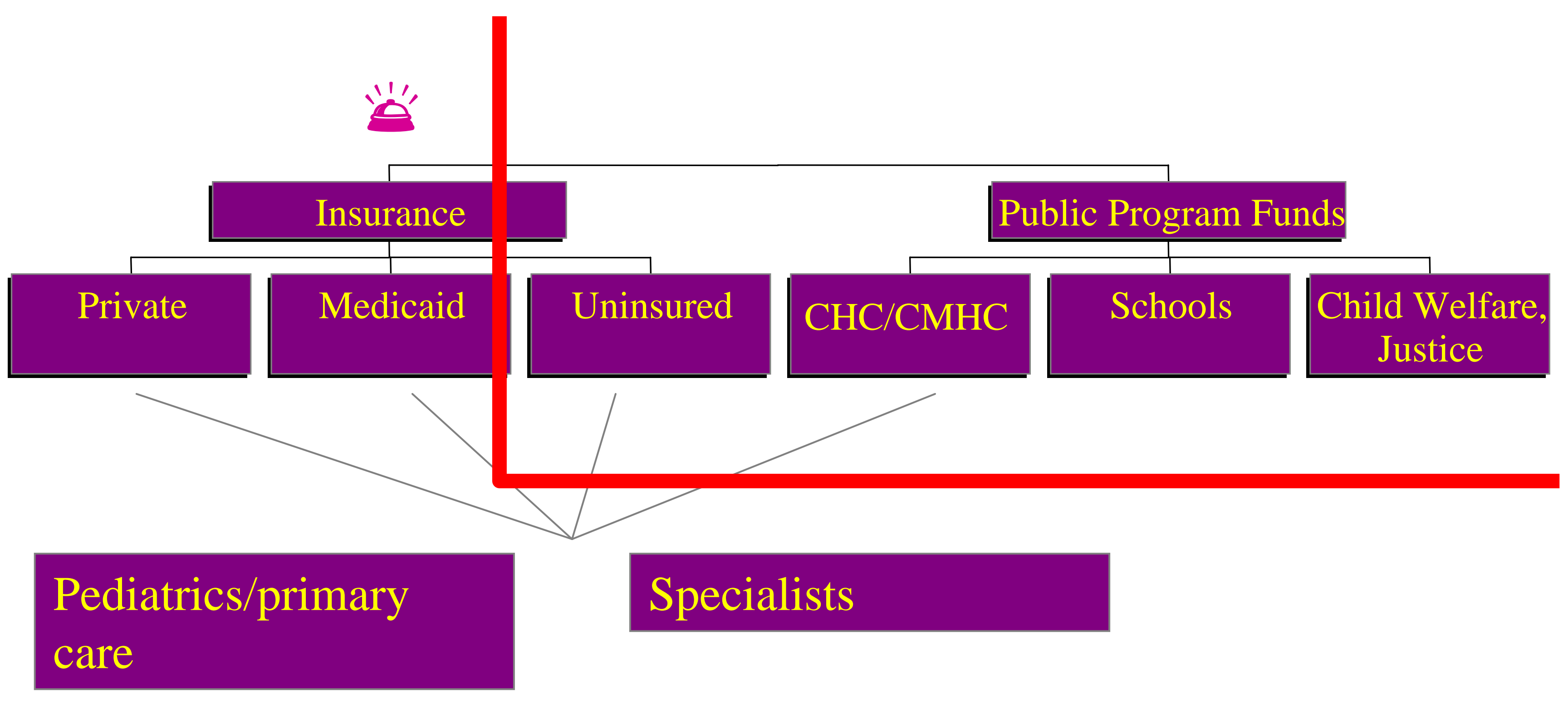
- Among children with a MH diagnosis, proportion Medicaid doubled over the 1990s

Managed Care

- Heavily used in state Medicaid and SCHIP programs – and private insurance
  - General managed care
  - Carve-outs
  - Special needs plans

- Contracts define objectives

Service Use



Form and Nature of Financing

- Insurance model
  - Defined services with related payment
  - Individual-related performance objectives
- Budget-funded/public program
  - Defined population (?)
  - Mix of services less clearly defined
  - Population-related performance objectives

Schools

- Treatment and recognition setting
- Responsible for/in contact with all kids

- Goals/funding
  - Improved SCHOOL outcomes

  ≠ improved health outcomes, family satisfaction etc.

