LEGISLATIVE RESEARCH COMMISSION

PROGRAM REVIEW
AND
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COMMITTEE

Impact Plus

Design of Medicaid-Funded Program for Children with Severe Emotional Disturbance Results in Rapidly Growing Expenditures and Difficult Policy Choices

Research Report No. 300

Prepared by:
Ginny Wilson, Ph.D., Committee Staff Administrator
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IMPACT PLUS:
Design of Medicaid-Funded Program for Children with Severe Emotional Disturbance Results in Rapidly Growing Expenditures and Difficult Policy Choices

Adopted by Program Review and Investigations

PROGRAM REVIEW & INVESTIGATIONS COMMITTEE
STAFF REPORT

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LEGISLATIVE RESEARCH COMMISSION

Frankfort, Kentucky

Program Review and Investigations Committee

Adopted: December 13, 2001

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FOREWORD

Program Review staff would like to acknowledge the extensive cooperation of Marcia Morgan, the Secretary of the Cabinet for Health Services, in providing information for the preparation of this report. Commissioner of Mental Health and Mental Retardation Services Margaret Pennington made her staff available to assist the research as needed. Viola Miller, Secretary of the Cabinet for Families and Children, was also helpful in this effort.

Many individuals provided valuable assistance. Program Review staff would like particularly to thank Stacie Otto and Jay Klein for their diligent work in delivering and explaining the documents that were requested and Stacey Owens and John Hoffman for their considerable help with the claims data.

We would like to acknowledge Dr. John Burke of the Kentucky Center for Autism Training, who spent several hours educating staff about autism on a tragic September 11th morning when distractions were impossible to ignore.

Finally, we would like to acknowledge the great respect we developed for the dedicated individuals who spend their careers attempting to improve the lives of troubled children and their families. The lives of those children and the future of the Commonwealth are better for their efforts.

Robert Sherman
Director

Frankfort, Kentucky
December 13, 2001

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MEMORANDUM

TO: The Honorable Paul E. Patton, Governor
The Legislative Research Commission, and
Interested Individuals

FROM: Senator Katie Stine, Chair
Representative H. "Gippy" Graham, Co-Chair

SUBJECT: Adopted Committee Staff Report: Impact Plus: Design of Medicaid-Funded Program for Children with Severe Emotional Disturbance Results in Rapidly Growing Expenditures and Difficult Policy Choices

DATE: December 13, 2001

In December 2001, the Program Review and Investigations Committee approved a study to review the Impact Plus program to ascertain why program expenditures had grown so rapidly and whether program managers were conducting effective utilization management.

Committee staff conducted numerous interviews with designers, managers, and staff of the program. Staff also talked with a selection of program providers, including an association of the directors of the community mental health centers. Representatives of parents were interviewed, along with a group of children who had received behavioral health services.

Based upon analysis of information obtained from numerous interviews with staff of the Impact Plus program, and the review of the information, the Committee adopted the following recommendations contained in the report. As noted by staff, the report did not make recommendations regarding whether the Impact Plus program should be continued and, if so, at what level the program should be funded since those decisions are policy decisions for the members of the General Assembly. However, if a decision is made to continue the Impact Plus program, the report offered recommendations to improve its operations. The following Major Conclusions are a summary of the results obtained by Program Review staff:

Major Conclusions

- Between its inception in January 1998 and October 2001, Impact Plus has received funding allotments that total $58.4 million. These funds have been used to pay the behavioral health claims from 214 providers on behalf of 6,402 children. In CY 2000, claims were paid for 4,229 children at a total cost of $24 million and an average cost of $5,719 per child.
- Parents, clinicians, and agency staff who deal with troubled children uniformly reported that the services of Impact Plus are beneficial to the children who have received them.
- The major reason costs increased so rapidly is that broad eligibility criteria were coupled with the federal requirement that Medicaid services be delivered as an entitlement to the population defined to be eligible.
- Another significant reason costs increased so rapidly is that no effective utilization control procedures were in place early in the program. Since July 2000, tightened eligibility controls and centralized prior authorization requirements have slowed program growth. The major related issue at this time is persistent provider complaints that slow authorization decisions reduce children's access to care and represent a significant financial burden for private providers.
- Performance information was not initially collected. Site reviews of providers and the collection of outcomes data have recently begun.
- Impact Plus does not sufficiently coordinate its services with other state and local agencies who also deliver behavioral health services to Medicaid-eligible children with similar behavioral health problems.
- Although it was originally said that Impact Plus would be funded with the savings it would generate from reducing institutional care, evidence indicates that substantial net new dollars were expended to pay for the new services delivered to a new population.
- The early program design flaws have created a situation in which policy makers must face the difficult decision of whether to continue funding the new services

for an unanticipated population which has expressed strong desire for those services, or whether to reduce program scope to relieve pressure on a Medicaid budget that is already facing serious deficits.

Summary of Recommendations

The following recommendations were offered to improve the program's operations. The full text of each recommendation can be found in the report.

Chapter 2: Programmatic Recommendations

Chapter 2 discusses two major programmatic issues regarding Impact Plus. The first is the recommended structure of the program as it relates to the provider pool available to deliver behavioral health services to children with severe emotional disturbance. The second is the lack of adequate coordination of behavioral health services for children among various state and local agencies.

Recommendation 2.1: The proposal put forward by the Kentucky Association of Regional Programs should not be adopted.
Recommendation 2.2: The current structure that designates two state agencies as Medicaid providers and allows those agencies to subcontract with an expanded provider pool restricted to this population should be continued.
Recommendation 2.3: Impact Plus managers should establish uniform reimbursement rates for all private providers in the program; and the Cabinet for Health Services should negotiate a rate package with the community mental health centers that allows them to be equitably reimbursed for Impact Plus services. All providers should be subject to the same prior authorization and quality control standards.
Recommendation 2.4: To improve equity of rates, consideration should be given to development of a simple and clear method to adjust the uniform rates for providing a specified service to children who are more difficult to treat.
Recommendation 2.5: The Cabinets for Health Services and Families and Children should explore options for continuing Medicaid reimbursement for residential care for children in state custody who have no alternate placement that will prevent deterioration of their behavioral health.
Recommendation 2.6: If such an option can be identified, the Secretary of the Cabinet for Families and Children should institute internal policies to require caseworkers to find an alternate nonresidential placement as quickly as practicable.
Recommendation 2.7: The Administrative Office of the Courts should better track required data on the reasons children are committed to state custody.
Recommendation 2.8: Policy guidelines should be developed so children in state custody have access to similar services. Also, decisions should be made regarding whether children not in the state's custody can access the services made available to committed children.
Recommendation 2.9: Impact Plus managers should require service coordinators to better coordinate Impact Plus service plans with existing individual education plans for the same children.

Recommendation 2.10: Schools should be encouraged to participate in Medicaid's school-based services program so the behavioral health services that they are required to provide can be funded with the 70 percent federal match.
Recommendation 2.11: The General Assembly should direct the 843 Commission, created to make recommendations on mental health issues, to develop a prioritized plan for the funding of behavioral health services for children for consideration in the 2004 Session.
Recommendation 2.12: If the policy decision is made to continue the Impact Plus program, and if it can demonstrate acceptable fiscal management, the Cabinet for Health Services should consider using Impact Plus as a pilot program for evaluating how the issues to be considered by the 843 Commission might be addressed in practice.

Chapter 3: Utilization Management Recommendations

Impact Plus was planned as a budget neutral program. This review did not find it to be so. Poor program design and inadequate utilization control allowed annual program costs to increase from $5 million in 1998 to $24 million in 2000. Impact Plus serves a different group of children than Medicaid has previously served. In particular, more children with conduct disorders and with autism accessed services through Impact Plus. The average expenditure per child, for all children served by Impact Plus in the calendar year 2000 was $5,719, and $13,477 for children with developmental disabilities such as autism. Given their relatively high costs and unique service needs, children with autism warrant special attention. Staff heard numerous complaints that the prior authorization process was cumbersome and that slow decisions were restricting children's access to needed care and imposing an unreasonable financial burden on providers.

Recommendation 3.1: The Secretary of the Cabinet for Health Services should explicitly state a target budget for Impact Plus to increase the ability to hold managers accountable for excess expenditures.
Recommendation 3.2: Legislative committees should be wary of the assumption that new programs will be funded entirely with "savings" and should require reasonable documentation of such estimates.
Recommendation 3.3: The Secretary of the Cabinet for Health Services should designate one or more individuals familiar with federal Medicaid rules and claims analysis to monitor the fiscal performance of Impact Plus. Those individuals should report directly to the Secretary on all matters related to Impact Plus.
Recommendation 3.4: The State Budget Director should be required to certify to the Appropriations and Revenue Committee that any new state-funded program to reimburse providers for services to eligible individuals has developed adequate utilization and quality control plans before funds are allotted to the program.
Recommendation 3.5: Program managers should be reminded to balance advocacy for the populations they serve with the fiscal priorities set by policy makers.

Recommendation 3.6: The Kentucky Autism Training Center should be directed to develop a "best practices" manual for the state-funded services provided to children with autism, who are high-cost utilizers of Impact Plus services.

Recommendation 3.7: Training should be given to case managers for children with autism to ensure they receive appropriate interventions.

Recommendation 3.8: Consideration should be given to delivering services to children with autism through early intervention and continuing programs for individuals with mental retardation and other developmental disabilities rather than through a program for children with severe emotional disturbance, such as Impact Plus.

Recommendation 3.9: Services delivered through Impact Plus should continue to be subject to centralized prior authorization requirements rather than being managed at the local level as they were originally.

Recommendation 3.10: The Department for Medicaid Services should require the Healthcare Review Corporation, the peer review organization that now does prior authorizations for Impact Plus services, to submit regular data on the time it takes to approve a service request. The Department should hold the Healthcare Review Corporation to reasonable standards for the time it takes to make a decision regarding a service request.

Recommendation 3.11: Current Impact Plus site review and outcomes measurement activities should be expanded. In particular, a clinician who can assess the appropriateness of the nature, frequency, and duration of the services included in the reviewed cases should be added to the site review team.

Questions or requests for additional information should be directed to Dr. Ginny Wilson, Committee Staff Administrator for the Program Review and Investigations Committee.

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EXECUTIVE SUMMARY

Impact Plus is a program that provides community-based behavioral health services to Medicaid-eligible children with severe emotional disturbance. The goal in creating the program was to pay for the new community-based services with expected savings from reductions in expensive institutional care for the children served. The Program Review and Investigations Committee authorized its staff to review the Impact Plus program and ascertain why program expenditures had grown so rapidly, and whether program managers were conducting effective utilization management. This report presents the results of that review.

Major Conclusions

- Between its inception in January 1998 and October 2001, Impact Plus received funding allotments that totaled $58.4 million. These funds were used to pay the behavioral health claims from 214 providers on behalf of 6,402 children. In calendar year 2000, claims were paid for 4,229 children at a total cost of $24 million and an average cost of $5,719 per child.
- Parents, clinicians, and agency staff who deal with troubled children uniformly reported that the services of Impact Plus are beneficial to the children who have received them.
- The major reason costs increased so rapidly is that broad eligibility criteria were coupled with the federal requirement that Medicaid services be delivered as an entitlement to the population defined to be eligible.
- Another significant reason costs increased so rapidly is that no effective utilization control procedures were in place early in the program. Since July 2000, tightened eligibility controls and centralized prior authorization requirements have slowed program growth. The major related issue at this time is the complaint by providers that slow authorization decisions reduce children's access to care and represent a significant financial burden for private providers.
- Performance information was not initially collected. Site reviews of providers and the collection of outcomes data have recently begun.
- Impact Plus does not sufficiently coordinate its services with other state and local agencies who also deliver behavioral health services to Medicaid-eligible children with similar behavioral health problems.
- Although it was originally said that Impact Plus would be funded with the savings it would generate from reducing institutional care, evidence indicates that substantial net new dollars were expended to pay for the new services delivered to a new population.
- The early program design flaws have created a situation in which policy makers must face the difficult decision of whether to continue funding the new services for an unanticipated population, which has expressed strong desire for those services, or whether to reduce program scope to relieve pressure on a Medicaid budget that is already facing serious deficits.

Summary of Recommendations

Recommendations are summarized in the order they appear in the report. Note that the report does not make a recommendation regarding whether the Impact Plus program should be continued and, if so, at what level it should be funded. Those are policy decisions not subject to staff review. However, if the decision is made to continue the program, the following recommendations are offered to improve its operations.

Brief summaries of the recommendations regarding each issue are listed. The full text of each recommendation can be found on the report page noted in the parentheses following each recommendation summary.

Chapter 2: Programmatic Recommendations

Chapter 2 discusses two major programmatic issues regarding Impact Plus. The first is the recommended structure of the program, particularly as it relates to the provider pool available to deliver behavioral health services to children with severe emotional disturbance. The second is the lack of adequate coordination of behavioral health services for children among various state and local agencies. The recommendations address those issues.

Impact Plus Structure and Provider Issues. Review of Impact Plus indicates that a major benefit of the program was the creation of an expanded pool of providers to deliver behavioral health services to children with severe emotional disturbance. This was possible because of an agreement that established the Department for Mental Health/Mental Retardation Services and the Cabinet for Families and Children as providers to the Medicaid program. These two providers then subcontracted with the actual providers who deliver the services. This arrangement allows access to the expanded provider pool to be restricted to the target population of children with severe emotional disturbance rather than making it available to all Medicaid recipients. A notable feature of this arrangement is that Impact Plus managers negotiated individualized rates with each subcontracted provider, so rates for the same service show great variation.

In response to problems with the management of Impact Plus, the Secretary of the Cabinet for Health Services requested that the Kentucky Association of Regional Programs, an association of the directors of the community mental health centers, develop a proposal for future management of Impact Plus. The proposal was that the community mental health centers become the central points of entry for eligible children and conduct initial evaluations and case management. They would present parents of enrolled children with a list of other providers available in the community. Program Review staff encountered widespread opposition to the possibility of having Impact Plus services delivered primarily through the community mental health centers. While some community mental health centers were said to provide outstanding services to children, others were seen as unresponsive to children’s needs.

Recommendation 2.1: The proposal put forward by the Kentucky Association of Regional Programs should not be adopted. (Page 39)

Recommendation 2.2: The current structure that designates two state agencies as Medicaid providers and allows those agencies to subcontract with an expanded provider pool restricted to this population should be continued. (Page 39)

Recommendation 2.3: Impact Plus managers should establish uniform reimbursement rates for all private providers in the program, and the Cabinet for Health Services should negotiate a rate package with the community mental health centers that allows them to be equitably reimbursed for Impact Plus services. All providers should be subject to the same prior authorization and quality control standards. (Page 39)

Recommendation 2.4: To improve equity of rates, consideration should be given to the development of a simple and clear method to adjust the uniform rates for providing a specified service to children who are more difficult to treat. (Page 40)

Recommendation 2.5: The Cabinets for Health Services and Families and Children should explore options for continuing Medicaid reimbursement for residential care for children in state custody who have no alternate placement that will prevent deterioration of their behavioral health. (Page 42)

Recommendation 2.6: If such an option can be identified, the Secretary of the Cabinet for Families and Children should institute internal policies to require caseworkers to find an alternate nonresidential placement as quickly as practicable. (Page 42)

Coordination of Services. Examination of this program indicated that the behavioral health problems exhibited by children in Impact Plus are similar to those of children in other public settings, including those in the juvenile justice system and in special education programs. Yet coordination of the services and funding streams was not generally apparent. The particular services received by children with severe emotional disturbance appeared to be a chance occurrence depending on which system they happened to encounter first. Better coordination and planning are critical not only to improve current service provision, but also to plan for expected increases in demand for such services.

Recommendation 2.7: The Administrative Office of the Courts should better track required data on the reasons children are committed to state custody. (Page 45)

Recommendation 2.8: Policy guidelines should be developed so children in state custody have access to similar services. Also, decisions should be made regarding whether children not in the state's custody can access the services made available to committed children. (Page 45)

Recommendation 2.9: Impact Plus managers should require service coordinators to better coordinate Impact Plus service plans with existing individual education plans for the same children. (Page 47)

Recommendation 2.10: Schools should be encouraged to participate in Medicaid's school-based services program so the behavioral health services that they are required to provide can be funded with the seventy percent federal match. (Page 47)

Recommendation 2.11: The General Assembly should direct the 843 Commission, created to make recommendations on mental health issues, to develop a prioritized plan for the funding of behavioral health services for children for consideration in the 2004 Session. (Page 50)

Recommendation 2.12: If the policy decision is made to continue the Impact Plus program, and if it can demonstrate acceptable fiscal management, the Cabinet for Health Services should consider using Impact Plus as a pilot program for evaluating how the issues to be considered by the 843 Commission might be addressed in practice. (Page 51)

Chapter 3: Utilization Management Recommendations

Impact Plus was planned as a budget neutral program. This review did not find it to be so. Poor program design and inadequate utilization control allowed annual program costs to increase from $5 million in 1998 to $24 million in 2000. The utilization problems encountered in this program are similar to other programs in which designers did not adequately plan utilization control and quality assurance systems before program implementation. However, actions taken by managers since the summer of 2000 have tightened eligibility criteria and imposed prior authorization requirements on service requests.

Impact Plus serves a different group of children than Medicaid had previously served. In particular, more children with conduct disorders and with autism accessed services through Impact Plus. The average per child expenditure for all children served by Impact Plus in calendar year 2000 was $5,719, and $13,477 for children with developmental disabilities such as autism. Given their relatively high costs and unique service needs, children with autism warrant special attention.

Complaints continue that the prior authorization process is cumbersome and that slow decisions are restricting children's access to needed care and imposing an unreasonable financial burden on providers. Given the conclusion that the expanded provider pool is one of the benefits of the Impact Plus structure, there is concern that inadequate performance by the Healthcare Review Corporation, the current utilization manager, will reduce providers' willingness to participate in the program.

Recommendation 3.1: The Secretary of the Cabinet for Health Services should explicitly state a target budget for Impact Plus to increase the ability to hold managers accountable for excess expenditures. (Page 66)

Recommendation 3.2: Legislative committees should be wary of the assumption that new programs will be funded entirely with "savings" and should require reasonable documentation of such estimates. (Page 66)

Recommendation 3.3: The Secretary of the Cabinet for Health Services should designate one or more individuals familiar with federal Medicaid rules and claims analysis to monitor the fiscal performance of Impact Plus. Those individuals should report directly to the Secretary on all matters related to Impact Plus. (Page 69)

Recommendation 3.4: The State Budget Director should be required to certify to the Appropriations and Revenue Committee that any new state-funded program to reimburse providers for services to eligible individuals has developed adequate utilization and quality control plans before funds are allotted to the program. (Page 71)

Recommendation 3.5: Program managers should be reminded to balance advocacy for the populations they serve with the fiscal priorities set by policy makers. (Page 73)

Recommendation 3.6: The Kentucky Autism Training Center should be directed to develop a "best practices" manual for the state-funded services provided to children with autism, who are high-cost utilizers of Impact Plus services. (Page 76)

Recommendation 3.7: Training should be given to case managers for children with autism to ensure they receive appropriate interventions. (Page 76)

Recommendation 3.8: Consideration should be given to delivering services to children with autism through early intervention and continuing programs for individuals with mental retardation and other developmental disabilities rather than through a program for children with severe emotional disturbance, such as Impact Plus. (Page 76)

Recommendation 3.9: Services delivered through Impact Plus should continue to be subject to centralized prior authorization requirements rather than being managed at the local level as they were originally. (Page 82)

Recommendation 3.10: The Department for Medicaid Services should require the Healthcare Review Corporation, the peer review organization that now does prior authorizations for Impact Plus services, to submit regular data on the time it takes to approve a service request. The Department should hold the Healthcare Review Corporation to reasonable standards for the time it takes to make a decision regarding a service request. (Page 83)

Recommendation 3.11: Current Impact Plus site review and outcomes measurement activities should be expanded. In particular, a clinician who can assess the appropriateness of the nature, frequency, and duration of the services included in the reviewed cases should be added to the site review team. (Page 85)

CHAPTER 1

INTRODUCTION

Impact Plus offers community mental health services to children with severe emotional disturbance.

Impact Plus was developed as a program to provide community behavioral health services to Medicaid-eligible children with severe emotional disturbance in an effort to reduce their costs of institutional care. In May 2001, the Program Review and Investigations Committee authorized a study of the Impact Plus program. The Committee was concerned about rapid growth in program expenditures and approved the following study objectives:

- To provide an accurate description of the operations of Impact Plus from inception to date;
- To determine why costs have increased so substantially for a program that was projected to be budget neutral;
- To ascertain if eligibility determination and service utilization review are consistent with accepted practice for behavioral health services;
- To determine the methods used by program administrators to project funding requests; and
- To assess the information used by administrators to manage the effectiveness and efficiency of the program and determine the feasibility of developing performance indicators.

Program Review staff conducted numerous interviews with designers, managers, and staff of the program. Staff also talked with a selection of program providers, including an association of the directors of the community mental health centers. Representatives of parents were interviewed, along with a group of children who had received behavioral health services.

Staff reviewed documentation of Impact Plus operations and procedures, regulations, and policy manuals. Minutes and meeting folders were obtained from all sessions addressing Impact Plus in the Budget Review Subcommittee on Human Resources and the Subcommittee on Families and Children of the Health and Welfare Committee. Staff obtained and analyzed all Medicaid behavioral health claims for children from 1995 through July 2001. Finally, the general research literature and information on programs in other states were examined for their relevance to this study.

Brief conclusions regarding the study objectives listed above are as follows.

- Between its inception in January 1998 and October 2001, Impact Plus has received funding allotments that totaled $58.4 million. These funds were used to pay the behavioral health claims from 214 providers on behalf of 6,402 children. In calendar year 2000, claims were paid for 4,229 children at a total cost of $24 million and an average cost of $5,719 per child.
- The major reason costs increased so rapidly is that broad eligibility criteria were coupled with the federal requirement that Medicaid services be delivered as an entitlement to the population defined to be eligible.
- There were no effective utilization control procedures in place early in the program, which is another significant reason costs increased so rapidly. Since July 2000, tightened eligibility controls and centralized prior authorization requirements have slowed program growth. The major related issue at this time is persistent provider complaints that slow authorization decisions reduce children's access to care and represent a significant financial burden for small providers.
- Program managers did not make projections of funding needs, but simply requested funds to cover claims that had already been incurred.
- Performance information was not initially collected. Site reviews of providers and the collection of outcomes data have recently begun.

Inadequate program design allowed costs to grow rapidly, leading to difficult policy choices.

It was originally stated that Impact Plus would be "budget neutral." The rationale given was that the costs of the community services provided by Impact Plus would be offset by the expected decrease in expensive institutional care. In fact, the program allowed Medicaid reimbursement for a new set of services from a new group of providers. Because early eligibility criteria were broad, the program served a larger group of children than had been anticipated and costs grew rapidly. Evidence indicates that the program was not budget neutral and cost the Medicaid program significant net new dollars. Since the summer of 1999, Impact Plus managers have instituted utilization controls and tightened eligibility criteria. This has caused growth in the program to slow. However, the major conclusion is that the early program design flaws have created a situation in which policy makers must face the difficult decision of whether to continue funding the new services for an unanticipated population, which has expressed strong desire for those services, or whether to reduce program scope to relieve pressure on a Medicaid budget that is already facing serious deficits.

The report does not make policy recommendations, but offers suggestions for improving program management.

This report makes no recommendation regarding whether Impact Plus should continue in existence, or at what level it should be funded. Those are policy matters not subject to staff review. Recommendations intended to improve program efficiency and accountability are offered if policy makers decide to continue the program. Improvements in accountability and efficiency are especially important because of the recent settlement of a class action lawsuit against the Department for Medicaid Services (DMS). The settlement requires the Department to offer child behavioral health services similar to those of Impact Plus and requires the Department to publicize the availability of the services. Thus, Medicaid behavioral health expenditures for children are likely to grow in the future, no matter what decisions are made about Impact Plus.

Organization of the Report

The structure of the report is as follows.

- **Chapter 1** summarizes four issues key to understanding Impact Plus. These include a description of severe emotional disturbance, wraparound services, Medicaid's Early and Periodic Screening, Diagnostic, and Testing program, and a class action lawsuit filed by the Division of Protection and Advocacy.
- **Chapter 2** summarizes the structure of Impact Plus and describes the children, services, and providers associated with the program. It also provides an assessment of several programmatic issues related to Impact Plus and makes recommendations regarding the structure of the program.
- **Chapter 3** addresses issues related to utilization management and budget growth and offers recommendations for improved program efficiency.

Gray boxes are used throughout the report to provide examples and clarification of information discussed in the text.

Key Background Issues

Impact Plus was modeled after the state-funded Kentucky Impact Program.

Impact Plus is a program of community-based treatment services to Medicaid-eligible children with severe emotional disturbance. It was first implemented in 1997 and was administratively modeled after the state-funded Kentucky Impact Program for children with severe emotional disturbance that was created in 1990. Executive branch officials proposed the program to legislators as a way to reduce costly Medicaid expenditures for placement of children in residential facilities, particularly out-of-state facilities. It was reasoned that by providing local, coordinated community services to children who are "at risk of institutionalization," less institutionalization would be needed, cost savings would occur, and children would be served in their communities.

This program is complex because of the individual and varied nature of "serious emotional disturbances," the lack of scientific and professional research on mental or behavioral health treatment efficacy, the difficulties of coordinating and collaborating services among different state and local entities, and the applicability of federal Medicaid rules and regulations.

Four issues are key to understanding Impact Plus.

This section provides brief overviews of four issues necessary to understanding the operation of Impact Plus: severe emotional disturbance in children, the concept of wraparound services, the Kentucky Impact program, and Medicaid funding for behavioral health services through the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) program.

Severe Emotional Disturbance in Children

Children with severe emotional disturbance exhibit various types of disorders.

Children with severe emotional disturbance exhibit various types of disorders. These might be broadly categorized as mood disorders, conduct disorders, development disorders, and adjustment disorders.[1]

Mood disorders in children include, among others, depression, anxiety, and bipolar disorder. These conditions can result in suicide attempts, panic attacks, or other serious mental health events. Children with mood disorders are said to "internalize" their emotional disturbance.

Children with severe conduct disorders often exhibit aggressive or violent behavior. Often such children have attention deficits or hyperactivty. They can be impulsive and oppositional, and may have rage episodes. Such children are said to "externalize" their emotional disturbance. Children with conduct disorders tend to have poor peer relations and cannot handle any type of frustration. When frustrated or angry, they often strike out at those around them or at themselves.

Children with developmental disorders, such as those with autism or schizophrenia, have brain dysfunctions that may be coupled with hyperaroused central nervous systems that make it difficult for them to process outside stimuli in a "normal" way. They often have very

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[1] These broad categories were developed by Program Review staff with the assistance of Dr. Robert Illback, Executive Director of R.E.A.C.H. of Louisville, Inc. He is the author of two evaluation studies of Kentucky Impact.

different perceptual realities, so communication and socialization can be limited.

Finally, children with adjustment disorders have difficulty adjusting emotionally after having endured difficult or stressful situations. For example, they may have prolonged post-traumatic stress disorder resulting from abuse and domestic violence. Some children who have been sexually abused become "sexually reactive" and act out sexual behavior. Prolonged neglect in infancy can impair brain development and functioning. Neglect and having inconsistent caretakers during the years of infancy can lead to "attachment disorders" that manifest as anti-social behavior. These children are often referred to as "having no conscience, no empathy, and no guilt."

Common Behavioral Health Disorders in Children

Anxiety disorders are the most common of childhood disorders. Children experience excessive fear, worry, or uneasiness. Anxiety disorders include phobias, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder.

Major depression is becoming recognized more frequently in young people. It is marked by changes in emotion (the child often feels sad, cries, looks tearful, feels worthless), motivation (schoolwork declines, the child shows no interest in play), physical well-being (there may be changes in appetite or sleep patterns and vague physical complaints), and thoughts (the child believes that he or she is ugly, that he or she is unable to do anything right, or that the world or life is hopeless).

Bipolar disorder (manic-depressive illness) is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). During a manic phase, the child may talk nonstop, need very little sleep, and show unusually poor judgment.

A child with **attention-deficit/hyperactivity disorder** is unable to focus attention and is often impulsive and easily distracted. Most children with this disorder have great difficulty remaining still, taking turns, and keeping quiet.

Learning disorders affect the ability of children to receive or express information. These can show up as difficulties with spoken and written language, coordination, attention, or self-control. These difficulties make it harder for a child to learn to read, write, or do math.

Conduct disorder causes children to act out their feelings or impulses in destructive ways. They repeatedly violate the basic rights of others and the rules of society. These offenses often get more serious over time. The offenses include lying, theft, aggression, truancy, firesetting, and vandalism. Children with this disorder usually have little care or concern for others.

Eating disorders can be life threatening. A young person with **anorexia nervosa** cannot be persuaded to maintain a minimally normal body weight. He/she is afraid of gaining weight and does not believe that he/she is underweight. **Bulimia nervosa** can cause children to feel compelled to binge (eat large amounts of food), and after they eat, they will rid their body of the food by vomiting, abusing laxatives, taking enemas, or exercising obsessively.

Autism spectrum disorder can appear in children less than three years old. Children with autism have problems interacting and communicating with others. They often repeat behaviors over long periods and can bang their heads, rock, or spin objects. They have limited awareness of others and are at increased risk for other mental disorders.

A young person with **schizophrenia** may have hallucinations, withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure.

Source: The Center for Mental Health Services, Mental, Emotional, and Behavior Disorders in Children and Adolescents (access date: August 9, 2001)
http://www.mentalhealth.org/publications/allpubs/CA-0006/Medbis2.htm

Their behavior is difficult to control and they can be dangerous to themselves and others.

Children with severe emotional disturbance present special challenges to parents and schools. Parents may be fearful of the behavior demonstrated or threatened by the child. Many parents simply do not have the skills to manage their children without assistance. Families may be receiving services for child abuse or neglect and the child(ren) have been recognized as having significant therapeutic needs. They are often placed in foster care where their behavior is extremely disruptive and, as a result, they can experience a number of placements. This inconsistency of treatment and placements often exacerbates the child's condition.

Treatment often requires re-teaching and re-socialization of children.

Effective treatment has been demonstrated for children with severe emotional disturbance. Treatment often focuses on the child's lack of internal control. The provision of external controls, through residential settings, outpatient therapy, partial hospitalization programs, behavioral training, social skill building, one-on-one role modeling, and medication therapy should lead to the child learning to internalize behavior changes so he or she can function in other social settings by exercising internal control. Treatment often requires re-teaching and re-socialization of children. Treatment options can be particularly difficult for children with "dual" diagnoses, such as those who are have mental retardation and are sexually reactive, or who have serious physical impairments coupled with explosive behavior. Effective treatment placements can be particularly difficult to find for children with multiple diagnoses.

Case Examples of Children with Severe Emotional Disturbance

Jennifer is a 6-year-old first grader in a regular classroom. The child has left the classroom on at least three occasions in an effort to go outside. She said that she is trying to help the squirrels that are calling for help and are "crying." She has been diagnosed with Major Depression with Psychotic Features. She was recently discharged from the crisis stabilization unit. She is taking Zyprexa. She is seeing a therapist once a week. Her mother is "worn out" because she can't sleep for fear the child will leave the house because of a hallucination. There is suspected sexual abuse by a past babysitter, but nothing has been substantiated.

Frank is an 11-year-old male who attends a K-8 school for children who need a self-contained class for children with emotional disturbance. He lives with his father, mother, and 7-year-old sister. He has a history of multiple psychiatric hospitalizations beginning at age 8. He has been diagnosed with Major Depression, but has been noncompliant in taking his medication. He was most recently hospitalized for cutting his wrists with tile that he tore up from the floor of the "time out" room at school. He spends about 50% of his time at school in the time-out room because of aggressive and threatening behavior. His mother has expressed fear of this child, who is large for his age. Neither parent has control of the child's behavior and he frequently terrorizes his mother and sister. There is a history of domestic violence between the mother and father. Both children have witnessed the violence and expressed fear for the mother's safety when the father "goes off."

Adam is a 3-year-old child diagnosed with autism. He lives with his mother and 1-year-old sister. His parents have recently divorced because of his father's shame about Adam's autism. He attends day care but he is at risk of losing that placement because of his aggressive and self-harming behaviors. When Adam becomes frustrated he throws toys, which sometimes hit other children, and he "claws" at his face and arms resulting in bleeding sores. Adam requires constant supervision to keep him safe. He is very limited in his self-care skills and he is not yet potty trained. Caring for Adam and his 1-year-old sister is very demanding of his mother and she describes herself as feeling overwhelmed and isolated from family and friends.

Cheryl is an 8-year-old child who was suspended last year from an alternative school and after-school program for fighting peers and refusing adult direction. She was "kicked out" of two summer programs and day care for these same behaviors. At one program, she kicked a child in the groin because she was angry. Also, over the summer she hit her 6-year-old brother hard enough to give him a black eye. Last school year she was also suspended for taking a knife to school. The child's aggressive behaviors have been escalating over the past year, which has caused her to move from three different treatment foster homes. The child repeatedly makes statements that she "hates her life" and a few months ago she attempted to cut her hand with a broken CD. This child has a history of sexual abuse. The child was removed from her mother's home when her mother threatened to kill the child and the CPS worker during a home visit. The child has been diagnosed with Major Depression, Attention Deficit Hyperactivity Disorder and Post-traumatic Stress Disorder. She attends individual counseling weekly at school and a sexual abuse group at a local counseling agency.

Case examples were provided in a training session for case managers and were developed by the Department of Community Based Services staff from actual cases. All names have been changed.

Wraparound Services

"Wraparound" services are flexible community-based services that are designed to meet the needs of the individual.

Wraparound services are flexible, community-based services intended to reduce institutionalization. According to the Center for Mental Health Services, wraparound is defined as "a 'full-service' approach to developing help that meets the mental health needs of individual children and their families. Children and families may need a range of community support services to fully benefit from traditional mental health services such as family therapy and special education."

Wraparound is meant to "wrap" the services around a child, not fit the child into an existing treatment plan. The services utilized in the wraparound process can include available services in the school or community, but can also include in-home services. A care coordinator is assigned to the child, and this coordinator, along with the child, his or her family, natural supports (which could include friends, church members, and relatives), teachers, and mental health staff, all help decide what plan of care is best for the child. Wraparound is intended to give the child and the family a voice in a coordinated and community-based treatment plan.

Essential Elements of Wraparound

1. Wraparound must be based in the community.
2. Services and supports must be individualized, built on strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school, and community.
3. The process must be culturally competent, building on the unique values, preferences, and strengths of children and families, and their communities.
4. Families must be full and active partners in every level of the wraparound process.
5. The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
6. Wraparound child and family teams must have adequate, flexible approaches, and flexible funding.
7. Wraparound plans must include a balance of formal services and informal community and family resources.
8. An unconditional commitment to serve children and families is essential.
9. The plan should be developed and implemented based on an interagency, community-based collaborative process.
10. Outcomes must be determined and measured for the system, for the program, and for the individual child and family.

Source: B.J. Burns and S.K.Goldman, (Eds.) (1999). *Promising Practices in Children's Mental Health*, 1998 Series, Volume IV. Washington D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

The concept of wraparound services has been discussed for many years and has been applied in many programs nationwide; however, major impetus was given to wider application of wraparound services as a result of the Olmstead decision.

The *Olmstead* Decision

In the Olmstead decision, the U.S. Supreme Court ruled that disabled people must be served in their communities, if possible.

The Olmstead case, Olmstead v. L.C., 119 S.Ct. 2176 (1999), was brought on behalf of two women with mental retardation and mental illness. They both lived in state-run institutions and sued the state of Georgia because they could have been appropriately served in a community setting. Attorneys for the women argued that holding them in an institution was a violation of their rights under the Americans with Disabilities Act (ADA), which obliges States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The U.S. Supreme Court agreed, stating it was a violation of the ADA for states to discriminate against people with disabilities by not providing community based services to those that could use them. States were mandated to develop compliance plans.[2]

There are requirements that must be met before the state must provide community services mandated by the Olmstead decision. First, treatment professionals have to determine that community placement is appropriate for the individual; second, transfer from the institution to the community is not opposed by the person; and third, the community placement can be reasonably accommodated by the state, taking into account the resources available to the state and the needs of others with disabilities.[3]

The U.S. Office of Civil Rights began working with Kentucky on compliance in March 2000. To comply with Olmstead requirements, Kentucky must have a comprehensive plan for placing all qualified persons with disabilities in less restrictive settings, and the waiting lists for community based services must move at a reasonable pace. A number of state agencies and state initiatives are involved in Olmstead compliance:

- Medicaid Services and its advisory committees;
- Office of Aging Services;
- Department for Public Health;

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[2] United States, Centers for Medicare & Medicaid Services, State Medicaid Director letter, January 14, 2000, p. 1. http//www.hcfa.gov/medicaid/smd1140a.htm

[3] *Ibid.*

- Supports for Community Living Waiver Program and the "144 Commission";
- "843 Commission" on services to persons with mental illness, alcohol and other drug abuse disorders, and dual diagnoses;
- Department for Mental Health and Mental Retardation Services;
- Long Term Care Quality Task Force; and
- Commission on Children with Special Health Care Needs.[4]

One of the challenges under this decision is how to more effectively use Medicaid funds to develop community based treatment.[5] This decision and its implications for the state will affect the population served under Impact Plus.