Options

- System of care grants

- Fee-for-service
- Per child
- Care purchaser

Fee-for-service

- Service provider paid a fee for delivering a specific service
  - Must identify and record existence of a service
  - Reimbursement for service must be commensurate with cost of performance

Fee-for-service Implications

- Competition for control -- collaborative structure
- Incentive to provide service (quality? P4P)
- No incentive to refer out

Fee-for-service Models

- Case management
  - Payment for case coordination
    - PCCM
    - Disease Management
  - Some narrowly defined models have shown efficacy
  - Hard to get buy-in if don't have direct payment for all providers

DRA limits Medicaid payments for case management if some other entity can pay -- unclear

Capitation – per child

- Contractual agreement to provide range of services per child
  - Need to define and measure outcomes
  - Payment must vary with severity of illness

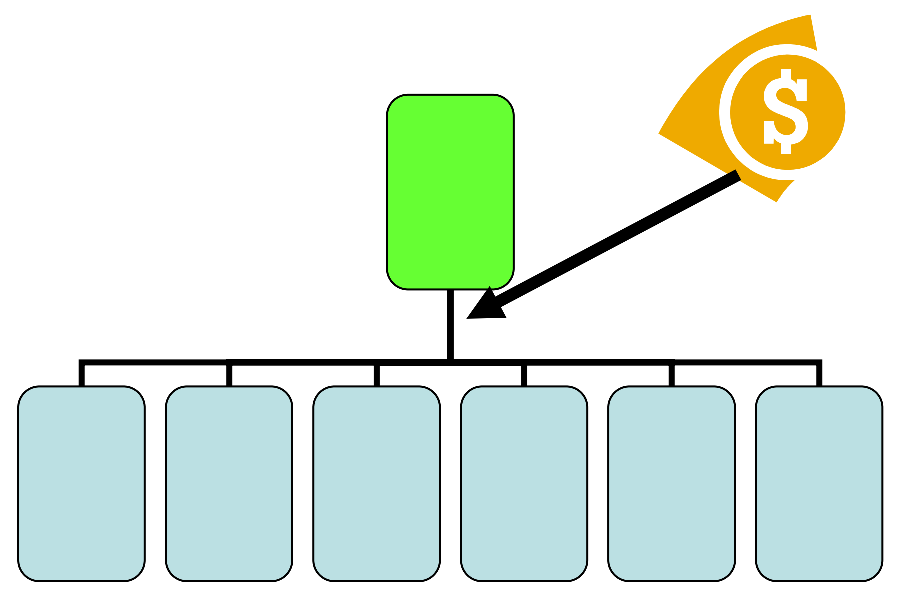
Capitation Implications

- Locus of control defined contractually
- Incentive to cost-shift
- Incentive to underprovide quality
- Substantial incentive to refer out