The Kentucky Impact Program: The Model for Impact Plus

Kentucky Impact was created in 1990 and is fully funded with state dollars ($5.2 million in FY 01.)

Kentucky Impact was created by statute in 1990 (KRS 200.501 to 200.509) in response to a rapid escalation of child mental health costs associated with psychiatric hospitalization and the desire to promote a more responsive, collaborative, and community-based approach to services, including wraparound services. The Kentucky Impact program provides services to children who are at risk of institutionalization for severe emotional disturbance and is funded entirely with state General Funds. General Funds allotted to the Kentucky Impact Program have grown from $3.1 million in FY 1991 to $5.2 million in FY 2001. In FY 2001, the program served a total of 5,717 children at an average of $912 per child.

The system is comprised of:

- a State Interagency Council (SIAC) that
  - is composed of representatives from all state agencies that serve children;
  - provides program oversight and coordination; and
  - receives staff support from the Department for Mental Health and Mental Retardation Services.

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[4] Marcia R. Morgan, Cabinet for Health Services, Kentucky's Response to the Olmstead Decision, Presentation to the Health and Welfare Committee, August 22, 2001.

[5] "A Conversation with Thomas Perez, " *Policy & Practice of Public Human Services: The Journal of the American Public Services Association* (September 2000), 21.

Regional interagency councils (RIACs)
  - are composed of representatives from local or regional offices of state agencies and parents and service providers;
  - determine eligibility for services, approve treatment plans, and approve and pay for services;
  - are chaired by the regional administrator of the Department for Community Based Services; and
  - receive staff support from local resource coordinators employed by community mental health centers.
- Local interagency councils (LIACs)
  - perform the duties of the RIAC in the more populated areas, and
  - are coordinated through a RIAC.

Flexible funds are managed by regional interagency councils to pay for individualized services.

A major component of the Kentucky Impact model is the availability of wraparound services. These services are funded by the Intensive Family Based Support Services (IFBSS) budget item of the Department for Mental Health and Mental Retardation Services. These are flexible funds used to support services tailored to each child and family. Requests for use of these funds for services are managed by the RIACs for children in the Kentucky Impact Program or by the community mental health centers for other children.

The Kentucky Impact Program has been evaluated at five and ten year intervals by R.E.A.C.H. of Louisville, Inc. These studies conclude that the program is serving the intended population, that an array of services has been developed, that there are positive clinical outcomes for children, and that there have been substantial reductions in psychiatric hospitalizations, resulting in cost savings.[6]

Medicaid Funding for Behavioral Health Services

Medicaid funding for child behavioral health is limited to certain services.

Before the implementation of Impact Plus, Medicaid funds for children's mental health and other treatment for serious emotional disturbance were limited to payments for services rendered by physicians, hospitals, psychiatric residential treatment facilities, and community mental health centers.

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[6] Robert J. Illback, et al. *Evaluation of the Kentucky Impact Program at Year Five: Accomplishments, Challenges, and Opportunities*, Louisville, KY: R.E.A.C.H. of Louisville, Inc., 1995. Robert J. Illback, Daniel Sanders. *Kentucky Impact at Year Ten*, report not yet published.

The following list displays the types of **behavioral health** services available for different categories of the Medicaid-eligible population.

Medicaid Behavioral Health Services

1. **Any Medicaid Recipient**
   - Physician services
   - Pharmacy
   - Outpatient hospital services
   - Rehabilitative services provided by community mental health centers
   - Targeted case management for adults provided by community mental health centers
2. **Any Medicaid-Eligible Child**
   - All services in Item 1
   - In-patient treatment at psychiatric hospital
   - EPSDT Special Services
   - Targeted case management by the Cabinet for Families and Children for any child in state custody
3. **Medicaid-Eligible Children with Severe Emotional Disturbance**
   - All services in Items 1 and 2
   - Residential treatment at a psychiatric residential treatment facility
   - Targeted case management by community mental health centers
   - Impact Plus services

Some Medicaid services are required by the federal government; others are provided at a state's option.

Some of these services are mandatory; the federal government requires their inclusion in the state Medicaid plan. Some are optional; the state may choose whether or not to cover the services. The only mandatory behavioral health services in Medicaid are:

- Physician services;
- Outpatient hospital services;
- In-patient treatment at a psychiatric hospital for children (subject to prior approval); and
- EPSDT Special Services.

All the other services listed in Items 1 to 3 above are covered by Medicaid at the state's option, and states may implement special requirements for the optional services. For example, Kentucky chooses to provide targeted case management only through the Cabinet for Families and Children or the community mental health centers.

EPSDT Medicaid Program

EPSDT is a mandatory screening & prevention program for Medicaid-eligible children.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated component of the state's Medicaid program. Its purpose is to finance early diagnosis and treatment of physical and mental conditions in children before the conditions become serious. There are two components of EPSDT: (1) preventive screening, called EPSDT; and (2) diagnosis and treatment, called EPSDT Special Services. Mandatory services under EPSDT Special Services include all medically "necessary health care, diagnosis, services, treatment, and other measures … to correct or ameliorate physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan."[7] Kentucky has not required a screening before approval for ESPDT Special Services, and all services provided under EPSDT Special Services must have prior authorization.

EPSDT Special Services are only authorized on a case-by-case basis.

EPSDT Special Services are individualized for children who have particular medical and treatment needs and are evaluated one at a time. A variety of providers, including out-of-state residential providers, are approved on a case-by-case basis. Each case, service plan, and provider must have prior authorization to receive Medicaid reimbursement for services.

EPSDT Special Services are available to all Medicaid-eligible children.

EPSDT Special Services are mandatory and considered an entitlement for Medicaid-eligible children. This is important to note because the types of services provided by Impact Plus may be provided under ESPDT Special Services when children are found ineligible for Impact Plus and the services are approved by Medicaid as "medically necessary." The administrative regulation for Impact Plus, 907 KAR 3:030, includes a requirement that Impact Plus case managers inform consumers of the availability of services under EPSDT Special Services when they are found ineligible for Impact Plus. Some children receive both Impact Plus services and EPSDT Special Services.

There are similarities and differences between EPSDT Special Services and Impact Plus.

EPSDT Special Services and Impact Plus are similar in may ways, and Impact Plus was first implemented as one method of reducing expenditures in EPSDT. However, there are several major differences between Impact Plus and EPSDT Special Services.

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[7] 42 *USC* 1396 d(a)

EPSDT Special Services	Impact Plus
Available to all Medicaid-eligible children	Available only to Medicaid-eligible children with severe emotional disturbance
Services decided on a case-by-case basis	Services delivered through an organized system
Restricted provider pool	Broader provider pool
Lack of consumer knowledge regarding availability	More widely known
Mandatory under federal rules	Optional under federal rules

EPSDT Court Cases

Lawsuits have been filed in 28 states alleging poor provision of EPSDT screenings and services.

Nationally, lawsuits have been filed alleging poor implementation of the mandatory EPSDT services. Since 1995, Medicaid recipients or advocates in twenty-eight states have sued, alleging that the states failed to provide children the required access to EPSDT services. Some of these cases have concerned program-wide failures in the delivery of services, such as in Tennessee. In Maine, a case involved only the delivery of mental health services.[8]

The Division of Protection & Advocacy (P&A) sued to force the Kentucky Medicaid program to better provide EPSDT services.

In Kentucky, a recent settlement agreement ended a class action lawsuit about EPSDT benefits. The Division of Protection and Advocacy brought a class action lawsuit to enforce the EPSDT screenings requirement. The lawsuit claimed that the Medicaid program failed to inform all eligible persons about the availability of EPSDT services and failed to adequately arrange for these services upon request.[9]

P&A system was created by Congress in 1986.

In 1986, Congress passed the Protection and Advocacy for Mentally Ill Individuals Act of 1986. This federal law created a protection and advocacy (P&A) system for individuals with mental illness in each of the states. Congress authorized the new system to protect and advocate the rights of the mentally ill and to investigate incidents of abuse and neglect of the mentally ill.[10] Three federal laws form the basis of P&A's authority to serve the mentally ill, the developmentally disabled, and other disabled persons.[11] This

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[8] U.S. General Accounting Office, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, Washington : GAO, July 2001, p. 9.

[9] *Jeremy and Darvin J. et al. v. Helton et al.* Civil Action No. C-96-48, Settlement Agreement, June 8, 2001, p. 1.

[10] 42 *USC* 10801 (2001).

[11] Interview with P & A Attorney, August 7, 2001.

discussion refers only to the statute that authorizes services for the mentally ill.

Kentucky's P&A unit operates as a state agency with a $1.6 million budget.

Although many states operate their protection and advocacy units as nonprofit organizations, Kentucky chose to operate its system through a state agency. Structurally, the Division of Protection and Advocacy acts as an advocate for the disabled and is a part of the Department of Public Advocacy in the Public Protection and Regulation Cabinet. The primary source of funding for P&A is the federal government.[12] In FY 2001, the federal government provided $1.15 million dollars of the total $1.61 million funding for P&A, while the state provided the remaining $460,000 from the General Fund. Of the $1.15 million federal funds, approximately $360,000 came from the funding of the Protection and Advocacy for Mentally Ill Individuals Act of 1986.[13] The Division of Protection and Advocacy acts as an advocate for the disabled.

In June 2001, the KY Department of Medicaid Services settled an EPSDT suit brought by P&A.

On June 8, 2001, a federal judge approved a settlement agreement that P&A reached with Kentucky Medicaid officials to end the lawsuit over the EPSDT program. The settlement agreement outlines the evidence of the Medicaid program's lack of compliance with EPSDT screening requirements and shows improvements that the program made since the lawsuit began. According to the settlement agreement, the Kentucky Medicaid program failed to meet federal goals for EPSDT screenings. In 1990, the federal oversight agency for the Medicaid program set a goal for each state for recipient participation in EPSDT. By FY 1995, each state was to achieve an eighty percent EPSDT participant ratio. This ratio indicates the number of children eligible for EPSDT screening services who received at least one EPSDT initial or periodic screening service. In Kentucky, this ratio has never been met. The participant ratio was thirty-nine percent in FY 1999. Kentucky had 302,115 children eligible for EPSDT services, but only 117,825 received a screening.[14]

To settle the case, Medicaid agreed to inform eligibles and train providers about EPSDT screenings as a means of achieving screening targets.

The settlement agreement articulates specific actions that state Medicaid officials must carry out in order to inform recipients and train providers. The settlement requires that Medicaid reach certain intermediate goals by the beginning of federal fiscal years 2004, 2005 and 2006. Medicaid is supposed to reach the eighty percent participation goal in EPSDT by October 1, 2006. This settlement

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[12] *Ibid.*
[13] Information provided by the Division of Protection and Advocacy on August 29, 2001 via e-mail.
[14] *Jeremy and Darvin J. et al. v. Helton et al.* Civil Action No. C-96-48, pp. 2 & 3.

requires Medicaid to effectively inform Kentucky's citizens about EPSDT services in a timely fashion. Additionally, the settlement requires that the state Medicaid program inform and train providers about EPSDT services.[15] Medicaid is also required to disseminate to providers written information on the scope of community-based mental and behavioral health related services that may be covered.[16]

The agreement specifies that community-based behavioral health services must be provided.

The settlement agreement addresses many behavioral health issues. The agreement states that Medicaid must provide medically necessary mental and behavioral health related services. The settlement specifies that the following community-based services should be offered:

- Case management;
- Evaluation;
- Individual community-based behavioral health services;
- Group community-based behavioral health services;
- Partial hospitalization;
- Intensive outpatient services;
- Children's therapeutic rehabilitation services;
- Behavioral health group treatment; and
- Collateral services and such other behavioral health and rehabilitative services as may be medically necessary.[17]

The agreement does not stipulate that the services must be provided through Impact Plus.

According to a P&A attorney, these services look similar to the Impact Plus services. Impact Plus is a tool through which the state delivers services to children; it is considered a "vehicle for EPSDT." Nowhere in the settlement agreement is there a requirement that the vehicle for these services must be the Impact Plus program or that Impact Plus services are the ones that must be provided. Now that Impact Plus services are subject to prior authorization just as EPSDT Special Services are, the difference between services under EPSDT Special Services and Impact Plus lies primarily in who can provide the services. Under the Protection and Advocacy Settlement Agreement, the Department for Medicaid Services maintains that the services agreed to can be provided solely by community mental health centers and need not be provided through Impact Plus.

According to the agreement, budget constraints cannot limit delivery of the agreed services.

According to the agreement, the provision of mental and health related services cannot be compromised by financial matters. The agreement specifically states, that "Any state budget constraints

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[15] *Jeremy…*, p. 8.
[16] *Jeremy…*, p.10
[17] *Jeremy…*, p. 9.

shall **not** cause failure to cover these services."[18] This settlement agreement could increase future Medicaid spending for children's behavioral health services, although the Secretary of Health Services believes that the most costly children are likely receiving the required services already.

In the future, federal courts may not hear cases to enforce Medicaid benefits.

If a recent federal decision is affirmed, P&A's ability to bring suits in the federal courts to enforce the Medicaid rights of the disabled could be substantially limited in the future. That is, the federal courts would not hear cases similar to the one just settled in Kentucky. In Michigan, a federal district judge dismissed a federal class action lawsuit challenging Michigan's slow implementation of EPSDT services.

In Michigan in 1999, Westside Mothers and Families on the Move, two groups of parents of Medicaid-eligible children, sued to require that state to meet EPSDT screening targets and provide related services. According to the case, the goal of the suit was to ensure that poor children in Michigan would have adequate medical care.[19]

A federal court in Michigan ruled that Medicaid recipients could not sue states in federal court.

The federal court in Michigan held that the federal courts do not have the authority to hear this case. According to the court, while Congress created the Medicaid program, that did not give Medicaid beneficiaries a right to sue the state to enforce benefits. Under federal Medicaid law, the federal government can only withhold federal funds from a state that is out of compliance. Federal law does not allow either the federal government or the Medicaid recipients to file lawsuits against the state.[20]

The Michigan federal court held that participation in the Medicaid program did not mean states lose sovereign immunity.

According to the court, Michigan cannot be sued in the federal court because Michigan has sovereign immunity under the 11th Amendment to the U.S. Constitution. The court stated that when a state accepts federal Medicaid money, this does not mean that the state consents to lawsuits by Medicaid recipients. The state of Michigan did not lose its sovereign immunity simply because it chose to participate in the Medicaid program. Unless the state consents to the suit, sovereign immunity under the 11th Amendment bars this type of lawsuit.[21] According to the P&A attorney, if the federal courts do not have the authority to hear the case, the only recourse is the law of the state. The P&A attorney stated that Kentucky law does not give Medicaid recipients the right to enforce

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[18] Interview with P&A attorney, August 7, 2001.
[19] *Westside Mothers v. Haveman*, 133 F. Supp. 2d 549, 552 (E.D. Mich. 2001).
[20] *Westside…*, p.p. 553-555.
[21] *Westside…*, p. 559.

federal mandatory Medicaid benefits. It would be difficult to bring a suit to enforce Medicaid recipients' rights under state law.[22]

The case is on appeal to the Sixth Circuit.

Federal appellate courts and the U. S. Supreme Court will determine this question. This case is now on appeal to the Sixth Circuit in Cincinnati. Kentucky and Michigan are both a part of the same federal appellate court circuit. If this case is affirmed, it would have a significant effect on Protection and Advocacy, according to officials, limiting the Division of Protection and Advocacy's litigation role in the federal courts. P&A would have to rely on the state courts because the federal courts would no longer have jurisdiction over this type of lawsuit.

Any new court ruling would not affect the existing settlement agreement in Kentucky.

However, it should be noted that, according to the P&A attorney, the recent settlement agreement with the Kentucky Department for Medicaid Services would probably not be affected by any federal ruling in the *Westside Mothers* case. Unlike the Michigan case, the parties settled the Kentucky case and the federal judge has approved the settlement agreement.

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[22] Interview with a P & A attorney, August 7, 2001.

CHAPTER 2

IMPACT PLUS USES MEDICAID FUNDS TO EXPAND COMMUNITY SERVICES

This chapter presents a description of the structure of the Impact Plus program and the children, services, and providers associated with the program. Rather than describe the operational intricacies of the program, which have changed frequently throughout its brief history, this chapter provides an overview of the major elements necessary to understand its current operation. A final section of the chapter raises programmatic issues of concern and offers recommendations for addressing them.

Impact Plus Is Created

Impact Plus was created to reduce the costs of institutionalization through the provision of community-based services.

Expenditures for EPSDT Special Services increased significantly in the 1990s. A 1996 review of state General Fund and Medicaid expenditures for children "with complex treatment needs" revealed that most of the funding, sixty-two percent, was for inpatient and residential services, yet this was serving only nineteen percent of the population. An interagency report, *Kentucky Impact Plus: A Blueprint for Expanding Services for Children with Complex Treatment Needs* was presented to interim committees of the 1996 General Assembly. This information, the knowledge that there were approximately 200 children in expensive out-of-state residential treatment facilities paid by Medicaid funds, and the state's continued commitment to local, flexible, coordinated funding for services that are the most appropriate and accessible and the least restrictive resulted in the creation of Impact Plus. It was determined that Medicaid dollars should be used for community-based treatment, similar to the "wraparound" approach, to return children to Kentucky and to prevent future need for residential treatment and psychiatric hospitalization.

Impact Plus Services

A service coordinator is paid to coordinate a plan for delivering the individualized services needed by each child.

Table 2.1 displays the services offered through Impact Plus and identifies who may provide the services. Once a Medicaid-eligible child is determined eligible to receive Impact Plus services, the child is assigned a service coordinator. The coordinator is paid a case management fee of $300 per month to schedule an initial evaluation of the child's needs, assemble a team that includes the parent or guardian to develop a service plan to address those needs, and make regular contact with the child, family, and treatment providers to ensure that care is proceeding according to the service plan.