Theory is clear but little evidence of cost-shifting except for Rx

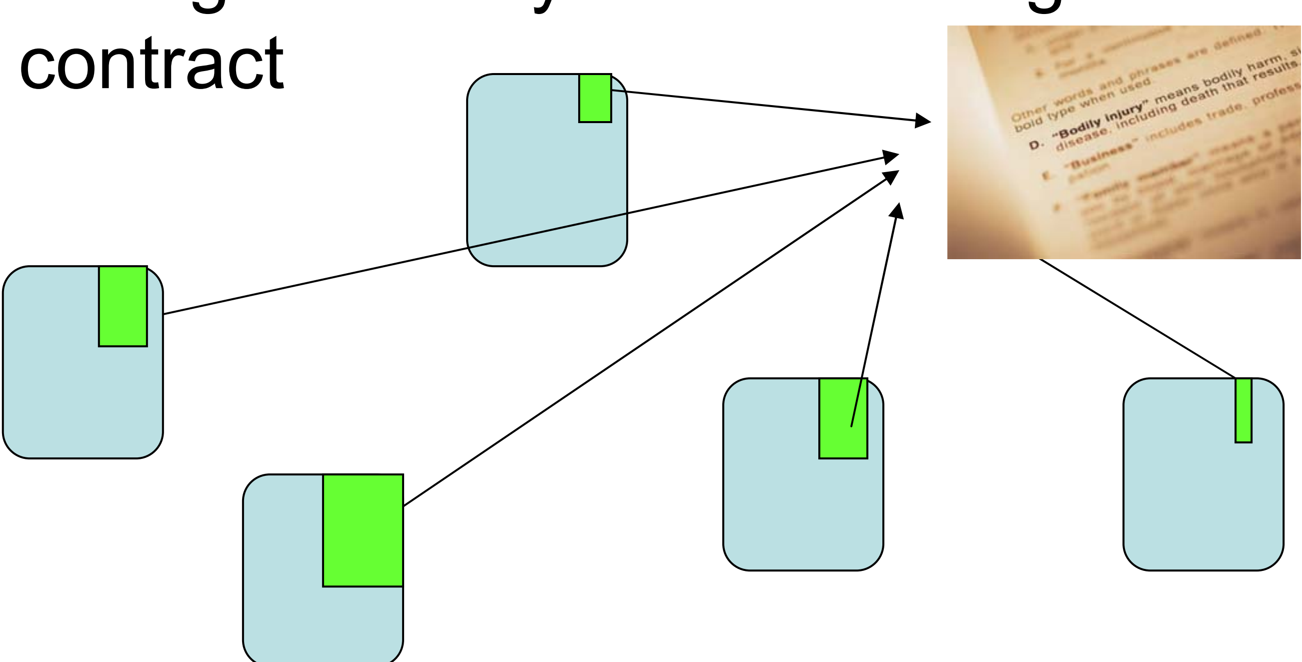
Capitation Models

- Assertive community treatment/multisystemic therapy
  - Care teams, comprising all/most necessary elements
  - Some Medicaid programs pay for ACT
  - Some Juvenile Justice programs fund MST



Capitation Models

- New Mexico mental health initiative
  - Combine mental health treatment services throughout all systems into single carve-out contract



Care Purchasing

- Patient/family/care manager has authority to spend case payment across a range of services
  - Monitoring appropriateness of services
  - Prices and information for negotiating with providers

Care Purchasing Implications

- Clear locus of control – quality of agent?
- Quality of services purchased?
  Satisfaction vs. outcomes
- No incentive to refer out

Care Purchasing Models

- Cash and Counseling
  - US DHHS + RWJF demonstration program
  - Elderly and disabled Medicaid beneficiaries can direct elements of their own care
  - "Cash & Counseling allows people to hire whomever they want to provide their care and decide for themselves if they would rather purchase a microwave oven to heat up their meals or hire an aide to cook for them."

Limits and Potential of Financing

- Necessary – but not sufficient
- Financing provides resources and incentives
  - Not services – must measure and enforce
  - Not quality – must measure and enforce
  - Not outcomes – must measure and enforce

Key Features

Money must flow through someone

Quality of services must be measurable and measured

Providers must be able to recognize and refer to high quality providers outside own system

What to do?

- Perfect vs. better
- Many models exist
- Further experimentation is warranted

The system is fundamentally broken, ensnaring the most vulnerable in our society in a cycle of dependence and poverty while failing to realize the benefits of emerging technologies and new capabilities in health …

Newt Gingrich