Table 2.1
Impact Plus Services, Providers, and Rates

Service	Description	Provider	Range of Reimbursement Rates
Case Management	Service plan development and service coordination	CFC, CMHC (usually billed through other Medicaid) or other qualified organization, experience required	$300 per month
Behavioral Health Evaluation	Face to face evaluation and diagnosis	Behavioral health professional*	$50-120/hour
Individual Therapy	Face to face service	Behavioral health professional	9 separate ranges of rates: child caring facility- $10 - $22.50;. psychiatrist- $20 - $40 / 15 minutes.
Group Therapy	Face to face service in a group of no more than 8	Behavioral health professional	Institutional: $3 - $12.50/ 15 minutes Individual - $4 - $15/ 15 minutes
Collateral Service	Face to face meeting with parent, legal representative, school personnel	Behavioral health professional	4 categories range from $10 - $30/15 min.
Therapeutic Child Support	Direct service to recipient or family for behavior management, in-home support, or transition to adulthood	Behavioral health professional with certain qualifications, experience and training	Differs by staff credentials: Para-Professional (High School Level): $7.50-$28/hour; Professional Level: $16-62/hour or $27-$75/hour
Parent to Parent Support	Direct service to parent for service plan, behavior management plan, support groups, transition	A parent of an SED child receiving services and is employed by a service agency	$8.50-$38/hour
After School or Summer Program	Individual and group activities	Behavioral health professional; child to staff ratio of 4:1;	Institutional - $10 - $28/hour; Individual - $10 - $15/hour.
Day Treatment	Treatment and educational services as part of a special education (or IEP program) on schools days or during summer; local education authority approval required	Behavioral health organization; excludes Medicaid's school based services program	Institutional $10 - $38/hour
Partial Hospitalization	Less than 24-hr care 5-7 days per week with management by psychiatrist; therapy and medications	Licensed hospital or CMHC; linkage agreements with local educational authority; excludes Medicaid's school based services program	$30 - $42/hour
Intensive Outpatient Therapy	2 hour individual or group therapy 3 times per week	Behavioral Health Professional; AODE program	$15 - $36/hour

Table 2.1 (continued)
Impact Plus Services, Providers, and Rates

Service	Description	Provider	Range of Reimbursement Rates
Therapeutic foster care	24 hour supervision and treatment in a foster home	Employed or contracted by licensed child placing agency	$55 - $155/day; Dual Diagnosis: $100 - $155/day
Therapeutic group residential	24 hour residential facility, psychotherapy, behavior management; skills training, independent living for youth age 14 and older	Child Caring facilities, AODE residential service providers	$110 - $230/day
Residential crisis stabilization	Short term assessment, intervention, and discharge planning	Child caring facilities, AODE residential service providers, hospitals, CMHC	$138 - $320/day
Wilderness Camp	Structured program for skill building through overnight experiences in an outdoor environment	Child caring facilities	$200 (only one agency has an established rate)

Definitions:
Behavioral Health Professional: Physican, psychiatrist, licensed psychologist, clinical social worker, ARNP, marriage & family therapist, professional counselor, professional art therapist, alcohol & drug counselor
CFC-Cabinet for Families and Children
CMHC-Community mental health center staff
SED – Severe Emotional Disturbance
IEP – Individual Education Plan
AODE-Alcohol or other drug entity residential program

Source: Department for Mental Health/Mental Retardation.

Impact Plus negotiated individual rates with each provider, so rates are not uniform for providers of the same service.

A notable feature of Impact Plus is that managers negotiated individualized rates with providers. This means that two providers might be reimbursed at very different rates for the same service delivered in the same locality. For example, one provider might receive $16 for an hour of group therapy, while another might receive $60 for the same service. Negotiation of these individualized rates took a great deal of staff time early in the program's development and created resentment among some providers who believed they had been disadvantaged.

The program was proposed as "budget neutral" because it was assumed that the cost savings from reduced residential treatment and hospitalization, both in-state and out-of-state, would be used to fund the community-based services through Impact Plus. Eligibility, service plans, and approvals for services were managed by the Regional Interagency Councils.

Quality problems and concerns about rapid growth were raised early in the program's operation.

Quarterly meetings of the State Interagency Council (SIAC) began to document regional inconsistencies in 1998 and 1999. There appeared to be different standards among the Regional Interagency Councils as to who was eligible for the services and what types of services were approved. There was also confusion about when to use the Kentucky Impact (state dollars) and Impact Plus (Medicaid dollars) funding streams. The program also experienced growth in number of children served and number of services provided. In mid-2000, the Department for Mental Health/Mental Retardation advised that the program had grown beyond capacity and cost containment measures were necessary. Chapter 3 will address these issues in detail.

Description of Children, Services and Providers

Impact Plus case managers meet with the child, family members, and service providers to develop a plan for services. The plan specifies the types of services needed, who is responsible for providing the services, and the time frames. All parties indicate their agreement with the plan by signing the service plan. The plan is submitted to HRC for approval. Two examples of service plans follow:

Female 5th Grade Student Service Plan: August 2000

1. Strengths: Artistic, affectionate, friendly, strong support from mother, gets along with peers, volunteers for duties in classroom, performs well in structure environment.

2. Current Behaviors that place child at risk of institutionalization: Self mutilation, low self-esteem, immature or regressive actions, psychotic episodes, maladaptive behavior precipitated by seizure disorder, aggressive behavior toward family members.

Goal One: Retain 5th grade placement and obtain appropriate middle school skills.

Tasks	*Frequency*	*Responsible Party*
Keep in regular classroom as appropriate	Daily	School
Adopt abbreviated special education assignments	Daily	School

Graduation Goal (when youth is ready to exit): Retain in 5th Grade and graduate on schedule.

Goal Two: Child will not be admitted to psychiatric hospital and will be maintained at home.

Tasks	*Frequency*	*Responsible Party*
Service coordination, team meeting	4 contacts/mo.	Impact Plus case manager
Individual therapy sessions	1 hour /week	Impact Plus provider -private psychologist
Mom to attend collateral therapy	1 hour/mo.	Same psychologist

Graduation Goal (when youth is ready to exit): No admission to psychiatric hospital for 6 months.

3. Crisis Action Plan (symptoms or behaviors that occur prior to crisis): Self-mutilation, aggressive behaviors toward peers, failing to initiate or respond to social interaction.

4. Strategies to Address Behaviors (in least restrictive order): Psychologist to consult with physician to distinguish seizure activity with maladaptive behavior; child to contact Crisis Hot Line; educate child on seizure activity and appearance of onset; partial hospitalization for 20 days; psychiatric hospitalization.

Male Middle School Student Service Plan: October 2000

1. Strengths: Athletic, outgoing, through previous placement has learned to take direction and use better judgment, realizes his family is struggling but dedicated to family staying together.
2. Current Behaviors that place child at risk of institutionalization: Is returning from a 4 month residential placement and must learn to readjust to family structure without losing his anger management skills.
Goal One: Stabilize and maintain home environment.

Tasks	*Frequency*	*Responsible Party*
Service coordination in the community	4 contacts/mo.	Residential staff providing service coordination
Work on setting limits and boundaries for behavior	Once a week	Therapist
Locate home or apartment for family	Ongoing	Service coordinator and CFC

Graduation Goal (when youth is ready to exit): Child will not be hospitalized and will not be committed to CFC.

Goal Two: Child will control anger outbursts and decrease aggressive behavior.

Tasks	*Frequency*	*Responsible Party*
Child and family create ways to redirect aggressive behavior	Weekly	Therapist
Set attainable goals to reduce outbursts	Weekly	Child, therapist, therapeutic support staff

Graduation Goal (when youth is ready to exit): Aggressive behaviors will decrease and new skills to deal with anger will be developed.

3. Crisis Action Plan (symptoms or behaviors that occur prior to crisis): Very aggressive, punches holes in walls, destructive to property, runs away from home and school.
4. Strategies to Address Behaviors (in least restrictive order): Family to contact therapist; contact school and truancy officer when absence increases; access caseworker for community resources.

Figure 2.A illustrates the age and gender characteristics of the 4,229 children that accessed Impact Plus services in calendar year 2000. The figure clearly illustrates that few children under 6 or over 17 are accessing Impact Plus services. The figure also shows that about one-third of the younger children are female while about one-half of the older children are female.

In Calendar Year 2000, services were provided to 4,229 children, many of them boys between the ages of 8 and 14.

$24 million was spent in Calendar Year 2000, for an average per child cost of $5,719.

Fifty-one percent of the recipients and forty-seven percent of the claims in calendar 2000 were for children whose primary diagnosis was some form of conduct disorder.[23] During that year, 4,229 children had Impact Plus expenditures totaling just over $24 million. The average expenditure per recipient was $5,719. Children with developmental disorders, primarily autism, were relatively

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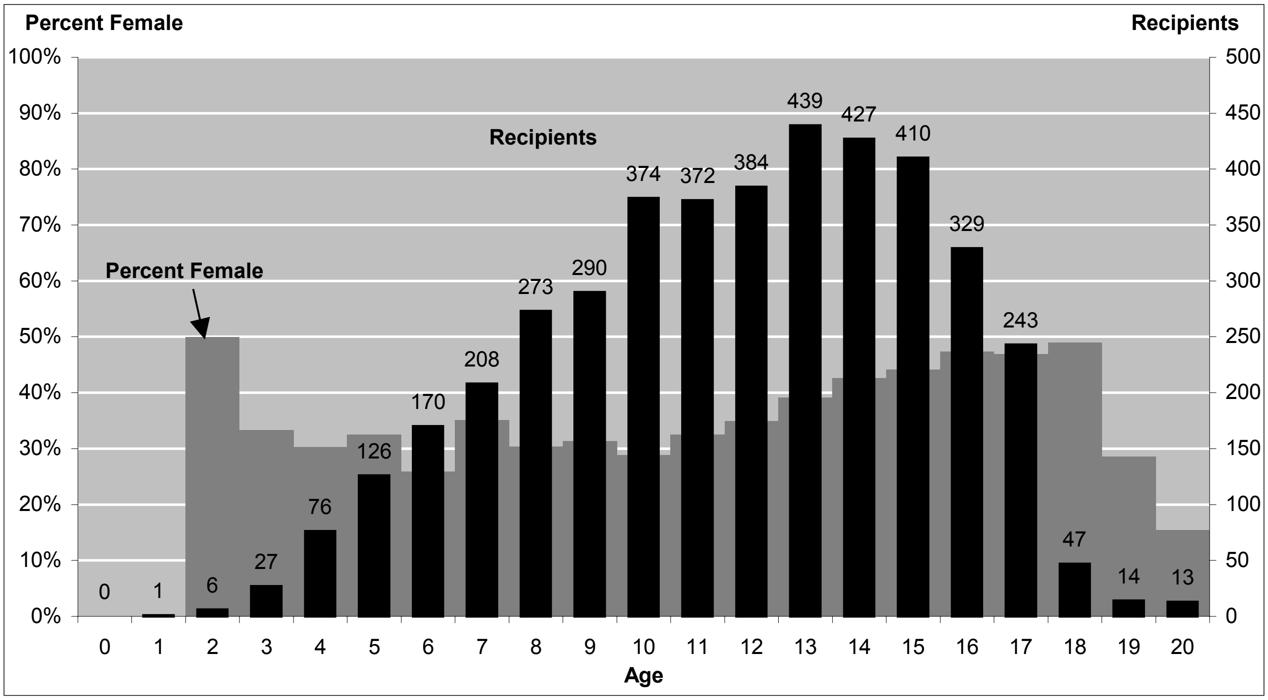
[23] Children often have multiple claims with different behavioral health diagnoses. For this analysis, the primary diagnosis is defined as that diagnosis associated with the largest dollars of claims.

expensive in this population. They accounted for three percent of recipients but eight percent of total expenditures. The expenditures per recipient were more than double those for the other diagnoses, at $13,477 (Table 2.2).

Figure 2.A
4,229 Impact Plus Recipients
Calendar Year 2000 Services



Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Table 2.2
Recipients and Expenditures by Major Diagnosis Category
Calendar Year 2000 Impact Plus Services

	Recipients		Expenditures		Expenditures per Recipient
Major Diagnosis Category	**Number**	**Share**	**Amount**	**Share**	**Amount**
Conduct (includes ADHD and Oppositional Disorder)	2,175	51%	$11,412,869	47%	$5,247
Mood	1,051	25%	$6,247,453	26%	$5,944
Adjustment	573	14%	$3,117,186	13%	$5,440
Developmental (includes Autism)	142	3%	$1,913,805	8%	$13,477
Unclassified	190	4%	$1,137,275	5%	$5,986
Drug Addiction/Abuse	98	2%	$357,527	1%	$3,648
Total	4,229	100%	$24,186,113	100%	$5,719

Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

The largest category of expenditures was residential treatment.

Of the $24 million Impact Plus claims in calendar 2000, the largest share (42%) was for residential care, with nearly three-fourths of that going for therapeutic group residential services (Table 2.3). The next largest category of services was for case management and service coordination, which accounted for nearly a fourth of total expenditures. This share is not surprising, since all children in the program receive these services.

Table 2.3
Impact Plus Expenditures by Type of Service
Calendar Year 2000 Services

	Recipients	Expenditures	Expenditures per Recipient
All Impact Plus Services	4,229	$24,186,113	$ 5,719
Case Management	2,576	$4,472,737	$ 1,736
Service Coordination	1,520	$1,350,232	$ 888
Collateral Service	1,256	$892,358	$ 710
Parent-to-parent Support Services	388	$457,874	$ 1,180
Therapeutic Child Support	1,711	$2,978,260	$ 1,741
Therapeutic Child Support Professional (BA/BS)	759	$1,412,097	$ 1,860
Therapeutic Child Support Professional (MA/MS)	50	$45,912	$ 918
Therapeutic Child Support Staff	1,206	$1,520,251	$ 1,261
Therapy	1,905	$2,380,405	$ 1,250
Group Service	149	$44,717	$ 300
Individual Service	1,758	$2,108,578	$ 1,199
Intensive Outpatient	175	$227,111	$ 1,298
Non-Residential Treatment	883	$2,767,573	$ 3,134
Day Treatment	103	$459,647	$ 4,463
Partial Hospitalization	225	$939,359	$ 4,175
Summer Program	5	$2,158	$ 432
Therapeutic After School	629	$1,366,409	$ 2,172
Residential	889	$10,236,906	$ 11,515
Crisis Stabilization	535	$1,317,969	$ 2,463
Therapeutic Foster Care	118	$1,549,035	$ 13,127
Therapeutic Group Residential	348	$7,363,734	$ 21,160
Wilderness Camp	9	$6,168	$ 685

Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Providers of residential treatment received the largest share of payments.

Table 2.4 displays the 20 Impact Plus providers who received the largest shares of total expenditures in calendar year 2000. The three top providers on this list received most of their payments for residential services. Buckhorn was the top recipient of overall payments largely because it was the top recipient of payments for residential services. The top recipient of payments for case management was Phoenix Preferred Care, and for service coordination the Institute for Family Services. BIFAC, an agency that provides intensive applied behavioral analysis therapy to children with autism, had the largest total billings for therapeutic child support. FHC Cumberland Hall was the largest single provider of group and individual therapy services, and Seven Counties Services was the largest provider of non-residential services, such as day-treatment and partial hospitalization.

Table 2.4
Top 20 Impact Plus Providers Based on Expenditure Amounts Broken Out by Major Category of Service Calendar Year 2000 Services

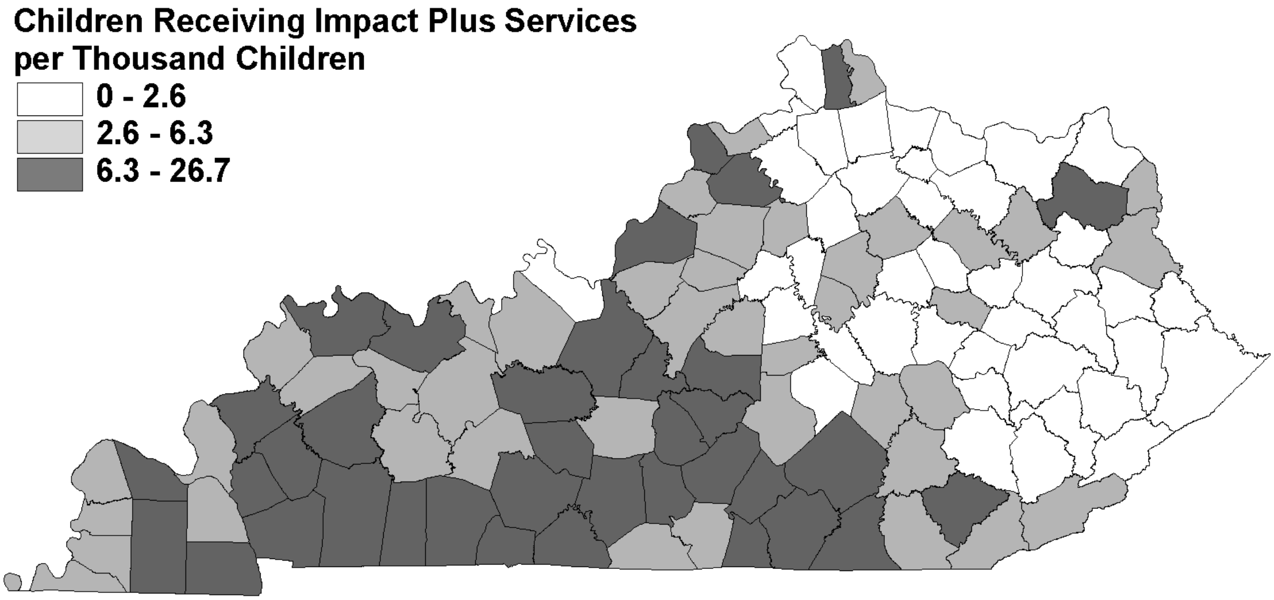
		Type of Impact Plus Service (top value for category is bolded)					
Vendor (CMHCs bolded)	**Total Impact Plus**	**Case Management**	**Service Coordination**	**Therapeutic Child Support**	**Therapy**	**Non-Residential Treatment**	**Residential**
Buckhorn Intensive Family Srv.	$1,814,248	$285,000	$82,934	$170,704	$24,627	$122,262	**$1,128,720**
Maryhurst, Inc.	$1,296,141	$66,300	$20,111	$53,583	$3,521	$329,206	$823,420
Brooklawn Youth Svcs.	$1,117,686	$55,500	$8,258	$63	$3,750	$0	$1,050,115
Seven Counties Srv.	$1,026,167	$49,800	$0	$55,344	$390	**$547,756**	$372,877
FHC Cumberland Hall	$881,164	$274,850	$3,605	$4,231	**$214,484**	$383,993	$0
Woodlawn	$793,785	$81,300	$6,886	$9,332	$1,544	$0	$694,723
Community Presence	$743,165	$86,588	$7,868	$28,943	$449	$38,170	$581,148
Intrust Health Care	$684,186	$275,400	$5,445	$369,312	$34,029	$0	$0
R.E.A.C.H. of Louisville	$670,225	$300	$0	$0	$0	$0	$669,925
Caritas	$599,865	$106,500	$570	$0	$48,283	$444,512	$0
Holly Hill Children's Home	$535,987	$201,700	$930	$52,555	$0	$0	$280,802
River Valley Behavioral	$521,404	$0	$0	$386,156	$575	$0	$134,673
Phoenix Preferred Care	$478,105	**$400,890**	$20,143	$36,607	$20,464	$0	$0
KY Baptist Homes for Children	$473,310	$38,700	$0	$900	$17,190	$0	$416,520
Institute for Family Services	$471,730	$180,300	**$128,875**	$154,220	$8,335	$0	$0
BIFAC	$441,723	$3,900	$14,486	**$423,337**	$0	$0	$0
St. Joseph Children's Home	$429,346	$107,400	$94,013	$39,780	$22,538	$19,605	$146,010
Home of the Innocents, Inc.	$377,544	$169,500	$0	$37,496	$7,740	$0	$162,808
Child Place	$366,720	$0	$600	$0	$1,980	$0	$364,140
LifeSkills, Inc.	$361,612	$0	$6,160	$139,736	$31,329	$0	$184,387

Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Utilization of Impact Plus services has been uneven across the state.

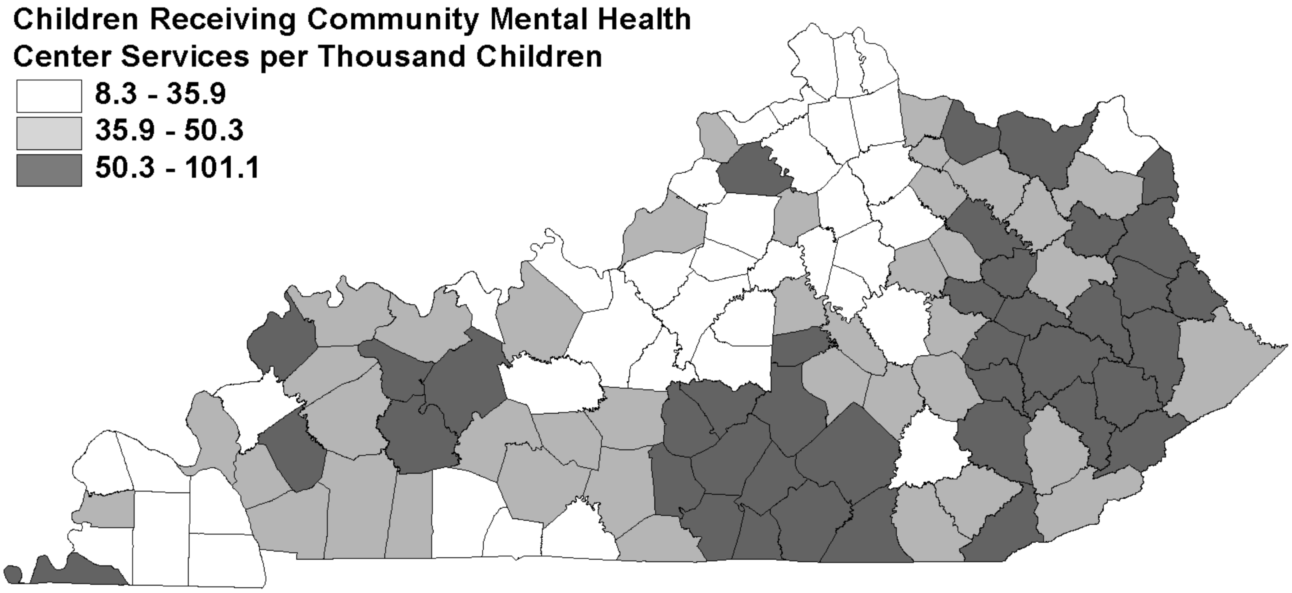
Figure 2.B shows the number of children who have received Impact Plus services per each 1000 children living in the county. Impact Plus services have been far less utilized by children in most parts of eastern and northern Kentucky than in southern and western Kentucky. However, this does not necessarily mean that children in the areas underserved by Impact Plus have gone without behavioral health services. Figure 2.C shows the number of children per 1000 that received Medicaid reimbursed behavioral health services from community mental health centers. This pattern shows much more statewide activity, and more activity in eastern Kentucky.

Figure 2.B
Children Receiving Impact Plus Services per Thousand Children
By County of Recipient's Residence
Calendar Year 2000 Services



Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Figure 2.C
Children Receiving Community Mental Health Services per Thousand Children
By County of Recipient's Residence
Calendar Year 2000 Services



Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Impact Plus Program Issues

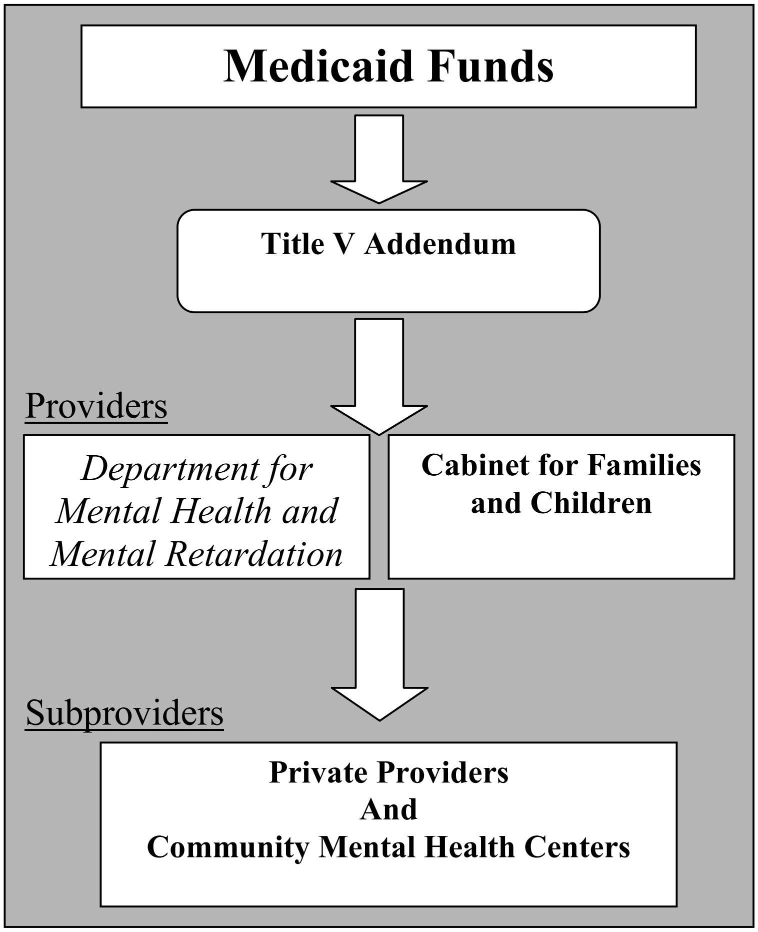
The major program issues are who will provide services and how services should be coordinated.

There are two major programmatic issues that merit particular discussion. One is whether the Title V agreement is the appropriate structure for Impact Plus. The second is whether Impact Plus services are sufficiently coordinated with other systems of care for children with mental health service needs.

Title V Agreement and the Provider Pool

The Title V Agreement permits Medicaid services to specially defined populations.

The Department for Public Health is the state's Title V Agency for Maternal and Child Health Services of the Social Security Act.[24] This Act permits contracts among entities to serve special at-risk populations with Medicaid funds. Title V agreements are in place for immunization programs, the HANDS home visitation program, and for federally defined rehabilitative services and targeted case management services provided to seriously mentally ill adults and children committed to the custody of the state. An addendum to the existing Title V agreement created the Impact Plus program.



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[24] Maternal and Child Health Services Block Grant, 42 *USC* 701(a)(1)(d)(1999).

Title V Addendum allowed expansion of the provider pool.

The Title V Addendum allowed program managers to accomplish two things. The first was to limit program enrollment to the population of interest: children with severe emotional disturbance in institutions, at risk of institutionalization, in the custody of the state, or at risk of being in custody of the state. The second was to allow expansion of the provider pool available to serve these children without making the providers available to the entire Medicaid population.

Prior to the Title V Addendum there was a more limited set of services covered by Medicaid and limits on who could provide the services.

Prior to the Title V Addendum, the rehabilitation services reimbursable by Medicaid were provided only by the community mental health centers and the Cabinet for Families and Children for children in their custody. With the Addendum, the Department for Medicaid contracts with the Department for Public Health (the Title V agency), which contracts with the Cabinet for Families and Children and the Department for Mental Health/Mental Retardation Services as the providers for Impact Plus services. Those departments, in turn, subcontract with individual providers for Impact Plus services. Only Medicaid-eligible children are served in this manner under the Impact Plus program. The Department for Medicaid Services pays the state match for these expenditures.

The Cabinet for Families and Children is responsible for children who are in state custody. The Department for Mental Health/Mental Retardation Services (DMHMR) is in the Cabinet for Health Services and, through Impact Plus, serves children not in state custody.

Title V Addendum is optional, but once in place, all children in the special population are entitled to services.

The Medicaid-Title V Addendum is an option for state Medicaid programs to provide unique services from specialized providers to a defined population. In this instance, the agencies were seeking specific types of providers for specialized services to children with complex treatment needs. Because Medicaid is an entitlement program, all children who meet the criteria of the special population are eligible for Impact Plus services.

The expanded pool of private providers is a key component of Impact Plus.

Thus, a key component of the Impact Plus program is the expanded pool of subcontracted private providers (through the Title V Addendum) enrolled in the program by the DMHMR. The private providers receive the bulk of Impact Plus payments, although the community mental health centers also provide Impact Plus services.

The key features of the Title V Agreement:

- Allows special services to a unique population;
- Limits who may access services by defining a special population rather than all persons eligible for Medicaid;
- Service providers are limited to Department for Mental Health/Mental Retardation Services and Cabinet for Families and Children;
- DMHMR andCFC specify requirements for subcontracts with individual community-based providers for direct services;
- DMHMR manages the pool of providers and CFC may access these providers for committed children; and
- Subcontracted direct service providers are not available to the general Medicaid population.

Private providers were recruited in anticipation of Medicaid behavioral health managed care.

When the program was first implemented through the Regional Interagecy Councils, benefit coordinators who were employees of the Department for Medicaid Services recruited private providers and negotiated rates of payment for the services they would deliver. It is important to note that this recruitment phase was implemented with the expectation of the forthcoming adoption of behavioral health managed care, and efforts were made to increase the provider pool so that behavioral health managed care organizations would have a more complete network of providers.

Private providers have demonstrated flexibility in designing and delivering “mobile” services, that are provided in the child's home, at school, during extra-curricular activities, or wherever and whenever appropriate behavior and social skills can be learned or re-learned.

Just as the Regional Interagency Councils experienced varying degrees of success with the management of Impact Plus, the CMHCs have had varying responses to developing and providing Impact Plus services. Some regions have developed new services and are actively providing Impact Plus services, while others have had little involvement (Table 2.5). However, in many regions of the state, the CMHC is the dominant provider of behavioral health services for children, particularly Medicaid funded services. This appears to be particularly true in the more rural regions of the state.

Without the Title V Addendum, all Impact Plus services would be delivered through the community mental health centers.

As noted in Chapter 1, the EPSDT Settlement Agreement between the Department of Public Advocacy and the Department for Medicaid Services requires Medicaid to provide Impact Plus-type services to children with a medical necessity. The Cabinet for Health Services maintains that all services included in the Settlement Agreement could be provided by CMHCs, and that the Title V Addendum is optional. Without the Title V Addendum, Impact Plus and Impact Plus-type services would be available only through the CMHCs.

Table 2.5
Community Mental Health Centers' Impact Plus Recipients and Expenditures
Calendar Year 2000 Services

Region	Center Name	Recipients	Expenditures	Expenditures per Recipient
1	Four Rivers Behavioral Health	50	$199,306	$3,986
2	Pennroyal Regional MH/MR Board, Inc.	158	$331,190	$2,096
3	River Valley Behavioral Health	191	$521,404	$2,730
4	Lifeskills, Inc	206	$361,612	$1,755
5	Communicare, Inc	124	$194,702	$1,570
6	Seven Counties Services, Inc.	411	$1,026,167	$2,497
7	NorthKey Community Care	34	$131,627	$3,871
8	Comprehend, Inc. MH/MR Board	5	$12,428	$2,486
10	Pathways, Inc.	57	$77,637	$1,362
11	Mountain Comprehensive Care	0	$0	$0
12	Kentucky River Community Care, Inc.	10	$263,360	$26,336
13	Cumberland River Regional MH/MR Board, Inc.	44	$20,961	$476
14	The Adanta Group	41	$341,239	$8,323
15	Bluegrass Regional MH/MR Board, Inc.	17	$14,524	$854

Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Community Mental Health Centers (CMHCs) provide most of the publicly funded mental health services in Kentucky.

The CMHCs have the responsibility for providing public mental health services. They are the "public safety net" and have crisis services available on a 24-hour/7-day-a-week basis. They are Medicaid providers and have established mechanisms for billing Medicaid for the general category of "rehabilitative services" and "targeted case management." (Targeted case management is a different budgetary line item than Impact Plus "case management"). Professionals with bachelor's degrees, such as social workers and psychologists, and other "professional equivalents" are approved Medicaid providers only when employed by a CMHC, but otherwise are not approved as Medicaid providers. CMHCs contract with other entities for specific services, but generally the CMHCs deliver most of the state and federal funded services for mental health and mental retardation in Kentucky.

CMHCs can access reimbursements through regular Medicaid and through Impact Plus.

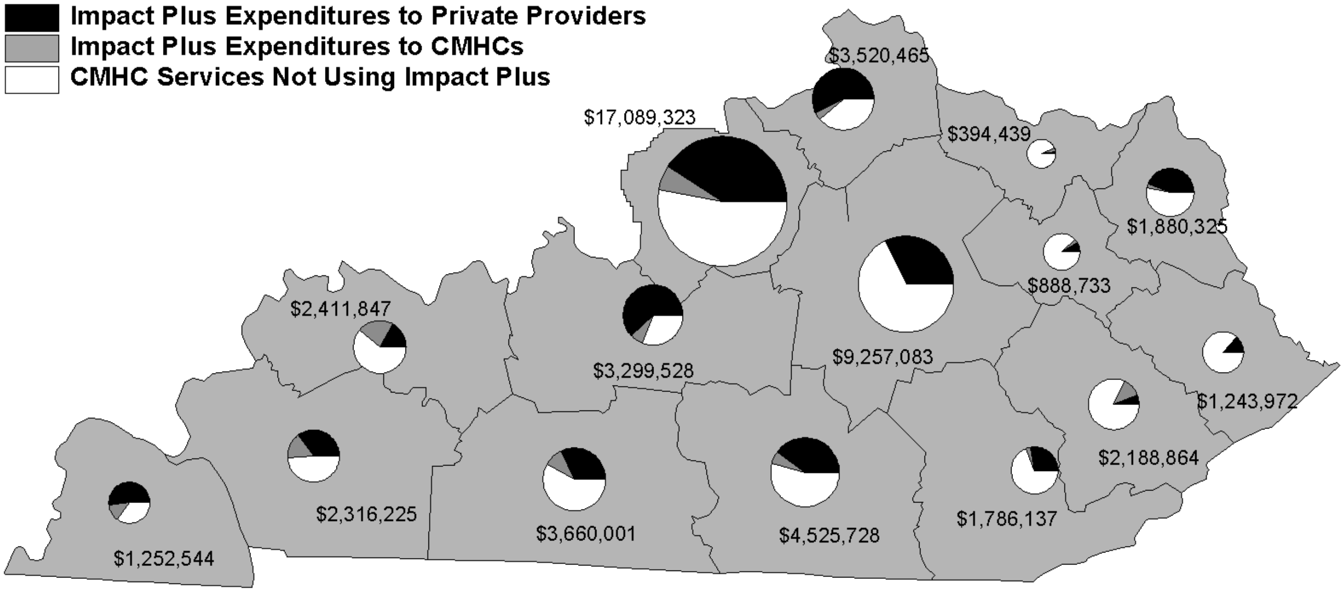
CMHCs access Medicaid funding for Impact Plus type services in two ways: 1) Rehabilitation services provided by CMHCs to Impact Plus children that are the same as regular Medicaid services continue to be billed to Medicaid under community mental health center services; and 2) Services provided specifically under Impact Plus that had no prior billing mechanism are billed to Impact Plus. Similar to rate negotiations with private providers, the CMHCs negotiated payment rates for the "new" Impact Plus services that had no prior billing mechanisms. Payments to CMHCs for Impact Plus services represent forteen percent of the total expenditures for Impact Plus, but this does not reflect all CMHC services to the Impact Plus population.

The most frequent and costly Impact Plus service provided by CMHCs are crisis stabilization services. While crisis stabilization services had been available prior to Impact Plus, the inclusion of these services in the Impact Plus program created a Medicaid funding stream for the crisis stabilization units. Children's crisis stabilization units are not available in each CMHC region.

In some parts of the state, payments to the private providers in Impact Plus are nearly as large as payments to CMHCs.

It is clear from Figure 2.D that Impact Plus has significantly changed the nature of the provider pool for the children's behavioral health services reimbursed through Medicaid. While the expenditures to CMHCs still account for the largest share of total expenditures in most areas of the state, the private providers added to the mix by Impact Plus account for a significant share in most areas of the state except eastern Kentucky.

Figure 2.D
Impact Plus and Community Mental Health Center Service Expenditures
By Area Development District of Recipient's Residence
Calendar Year 2000 Services



Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

An association of community mental health centers (CMHCs) wants Impact Plus to continue but has concerns about its current operation.

- The Kentucky Association of Regional Programs (KARP) is an association of the executive directors of the regional mental health/mental retardation boards. Program Review staff met with members of the Association on September 9, 2001 and heard the following concerns about the Impact Plus program:

- Desire for continuation of this type of a system of services for children with severe emotional disturbance;
- Management is needed for consistent eligibility;
- Private and public providers are not on a level playing field;
  - 24/7 availability is required of CMHCs;
  - CMHCs were not permitted to negotiate reimbursement rates for all Impact Plus services they already provided through Medicaid;
  - In some areas, Impact Plus pays more for "case management" than the CMHCs receive for targeted case management;
  - CMHC system is subject to oversight and accountability by other public agencies for staff credentials and accreditation of programs and services;
- CMHCs did not develop Impact Plus-type services because there was no funding stream for these services prior to implementation of Impact Plus; and
- Impact Plus became a separate system of care for Medicaid-eligible children when it was removed from the Regional Interagecy Councils and lost the local accountability that has been successful in the Kentucky Impact Program.

CMHCs proposed that they become the central coordinators of care for children in Impact Plus.

By request of the Cabinet for Health Services, KARP convened a workgroup that submitted recommendations for a "template of operation" for Impact Plus. These were presented in a February 8, 2001, letter to the Secretary of the Health Services Cabinet. The recommendations would give community mental health centers a larger role in initial program screening and case management.

Impact Plus allowed Medicaid reimbursement of two new services.

Several issues are relevant to consideration of the proposal developed by KARP for the future management of Impact Plus. One of the official reasons given for the creation of Impact Plus was to allow Medicaid to reimburse providers for a new set of community-based behavioral health services designed to keep children out of institutions. However, examination of the set of services covered under Impact Plus indicates that it brought only two new services to the mix. Therapeutic child support services had not previously been approved for Medicaid reimbursement. Reimbursement for therapeutic group residential was only available if the child was in the custody of the Cabinet for Families and Children. Thus, Impact Plus allowed parents and guardians to access payments for therapeutic group residential services without having to relinquish custody, as they had previously.

KARP Recommendations for Impact Plus

- Development of infrastructure in each region for medically necessary safety net services;
- Establish the CMHCs as a single point of entry for Impact Plus;
- Require case management by CMHC and provide the names of all (public and private) providers to facilitate choice for consumers;
- Use Impact Plus funds to cover only those treatment services not already covered by "regular" Medicaid;
- Permit crisis stabilization services to be covered by “regular” Medicaid;
- Address rate-setting and standardization of services for all providers;
- Hold all providers accountable for data collection and outcome evaluation; and
- Continue eligibility and service plan approval with Medicaid’s peer review organization.

Impact Plus allowed Medicaid reimbursements for a new group of private providers.

While Impact Plus may not have greatly expanded the type of services available through Medicaid, it did greatly expand the number of providers of those services. Prior to Impact Plus, many child behavioral health services were provided through EPSDT rehabilitative services. Although the state plan definitions do not limit who can provide these services, the community mental health centers are the only entities approved in the state regulations to do so.

Parents and field workers for children reported that the addition of the new provider pool was beneficial.

It was not within the assignment of Program Review staff to assess the quality of the child behavioral health services provided by the community mental health centers, and we have not done so. However, it was made clear in many interviews with parents and field workers from a variety of state and local agencies who deal with troubled children, that there is a broad opinion that some of the community mental health centers are not responsive to the needs of such children. When asked about this perception, officials at the KARP meeting replied that they were the only state-wide entities who were on the line to address crisis situations twenty-four hours a day, seven days a week, and that the funding they received was often inadequate to allow them to do all that they were expected to do.

CMHCs said the rate differences were unfair, since they often treat the most difficult cases.

Officials at the KARP meeting also complained about the fact that some Impact Plus providers had negotiated rates higher than those paid the community mental health centers through their existing Medicaid contract, even though they were providing the same services. They also expressed the opinion that some of the for-profit Impact Plus providers took the easy cases that fit a weekday schedule and left the community mental health centers to handle the difficult cases and those that needed attention at night or on weekends.

Again, it was not within the scope of this study to assess the quality of the services delivered to children by the community mental health centers. However, Program Review staff did encounter widespread opposition to the concept of designating them as the central providers for Impact Plus. While some community mental health centers were said to provide outstanding services to children, others were seen as unresponsive to children’s needs.

The demand for services likely exceeds the ability of one group of providers to deliver all care.

The intensive therapies often needed by children with severe emotional disturbance indicate that it would be difficult for one agency or one provider to adequately serve the population in any given area or throughout the state. Kentucky has been a state characterized by numerous “health professional shortage areas,” and this is particularly true for mental health and substance abuse treatment professionals. Based on a desired ratio of two mental health/substance abuse professionals per 1,000 residents, the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Disorders, and Dual Diagnoses reports that over 3,000 professionals are needed across the state. The estimates range from a low of 82 needed professionals in the Comprehend region (Bracken, Fleming, Lewis, Mason, and Robertson counties), to a high of 447 in the Northkey region (Boone, Carroll, Campbell, Gallatin, Grant, Kenton, Owen, and Pendleton counties). Except for the urban regions surrounding Louisville and Lexington, all other regions reported a need for approximately 200 additional professionals.

Review of provider qualifications and enrollment are the responsibility of the DMHMR. Recent administrative efforts by DMHMR that include provider site visits, case reviews, reviews of documentation of services, and clinical outcomes appear to be increasing the accountability of all providers. DMHMR has advised that some providers have been asked for and have submitted plans of corrections, others have not been re-approved, and some have been reported for possible Medicaid fraud. DMHMR has also instituted required outcome measures for all providers of Impact Plus services. These efforts should help "level the playing field."

There was strong resistance encountered to having CMHCs act as the central providers for Impact Plus.

Many professionals and parents involved in Impact Plus have advised that the types of services they need have not been provided by CMHCs. The availability of individualized support services, provided in the natural settings of the child and family (therapeutic child support services) have been described as some of the most beneficial aspects of the Impact Plus program. There have been reports of long waiting lists for CMHC services, rejection as a provider of services from the CMHCs, a lack of expertise in specific children's issues, and concern that the primary services offered through the CMHC are individual and group therapy sessions, a fifty minute office visit for "talk therapy" that does not meet the needs of the Impact Plus population. Agency staff report that, when waiting lists were encountered at the CMHCs, a private provider was always willing to assume services or case management. Few private providers maintained any type of waiting list.

Given these strong opinions, it does not seem prudent to centralize intake and initial case management responsibilities in the community mental health centers. Conversely, it does not seem fair that the community mental health centers should provide similar services for fees less than other Impact Plus providers. The setting of uniform rates would also significantly reduce the significant administrative burden of negotiating and enforcing individual rates.

CMHCs should receive equitable reimbursement for the services they provide to Impact Plus.

Discussions with officials of the Cabinet for Health Services indicate that it may be difficult to simply set CMHC rates for Impact Plus services that are the same as for private Impact Plus providers. The package of CMHC services billed by Medicaid may not allow easy separation of reimbursements for specific Impact Services. It was also noted that in several instances the regular Medicaid rate received by CMHCs for services like those in Impact Plus is higher than some rates received by private Impact Plus providers. Naturally, the issue of the adequacy and fairness of rates is a major concern of both public and private Impact Plus providers. Managers should take steps to address these concerns in a reasonable way through the establishment of uniform rates for private providers, and equitable rates for the CMHCs.

Rates in some programs are adjusted for severity of treatment needs.

Another possibility for improving the equity of rates paid to providers would be to adjust rates with some measure of the difficulty of treatment represented by each child. Two state agencies that provide treatment services to adults and children have implemented systems that review the intensity of treatment needs and assign a "level of care" for that individual. The Cabinet for Families and Children uses a level of care model for children experiencing an out-of-home placement, and the Division of Mental Retardation uses an assessment to determine the intensity of need for individuals with mental retardation or other developmental disabilities who are receiving services from the Supports for Community Living Waiver Program.

When all providers receive a flat rate, no matter the difficulty of treating an individual child, the incentive is for providers to seek children that are less costly to treat and avoid the more difficult cases. Adjusting rates for case difficulty can reduce this incentive. For example, in the Cabinet for Families and Children program, the daily rate for placement of a child with the lowest level needs (needs only regular supervision and guidance) is $48. This compares to $182 a day for a child with the highest level needs (severe impairment; unwilling or unable to cooperate in own care).

One risk of adjusting rates for difficulty of care is that providers will exert pressure for more cases to be defined to meet the criteria of the higher rate. Thus, if such an adjustment is created, it should be simple and clearly defined.

CMHCs should play a role in Impact Plus, but not the dominate role.

The conclusion regarding providers in Impact Plus is that there should be a viable role for the public mental health agency in a system of publicly funded mental health services. In fact, all CMHCs should participate in the Impact Plus program because of their ability to provide "rehabilitative services" through Medicaid. There should also be freedom of choice of qualified providers as required by other Medicaid programs. The original Impact Plus Program Manual, incorporated in the administrative regulation, included "Client Rights" to freedom of choice for case managers and all service providers.

The current capacity of community mental health centers is not sufficient to deliver the system of services provided under Impact Plus.

Regional variations are expected and even compensated in some programs. Simply assigning a program requirement, such as case management, to the public agency (as would occur with adoption of the KARP recommendations) may not assure adequate staff availability, quality services, and improved outcomes. Findings from this study of the Impact Plus program indicate that the capacity and service delivery of the CMHCs alone are not currently adequate for the system of services provided under Impact Plus.

Recommendation 2.1

The Cabinet for Health Services should not adopt the proposal put forward by KARP that the community mental health centers act as the central points of entry and conduct initial case management for all Impact Plus recipients.

Recommendation 2.2

The Title V structure should be continued. This arrangement limits the population to be served, permits access to specialized professionals only by the defined population, increases the number of overall providers, and establishes specific oversight and accountability requirements for these providers. New requirements for outcome data from all providers should help families select quality services. Continuation of the Title V structure will also foster competition among providers and choice for families for specialized services to children with severe emotional disturbance. Without the Title V structure, services would be limited to only those services and only those providers associated with CMHCs. This would essentially move the program back to "square one" and the circumstances that gave rise to the Impact Plus program. Families and providers could be adversely affected by limiting the program to CMHCs and protest would be expected. Adoption of Recommendation 2.3 for standardizing rates for services would also promote competition and choice.

Recommendation 2.3

Impact Plus should establish a level field for all Impact Plus providers by developing a uniform reimbursement rate for each service that applies to all private providers of that service. The Secretary of the Cabinet for Health Services should determine an overall Medicaid reimbursement rate package for the community *mental health centers that allows them to compete on an equitable basis for provision of Impact Plus services. All Impact Plus providers should also be equally subject to the quality and utilization control associated with the activities of the Healthcare Review Corporation, the site review process, and outcomes measurement.*

Recommendation 2.4

Consideration should be given to adjusting the uniform rates for each service by a measure of the difficulty of the treatment required. If such adjustments are adopted, they should be simple and clearly defined to reduce providers' ability to move children into the higher rate categories without justification.

Coordination of Mental Health Services for Children

Several state systems provide behavioral health services for various groups of children.

There is a varied set of programs that offer some level of services to children with behavioral health service needs. It is often mere chance that determines which system a child falls into. Some children act out in school and receive some services through special education programs. Others live in families that cannot take care of them and fall into state custody. Children who behave in a criminal manner may wind up in the juvenile justice system. Medicaid-eligible children with mental health problems can access some medically necessary services at the state's expense, and Medicaid-eligible children with severe emotional disturbance can receive services from Impact Plus. Children who are not Medicaid-eligible may access services through Kentucky Impact, from the community mental health centers, or through private insurance. Many other children may simply fall through the cracks and go untreated.

Many of the children are similar, but the treatments can be different.

One conclusion apparent from this study is that, in many ways, the children in these different categories are similar. This section will describe some of the different "categories" of children and their service systems and make recommendations about improvements in coordination.

Some children are wards of the state, while others are in the juvenile justice system.

State Agency Children. A child who is found by a district court to have been abused or neglected, or is "dependent," meaning the child's needs are not being met but there may be no fault of the parent, may be committed to the custody of the Cabinet for Families and Children (CFC). A child found to be a status or youthful offender by a court may be committed to the custody of the Department for Juvenile Justice (DJJ). Some parents decide they cannot handle their children and voluntarily seek commitment of the child to the state. The state agency assumes the legal and financial role of parent.

Special treatment issues exist with children who are committed to the state. For many CFC-committed children, the lasting effects of abuse and neglect must be addressed and treatment provided to enhance that individual's functioning and to hopefully prevent the child from becoming a perpetrator of abuse or neglect. Some of the parents simply do not have the capacity or skill needed to address a child's emotional needs or manage a child's behavior. A child involved in treatment may have to learn to deal with his parents' alcohol or drug abuse, apathy, disinterest, inconsistency, or inability to parent and may experience a termination of the biological parent's rights. Many adopted children have special treatment needs that focus on dealing with rejection, attachment, and acceptance.

Medicaid does not pay for all services needed by wards of the state.

A committed child receiving Impact Plus services may be "decertified" by Medicaid, stating the child no longer meets the "medical necessity" requirement for services, or there is no further expectation for improvement from the current services, or the child no longer needs the services. When a child is decertified and CFC seeks continuing services, then what was funded by Medicaid must now be funded with 100% state General Funds. This is a particular problem when the child is in a residential setting and becomes decertified, and yet CFC cannot return the child to his home for safety reasons and another placement is not readily available.

The Impact Plus regulation (907 KAR 3.030E) includes a definition of "medical necessity" that stipulates that covered services must be:

- "reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or *prevent* a disease, illness, injury, disability, or other medical condition…" (italics added.)

It seems somewhat unreasonable to risk losing whatever gains were made in a residential treatment program by releasing a child to a situation that presents a danger to continued mental health stability. Officials of the Department for Medicaid Services indicate that this issue has been discussed before, and that federal limits have prohibited Medicaid reimbursement for decertified children. However, if continued residential placement can be justified under the federal rules, it would be beneficial to the state budget to take advantage of the federal match available if the services are funded through Medicaid. That said, an ability to maintain children in residential facilities for short-term prevention of mental health deterioration until a more appropriate placement can be found should not be allowed to become an "easy out" for child placement workers who need to exert all reasonable efforts to find a more suitable placement.

Recommendation 2.5

The Cabinet for Health Services and the Cabinet for Families and Children should continue to explore avenues to accommodate cases in which children in state custody are maintained for a short time in residential facilities because there is no alternate placement that will not put the child at serious risk of reversing the mental health improvements achieved by the residential treatment. If such an avenue is identified, the Cabinet for Families and Children should reimburse the Cabinet for Health Services for the state share of the Medicaid match in those cases.

Recommendation 2.6

If such an arrangement can be developed, the Secretary of the Cabinet for Families and Children should implement whatever internal policies are necessary to require placement workers to identify alternate placements for children as quickly as practicable, without unduly risking the health of the child.

Children who are committed to the DJJ are committed either as a youthful offender or delinquent; or they may be committed as a status offender, charged with offenses that would not be crimes if they were adults (truancy, beyond control of parents, breaking curfew). DJJ has limited residential treatment resources and children who meet a certain degree of "criminality," based upon an assessment, may be placed in residential settings.

"These are all the same kids…those in DJJ just got caught."
Quote from DJJ staff

DJJ staff advise that a number of their committed children had previously been committed to CFC, but once the child has been in court on youthful or status offenses, the commitment is changed to DJJ. It is also reported that a disproportionate number of DJJ committed children are from poor families or are African Americans. The largest age group is composed of 14-18 year-olds. It was also reported that many DJJ children have mental health and behavioral disorders, but their acting-out behavior and their age often lands them in detention and in the courts. It was also noted that there is a perception that the agency has more treatment resources at its disposal than CFC and judges sometimes prefer commitment to DJJ.

Department of Juvenile Justice officials would like to access Impact Plus for children in their custody.

DJJ staff also advised that very few of the children in their custody receive Impact Plus services. The ones who are participating tend to have been receiving services, primarily from hospitals, prior to commitment to DJJ, so the services have continued. Seventeen children who have been adjudicated as sexual offenders and are placed in a children's psychiatric hospital also receive Impact Plus services. DJJ staff reported little success in obtaining new services through Impact Plus, even though many of the children in custody meet the eligibility criteria. There have also been difficulties in recruiting providers to work with the DJJ population because of court involvement and perceptions of liability issues for therapists. Most of the therapeutic services these children receive are from DJJ professional staff and from DJJ-contracted service providers.

The 1996 General Assembly enacted SCR 107 that authorized the Legislative Research Commission to create the Task Force on Children in Placement. The Task Force was charged with conducting a comprehensive study of children in out-of-home placement to:

- Develop a baseline of information about facilities serving children;
- Develop a profile of children served by these facilities;
- Identify mechanisms for decision making regarding placement;
- Explore the range of placement options;
- Review current licensing requirements and assessment procedures;
- Examine sources of funding and current reimbursement structures; and
- Identify high priority areas and make recommendations for system improvement.

The Legislative Research Commission's Research Report No. 280 of November 1998 is the Final Report of the Task Force on Children in Placement. The report includes data on the types of commitment and concludes that the number of children committed to the state because the parents sought commitment to access funding for treatment services is unknown.[25] Parents may be confronted with inadequate resources or insurance coverage to pay for therapeutic services and may resort to filing a petition in district court to commit their child as "beyond parental control" or "dependent." Parents also may not be able to access the needed treatment without committing the child to the custody of the state. Once committed, the state agency pays for treatment services.

A new category of commitment "for extraordinary services" was created by the 1998 General Assembly.

One of the recommendations of the Task Force was to enact a special category of commitment type in order to be able to document commitment for treatment needs of mentally ill or emotionally disturbed children. HB 449, enacted by the 1998 Session, created the category of commitment for "needing extraordinary services."

The Administrative Office of the Courts (AOC) maintains a database on the number of commitments by type. There were 6,513 children committed under abuse, neglect, dependency, and status at some time during FY 2001. Some records are incomplete and do not indicate type of commitment, and almost one-third of the children were released from commitment during the year. For the 3,793 children who remained committed to DCBS at the end of FY 2001 for whom information was available, the following details the types of commitment (Table 2.6).

Table 2.6
Types of Commitment for Children with Case Information Available
End of FY 2001

Type	Number	Percentage
Abuse	435	11.5
Neglect	1,185	31.2
Dependency	1,620	42.7
Abuse and Neglect	432	11.4
Status	121	3.2

Use of this new category has not been tracked.

Neither AOC nor DCBS report any information on commitment for extraordinary needs. DCBS staff advise that in their experience, the courts appear not to be using this category of commitment but tend to use the "dependency" category.

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[25] Legislative Research Commission, *Final Report of the Task Force on Children in Placement*, Research Report No. 280, November 1998.

Recommendation 2.7

The AOC should strengthen efforts to maintain a complete database on committed children that includes the type of commitment. The DCBS and the AOC should meet their respective statutory mandate to report on commitment for extraordinary needs.

Children in the custody of the state should be given access to needed behavioral health services.

The state's responsibility to provide needed services to its "wards" is clear. Except for the clearly criminal activity, there appear to be few distinctions between the populations of children committed to DCBS and DJJ. Both of the groups are the responsibility of public agencies and should have equal access to publicly funded treatment services. When services can be provided by a federal funding stream with an attractive state match, like the Medicaid program, state General Fund dollars may be saved or used for other purposes. When there is no federal funding stream or committed children are found to be ineligible for federally funded services, then needed services must be provided by 100% state General Funds. The state maintains financial responsibility regardless of the funding source.

Policy guidelines are needed for what children should receive which services at the state's expense.

Impact Plus provides a mechanism for services to children who are "at risk of institutionalization" and "at risk of being in custody of the state." If funding for Impact Plus is reduced or significantly changed, children who are not in the state's custody may not receive services. Clear policy guidance is needed as to whether children must be in the state's custody before they can access the same types of services that are available to committed children. Family integrity and responsibility and the potential for additional expenditures of state funds must be considered in the development of policy guidelines.

Recommendation 2.8

Policy guidelines are needed for situations in which children can only access intensive services if they are in the custody of an agency of the Commonwealth. Care should be more uniformly available for all children in state custody. Policies should also be developed regarding whether children not in the state's custody can access similar services without their parents or guardians having to relinquish custody.

Schools are required to provide all services necessary to allow a child to reach educational goals, including behavioral health services.

Schools. School personnel may have difficulty managing children with severe emotional disturbance in regular classrooms, and some of the children do not have the social skills or impulse control to function well even in special classrooms. Many of these children fall under the federal Individuals with Disabilities Education Act (IDEA) that requires schools to provide whatever services are necessary to help the child reach his or her educational goals. The services identified as necessary for the child on an Individual Education Plan (IEP) must be provided by local school districts. According to an official with the Kentucky Department of Education, funds for expenditures on special education have an approximate ten percent federal match rate.

To explore the question of whether Impact Plus service plans and IEPs for the same child showed evidence of coordination between the two systems, a random sample of twenty-five Impact Plus recipients was selected by Program Review staff. Staff of Impact Plus contacted the service coordinator for each of those cases and asked for copies of the service plans and IEPs. Impact Plus staff removed all identifying information from the files and forwarded them to Program Review staff.

There does not appear to be wide coordination between school services and Impact Plus services for the same children.

Of those twenty-five randomly selected cases, twelve had a current IEP, including three who had an IEP prior to Impact Plus services. Eleven cases had no IEP, including eight who are in a regular classroom. Information was incomplete on the remaining recipients. Review of the twelve cases where there was both an active Impact Plus service plan and an IEP revealed only one situation in which the service plan discussed the existence and features of the IEP. Based on this small random sample, it appears that Impact Plus service coordinators do not frequently coordinate a child's care with the schools that are likely addressing many of the same behavioral health issues. The Cabinet for Health Services indicates that this review prompted an internal quality improvement project. Impact Plus managers plan to review a larger sample of service plans regarding this issue and say they will develop strategies to ensure that case managers are participating in the development of IEPs and coordinating Impact Plus services with them.

The distinction between "educational" services and "behavioral health" services is not clear, but is important for accessing federal dollars.

This type of inconsistency is not surprising given the ongoing national professional debate about interpretations of "behavioral" and "educational" issues and which agency should be providing what type of services in what settings. There is also the very real issue of who pays for services and to what extent the federal government matches payments made by state agencies and local school districts. For example, if a child receives a behavioral health service through Impact Plus, seventy percent of the cost is borne by the federal government. If a local school district provides the same service for the same child, the federal government only bears ten to twenty percent of the cost.

As of December 2000, 5,872 children were identified by schools as having emotional behavioral disability.

Data from the Kentucky Department of Education, Office of Exceptional Children, indicate that as of December 2000, there were 5,872 children in Kentucky public schools identified as having an "emotional behavioral disability." Another 3,115 children are classified as functionally mentally disabled, and 1,032 children were identified as autistic.

Fifty four percent of KY schools participate in the Medicaid school based services program.

Some schools exercise an option to be authorized as a provider of Medicaid services under Medicaid's "school-based services" program. Schools hire or contract with approved health practitioners and bill for services provided to Medicaid eligible children. The Legislative Task Force on Health Care in the Schools conducted a survey of local school districts and reported in October 1999 that of the 130 districts that responded, 57 (forty-four percent) participated in the school-based services program. Thirty percent of the non-participating districts indicated that a "cumbersome administrative process" was a reason for not participating; twenty percent indicated insufficient reimbursement rates as a reason; and nineteen percent indicated that not enough students were qualified to justify the administrative activity.

Recommendation 2.9

Impact Plus managers should be required to follow through with the promised initiative to ensure that Impact Plus service plans are better coordinated with existing Individual Education Plans for the same children.

Recommendation 2.10

Schools should be encouraged to participate in Medicaid's school-based services program to increase access to health care services, including any required behavioral health care. The federal match rate for Medicaid funded services is more favorable to states than the federal match rate for special education services and services required under Individuals with Disabilities Act.

HB 843 created a statewide commission to develop a 10-year plan for mental health and substance abuse services.

843 Commission. The 2000 General Assembly passed HB 843 creating the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Substance Abuse and Other Drug Disorders, and Dual Diagnoses to examine the system of mental health and substance abuse services. The law also required the establishment of "regional planning councils" in each mental health/mental retardation region of the state. Each regional council receives administrative support from the community mental health centers, the established regional planning entity for mental health and mental retardation services. Regional planning councils forwarded recommendations to the "843 Commission," which then developed statewide recommendations and produced a report that serves as a ten-year plan of improvement and that forms the basis of the Commission's legislative and budgetary initiatives for the 2002 Session. The Commission's report, Template for Change, distributed in June 2001, also serves as a guide for the continuing work of the Commission and the regional planning councils.

According to the legislative mandates for the 843 Commission, the commission shall:

- "recommend comprehensive and integrated programs for providing mental health and substance abuse services and preventive education to children and youth, utilizing community resources"; and
- "develop a comprehensive state plan that will provide a template for decision making regarding program development, funding, and the use of state resources for delivery of the most effective continuum of services in integrated settings appropriate to the needs of the individual…"

The work plan for the next two years is to address children's behavioral health services.

The recommendations of the 843 Commission include increased state funding for mental health and substance abuse services and funding for new "flexible safety net" services designed to meet the distinct needs of each region. There are also recommendations that the Commission develop a specific work plan for the next two years that includes issues pertaining to children's behavioral health services.

The study of Impact Plus indicates that research, planning, and coordination are needed.

One of the conclusions of this study is that prior to the Impact Program, and more specifically, prior to the Impact Plus Program, there was a very limited system of evidence-based treatment available for children in community settings. The system fragments even further when specific populations are targeted: children who are in the custody of the Cabinet for Families and Children, those in custody of the Department for Juvenile Justice, those who are Medicaid-eligible, those who have private insurance, and those who have no ability to pay and no other payer for services. Children have to "fit" within structures with little coordination, rather than access a seamless system of services regardless of the child's "category." The "wraparound" model of service delivery and the local coordination of services has been found to be very effective in the Kentucky Impact program.[26]

Coordination of funding is particularly important.

Another conclusion from this study is that it is often the various funding streams and associated rules that cause children to bounce from one program to another, sometimes getting the services they need and sometimes not. In order to serve as many children as possible, within whatever overall global budget that is set by policy makers for such services, it would be in the best interests of the Commonwealth to maximize funding for such services through Medicaid because of the seventy percent federal match. That said, it is not feasible to keep adding net new state dollars to the Medicaid budget. Even with an attractive federal match, there is some point at which the Department for Medicaid Services cannot absorb the costs of programs developed and managed by other state agencies. Impact Plus stands as an example of the problems that can emerge when program management and fiscal management are not adequately integrated.

The nature of the 843 Commission, with its regional focus coupled with the involvement of Executive Branch officials, legislators, and advocates, places the Commission in a unique position to conduct a more thorough review of Kentucky's current system of delivering and funding behavioral health services for children. The Commission should be charged with developing recommendations regarding the highest priorities for funding of child behavioral health services, for the most effective and efficient system design, and for the most workable long-term implementation strategy.

Planning is important because demand for behavioral health services for children is expected to grow.

Development of such a global long-term plan is considered important for several reasons. First, during the current study clinicians consistently reported that in general more children are being identified with more serious behavioral health problems

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[26] Robert Illback, *An Evaluation of Impact at Ten Years*, 2000.

and at an earlier age. Also, there is a continuing movement to bring parity between funding for physical health and mental health services. Both of these factors will likely intensify the pressure for increased expenditures for behavioral health services for children, which are already considerable.

Without planning, state resources may not be used in the manner that benefits the greatest number of children over the long run.

There is concern that, without a plan that specifies priorities, constraints on resources will result in groups who are the most vocal capturing the most resources. Yet the resulting funding allocation may not be that which results in the greatest overall improvement in the behavioral health of all children in the Commonwealth. This is important because an absence of effective behavioral interventions in childhood can have major long-term fiscal consequences for the Commonwealth, particularly in the programs for adult mental health, the criminal justice system, and those that will address the needs of the next generation of children whose parents did not receive the early interventions that might have broken the cycle.

Recommendation 2.11

The General Assembly should direct the 843 Commission to develop recommendations for a prioritized plan for allocating funds to the Commonwealth's system of behavioral health services for children. The Commission should involve the State Interagency Council in a leadership role in this task. A report detailing the recommendations should be delivered to the Governor and General Assembly by July 1, 2003, to give time for consideration in the 2004 budget of the Commonwealth. At a minimum the recommendations should address:

- *The recommended continuum of behavioral health services for children;*
- *A description and projected number of children likely to be served at each point along the continuum;*
- *Recommendations to address access to services by all children, including recommendations addressing the unique needs of children in the custody of the state, and children who are not Medicaid-eligible;*
- *Recommendations for balancing the need for local flexibility with state oversight for system accountability, including coordination of mental and behavioral health services within the school system;*
- *Recommendations regarding the most appropriate roles for public and private service providers, including the community mental health centers;*

- *Recommendations regarding the efficient and equitable balance of funding between children with severe conditions requiring intensive and expensive services, and children with less severe conditions more likely to be ameliorated with less expensive interventions;*
- *Recommended methods to maximize federal funding streams for behavioral health services without imposing an excessive General Fund burden to be borne entirely by the Department of Medicaid Services;*
- *Recommended management structures that allow coordination of programs among agencies, but still maintain fiscal accountability; and*
- *Recommendations for preferred practice protocols, acceptable outcome measures, including site reviews, and exit criteria for behavioral health services.*
- *An enumeration of the public dollars currently spent for child behavioral health services in the Commonwealth and recommendations for how the spending of those dollars should be prioritized.*
- *Identification, in priority order, of the most pressing unmet needs for behavioral health services for children and the estimated cost of an effective program to address each prioritized unmet need.*

Recommendation 2.12

If a policy decision is made to continue the Impact Plus program, and if the program can demonstrate an acceptable level of fiscal accountability, then thought should be given to treating it as a pilot program for consideration of the issues to be addressed in recommendation 2.11. Most of the issues specified for consideration by the 843 Commission exist within the Impact Plus program, which is a limited program for a specified group of children. If the issues of priority setting, coordination of services, coordination of funding streams, cooperative management arrangements, practice protocol standards for publicly funded services, and the preferred balance between treatment and prevention can be successfully negotiated for this relatively small program, it would increase confidence that the recommendations would be likely to improve the system as a whole.

CHAPTER 3

INADEQUATE PROGRAM PLANNING ALLOWED IMPACT PLUS COSTS TO ESCALATE RAPIDLY BUT RECENT ADJUSTMENTS REDUCED RATE OF GROWTH

The Committee asked why the budget grew so rapidly and whether the money was used appropriately.

The Program Review and Investigations Committee raised two key questions about the rapid budgetary growth of Impact Plus displayed in Table 3.1. First was why the budget for Impact Plus grew so rapidly beyond the amount that was anticipated, either by the General Assembly or by managers themselves. Second was whether program managers had instituted appropriate utilization management controls to ensure that program dollars were being spent as intended. This chapter addresses those questions and offers recommendations for improved budgetary control.

Table 3.1
Impact Plus Appropriation Increases

Appropriation Increase	Appropriation Increase Date
$215,700	6/15/1997
$4,800,000	8/19/1997
$1,000,000	1/8/1999
$2,000,000	8/30/1999
$7,800,000	6/14/2000
$8,800,000	11/14/2000
$10,000,000	12/28/2000
$9,800,000	3/28/2001
$15,000,000	6/14/2001
$59,415,700.00	**Total to Date**

Impact Plus Spending

Medicaid behavioral health claims for children were analyzed.

As one means to address the Committee's questions, staff obtained a database of all Medicaid behavioral health claims paid on behalf of children for services delivered from January 1996 through June 2001. Each claim is designated as being from one of the following nine types of providers:

- Acute Inpatient
- Mental Hospital
- Psychiatric Residential Treatment Facility (PRTF)
- Targeted Case Management
- Impact Plus
- Community Mental Health Centers

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Pharmacy
- Physician

Note that all charts and tables of claims are presented on a calendar year basis, rather than a fiscal year basis. Also, all paid claims are by date of service.

Since program inception, $51.4 million in claims have been paid to 214 providers on behalf of 6,402 children.

Examination of claims records provided by Unisys, Medicaid's fiscal agent, indicates that, between program inception in February 1998 and June 2001, Impact Plus paid a total of $51.4 million in claims from 214 providers for mental health services delivered to 6,402 children.[27] As shown in Table 3.2, annual numbers of recipients, total expenditures, and average costs per recipient increased rapidly through calendar year 2000. This growth, in itself, is not a surprising pattern for a new program. What was surprising was that program costs grew so much faster than expected, as evidenced by recurring requests for the large appropriations increases shown in Table 3.1.

Table 3.2
Impact Plus Recipients and Claims Paid

Calendar Year of Service	Recipients	Impact Plus Claims Paid	
		Amount	Average per Recipient
1998	1,255	$3,169,674	$2,526
1999	3,223	$14,427,792	$4,477
2000	4,229	$24,186,114	$5,719
2001*	2,574	$9,617,338	$3,736
		$51,400,918	

Note: 2001 figures are for claims paid from January through June 2001.

One question is whether the growth was unexpected because of incorrect projections or whether implementation deviated from the original design. The first part of that question will be addressed here while the latter part will be addressed in a subsequent section.

Program Projections

In 1997 legislators were concerned about the large number of children in out-of-state placements.

Officials of the Cabinet for Health Services testified before the Families and Children Subcommittee of the Health and Welfare Committee on March 18, 1997, that the Cabinet was paying for

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[27] Data for calendar year 2001 may not reflect some claims for which the service has occurred, but the claim has not been processed into the Unisys Medicaid claims data.

the care of 189 children in out-of-state mental health facilities.[28] Legislators became concerned about the large number of children who were being treated far from their home communities and about the substantial funds that were being sent out of state. The original rationale given for development of Impact Plus was to reduce the number of these children in out-of-state placements by providing a system of intensive community supports that could allow them to be treated closer to home.

The number of out-of-state placements fell from 436 in 1997 to 11 in the first half of 2001.

While it is clear that the number of out-of-state placements declined significantly, from 436 at any point during calendar 1997 to 11 through the first half of calendar 2001, any resulting savings do not appear to be a direct result of the Impact Plus program.

It does not appear that Impact Plus accounts for the decline.

Examination of the claims records indicates that of the 436 children in out-of-state placements in 1997, 89 received Impact Plus services in 1998, and 94 received Impact Plus services in 1999 (Table 3.3). Thereafter, the numbers decline, likely due to attrition. Total costs and per recipient costs of the behavioral health services for the 94 children receiving Impact Plus services in 1999 were lower than their costs in 1997. While their costs were similar to those of Impact Plus recipients in 1997, the costs of the 113 children who **did not** ever receive Impact Plus services but **did** receive other behavioral health services in 1999 declined by a much greater amount. Although Impact Plus may have had some effect on reducing the costs of behavioral health services for these children, it is clear that other forces were having a large effect as well.

Table 3.3
Children Who Were in Out-Of-State Placements in 1997 . . .

	. . . And Received Impact Plus Services in 1999	**. . . And Received Other Behavioral Health Services in 1999, but Never Received Impact Plus Services**
1997		
Number	94	113
Total Behavioral Health Costs	$5.5 million	$6.2 million
Average Behavioral Health Costs	$58,900	$54,900
1999		
Number	94	113
Total Behavioral Health Costs	$3.4 million	$1.2 million
Average Behavioral Health Costs	$35,7000	$10,700

Note: The remaining 229 children who received out-of-state services in 1997 either had no behavioral health claims in 1999 or received Impact Plus services in another year.

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[28] That number appears to have referred to an average daily census. Claim records indicate that 436 children had out-of-state placements at some point during calendar year 1997.

Original Impact Plus projections were that 4,600 children were in out-of- home care and 10,000 to 15,000 were at risk.

In the July 1997 document *Kentucky Impact Plus: A Blueprint for Expanding Services for Children with Complex Treatment Needs,* it was stated that there were 4,000 children with severe emotional disabilities. When asked for the source of this estimate, officials of the Department for Mental Health/Mental Retardation Services provided the chart shown as Figure 3.A. According to this chart, 4,619 children had in-patient hospital admissions reimbursed by the state at a total cost of $50 million.

Figure 3.A
Estimates From the Division of Mental Health and Mental Retardation Services To Support Original Impact Plus Estimates

		Number of Children				COST (millions)
COMPONENT	Subcomponent	DMHMRS	DSS	Medicaid	TOTAL	
Psych Hospital	IMD			2992	**4619**	**$50.20**
	Med/Surg			1134		
	EPSDT			83		
	DSS/OLOP		410			
Partial Hosp.						
Juv Res Svs	Res Tx Ctr		960		**1270**	**31.4**
	Group Home		310			
Res Sub Abuse		142			**152**	**1.4**
	EPSDT			10		
	DSS					
PRTF	Inpt Benefit			121	**121**	**4.5**
	DSS					
Re-ed			56		**56**	**1**
Priv Ch. Care			2680		**2680**	**37.4**
Fos Fam	Clinical				**5600**	**26.2**
	Non-Clin Supp					
	Rm. And Bd		5600			
Crisis Stab		821			**821**	**0.7**
Day TX	SED inc. aftsch	319			**1469**	**4.6**
	Juv. Serv		1150			
Int. In-Home		704		567	**3481**	**4.8**
Family Pres.	SED		2210			
Wraparound	Non-Clin Supp	868	36		**1151**	**4.7**
	Other Flex	578	29			
Tgt Case Mgt		473		2189	**2662**	**5.3**
Interag Coordn						**1.6**
Specl Init			950		**950**	**2.6**
Outpatient MH		3960		18,348	**22,308**	**26.2**
	TOTALS	**7865**	**14,391**	**25,444**	**47,700**	**$202.6**

The Blueprint goes on to estimate that there were "between 10,000 and 15,000 children in Kentucky in out-of-home care who have significant treatment needs or who are at risk of out-of-home care because their treatment needs have overwhelmed their families" (Page 3).

"At risk" was not initially defined.

One problem for managers in estimating the number of children who might access services through Impact Plus is that in the beginning there was no firm definition of who would be eligible. The initial eligibility criteria for children were set out in the original regulation as follows:

> Impact Plus services shall be available to Kentucky Medicaid-eligible children under age 21 who have complex behavioral health care needs and:
>
> 1) …defined as a child in custody of the state, under the supervision of the state or at risk of being in the custody of the state and is in an institution or at risk of institutionalization.
>
> OR
>
> 2) Is in an institution or is at risk of institutionalization.

The target population of Impact Plus was not clearly specified, so estimates of recipients were unclear.

Given that there were no initial guidelines imposed for determining what children could be considered "at risk of institutionalization," it is understandable that managers would have difficulty in determining how many children might enroll. This is particularly true because the actual eligibility determinations were made at the local level by the Regional Interagency Councils, without strong guidance or review from Impact Plus managers.

Thus, in the early stages of the program, it was not clear whether Impact Plus would:

- provide Kentucky residential services to children so they could stay in-state,
- provide "community" services to all hospitalized children so they could be transitioned to lower levels of care,
- provide "wraparound" services to a broader range of children with severe emotional disturbance so that they might avoid institutionalization or commitment in the future, or
- all of the above.

The distinction between these populations had major budgetary implications, given that the estimates offered by the Cabinet of their respective sizes ranged from 200 for the first group to 4,000 for the second group to 10,000 to 15,000 for the third.

It is clear that early information provided to legislative committees indicated that the target population of the program would be children in institutions, with particular emphasis on those in out-of-state facilities. It is also clear that this same emphasis was not clearly communicated to the local agencies actually making the eligibility determinations.

The federal government produced estimates of children with severe emotional disturbance.

The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services reviewed the available literature on the number of children with mental health problems and their costs of treatment in order to develop a model states could use to estimate the behavioral health costs associated with implementation of the State Children's Health Insurance Program (SCHIP)[29]. The range of estimates for the prevalence of severe emotional disturbance, and the point estimate, are shown by age category in Table 3.4

Table 3.4
Prevalence Estimates for Severe Emotional Disturbance
Percent of Children by Age Group

Age	Estimate Range	Point Estimate
0-5	3% - 8%	6%
6-11	4% - 13%	6%
12-20	4% - 13%	9%

Source: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Using national estimates, between 22,000 and 38,000 Kentucky Medicaid children have severe emotional disturbance.

These estimates of prevalence were applied to the current number of Kentucky children in the Medicaid program. The resulting estimate is that there are 22,000 to 38,000 children enrolled in the Medicaid program who have severe emotional disturbance, depending on whether the point estimate or high-end of the estimate range is used. Since Medicaid children are known to be poor and likely to have the associated physical and mental health issues, the high-end of the estimate range is expected to be more accurate than the point estimate.

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[29] Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2000). Mental Health and Substance Abuse Services under the State Children's Health Insurance Program*.* *Designing Benefits and Estimating Costs.* (DHHS Publication No. [SMA] 01-3473). Rockville, MD.

National estimates indicate that 3,000 to 5,500 of those children would be institutionalized during the year.

The SCHIP cost model also included estimates of the percentage of children with severe emotional disturbance who would likely receive in-patient hospitalization during the year. Applying these estimates to those above indicates that approximately 3,000 to 5,500 Medicaid children with severe emotional disturbance would be expected to be hospitalized at some point during the year.

It is not necessarily true that Impact Plus was only serving those children likely to be hospitalized for severe emotional disturbance. However, the number actually served by the program is within the range of that which would be expected based on the available data from both Figure 3.A and the national estimates developed by the Substance Abuse and Mental Health Agency for the SCHIP cost model.

Impact Plus Was Not Budget Neutral

EPSDT expenditures declined, but this does not appear to be due to Impact Plus.

Review of the claims data leads to the conclusion that Impact Plus was not budget neutral. Since Impact Plus was implemented, costs of other behavioral health services for children, particularly EPSDT, have declined. However, it does not appear that Impact Plus was responsible for most of this decline.

Figure 3.B shows total expenditures of the major types of behavioral health services that program managers said would be reduced by the community services.[30] The large decline in expenditures was in the EPSDT program. The trend of decline began prior to the time when Impact Plus had delivered a significant amount of services. The change in the trend in EPSDT expenditures is better explained by the fact that prior authorization requirements were imposed on EPSDT special service requests beginning in September 1997.

The number of children in institutions did not decline with implementation of Impact Plus.

Two additional types of information appear to make it unlikely that Impact Plus could be responsible for continuing declines in EPSDT and mental hospital expenditures since program inception. First, as shown in Figure 3.C, the number of children who receive institutional care does not show a noticeable decline with the availability of Impact Plus services.[31] What is most noticeable is the growth in recipients of Impact Plus services.

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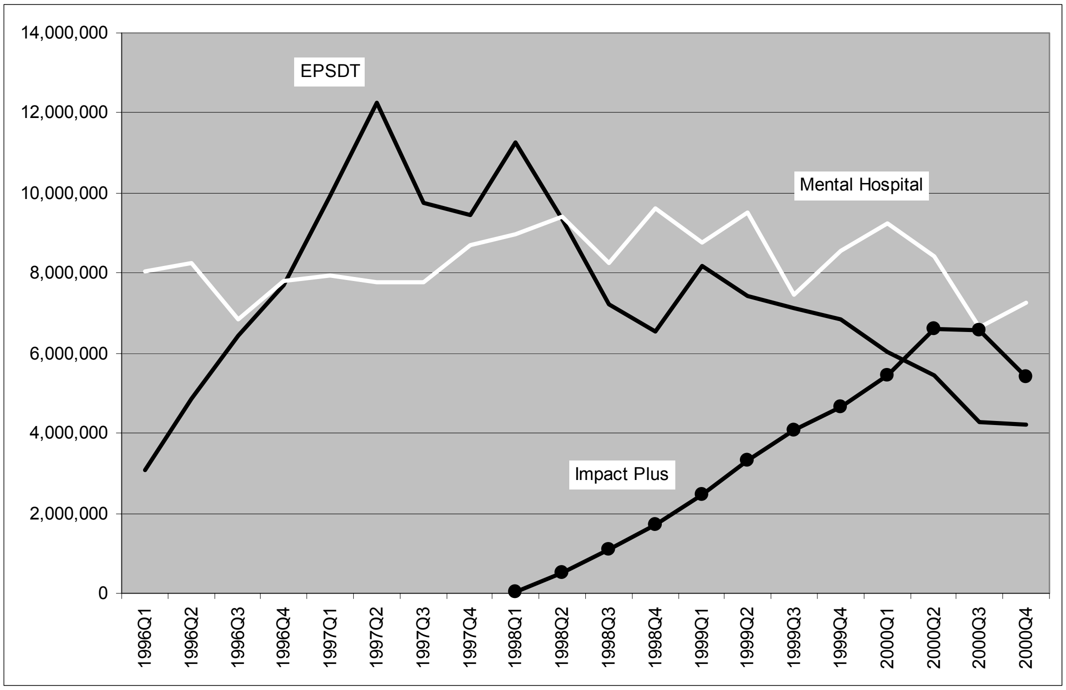
[30] Costs of acute inpatient behavioral care and psychiatric residential treatment facilities were also analyzed. They showed little change over the period so were removed from the figure for simplicity.

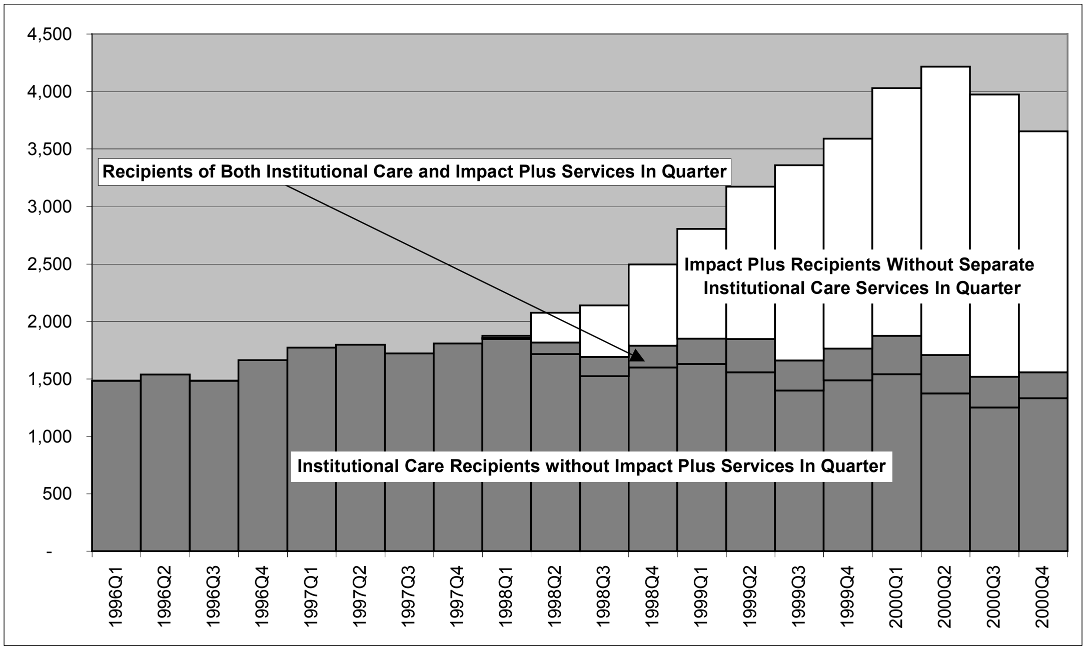
[31] Institutional care is defined as that received in an institution through EPSDT, mental hospitals, acute inpatient, and psychiatric residential treatment facilities.

Figure 3.B
Quarterly Behavioral Health Expenditures
By Calendar Quarter of Service



Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Figure 3.C
Number of Institutionalized Recipients and Impact Plus Recipients
By Calendar Quarter of Service

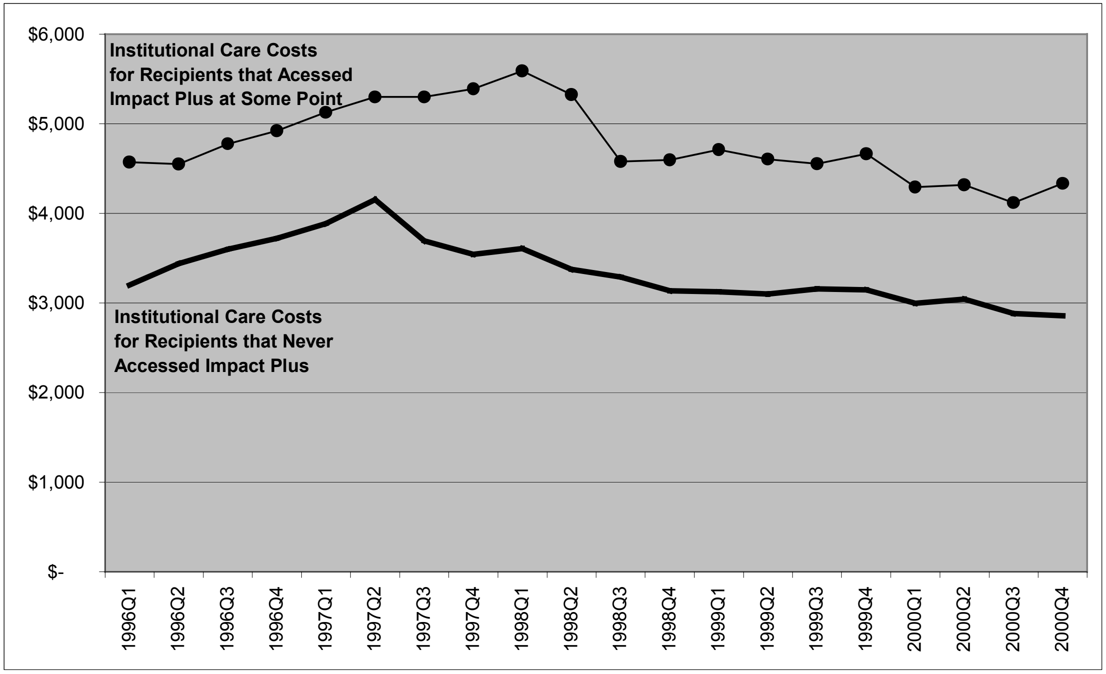


Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

The average costs of children not receiving Impact Plus services declined over the period.

Also, if Impact Plus were having a substantial effect on costs of institutional care, it would be expected that there would be no decline in average institutional expenditures for children who did not receive Impact Plus services. Figure 3.D shows this is not the case. The average institutional expenditures for children who did not receive Impact Plus services declined at a steady rate over the period. Like the above comparison of the specific children institutionalized in 1997, this indicates that cost reduction forces other than Impact Plus were having an effect. Also, as can be seen in Table 3.5, the per recipient costs of children who received EPSDT services declined in a similar fashion, whether they were receiving Impact Plus services or not.

Figure 3.D
Average Recipient Costs
By Calendar Quarter of Service



Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Evidence indicates that Impact Plus was not budget neutral.

Based on this analysis, the conclusion is that, rather than being budget neutral, Impact Plus enrolled new providers to provide a new set of services to many new children and that these new services were funded with a substantial amount of net new dollars.

Table 3.5
Impact Plus and EPSDT Recipients and Expenditures Per Recipient Differentiating Between Those That Received Both Services And Those That Did Not By Calendar Year of Service

	Impact Plus Recipients That Never Accessed EPSDT		**Impact Plus Recipients That Accessed EPSDT at Some Point in Time**				**EPSDT Recipients That Never Accessed Impact Plus**	
			Impact Plus		**EPSDT**			
Year of Service	**Recip-ients**	**Expenditure per Recip.**	**Recip-ients**	**Expenditure per Recip.**	**Recip-ients**	**Expenditure per Recip.**	**Recip-ients**	**Expenditure per Recip.**
1995					17	$13,902	85	$14,478
1996					145	$31,118	654	$26,890
1997					297	$41,800	1,002	$28,896
1998	846	$2,091	409	$3,424	466	$36,979	700	$24,557
1999	2,437	$3,753	786	$6,719	540	$29,345	611	$22,441
2000	3,432	$4,984	797	$8,884	403	$22,726	574	$18,860
2001*	2,151	$3,394	423	$5,477	193	$18,391	272	$15,493

** Calendar Year 2001 represents claims paid through June 2001.*
Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Program Design and Utilization Management

Inadequate program planning allowed costs in Impact Plus to escalate rapidly to the point at which serious budget constraints caused Cabinet officials to take actions to limit additional spending on the program. Figure 3.E shows both the dramatic growth of the program and the significant effect recent program changes have had on that growth. This section identifies the major factors that allowed costs to increase so quickly and summarizes the actions Cabinet officials have taken to reduce costs.

Four factors contributed to rapid program growth.

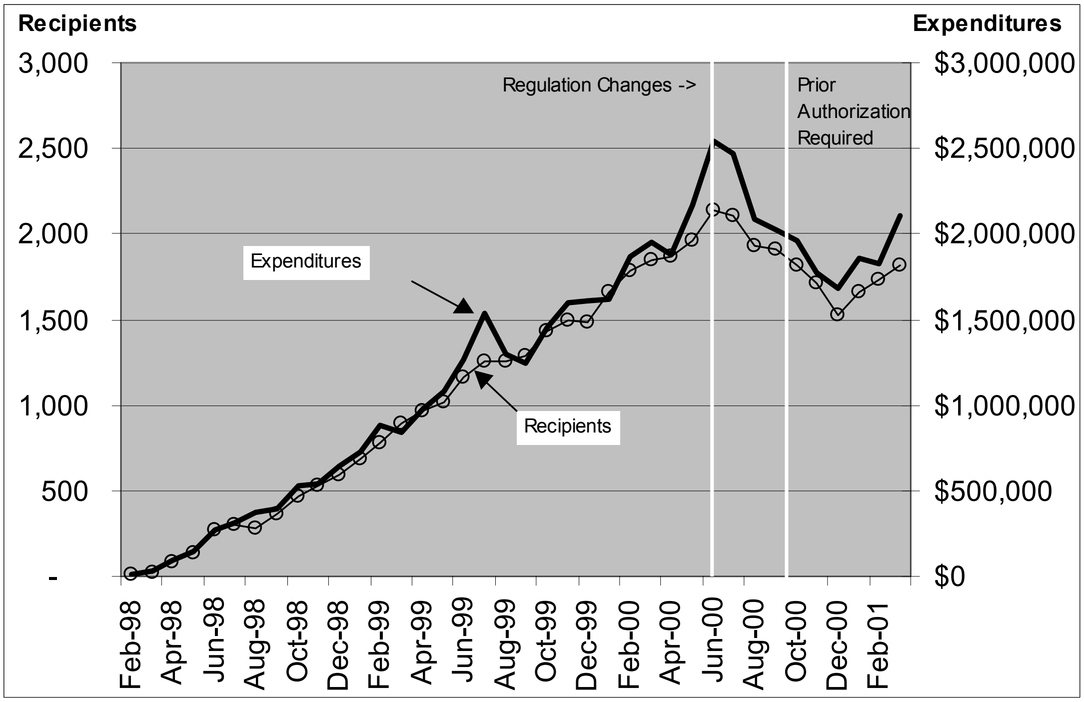
Factors that Caused Rapid Program Growth

Review of program development indicates that there were four major factors that contributed significantly to the rapid escalation of costs for Impact Plus:

- The expected program scope was not explicitly defined;
- The original capitation arrangement with the Regional Interagency Councils was abandoned;
- No effective utilization controls were in place when the capitation arrangement was dropped; and
- There was great demand for program services.

A discussion of each of these factors follows.

Figure 3.E
Impact Plus Monthly Recipients and Expenditures
By Month of Service



Although a collaboration of three departments, program managers are mostly discussed as one group.

Throughout most of this section, Impact Plus expenditures are discussed as a single total and program decision-makers are referred to by the generic term “program managers.” There are two reasons for this. First, all of the funding for Impact Plus services comes from the claims filed with Medicaid. Thus, the central question is the effect of the total program on the Medicaid budget. Second, the decision-making structure for Impact Plus included a collaborative arrangement between the Departments for Mental Health/Mental Retardation Services and Medicaid Services within the Cabinet for Health Services, and the Department for Community Based Services within the Cabinet for Families and Children. Throughout its history, there was never really one department completely in charge of Impact Plus, and effective control of the program appears to have changed for various decisions. Therefore, the general terms seem more accurate.

That said, it is also true that there was a clear difference in the trends of expenditures for the two distinct populations included in Impact Plus. The first population was children in the custody of the state. The case managers for these children were the Department for Community Based Services field workers assigned to the cases. The second population was children in the community who qualified as “at risk” for institutionalization. Their services were included in the aspect of the program more directly managed by the two departments within the Cabinet for Health Services.

Impact Plus expenditures did not grow as rapidly for children who were in state custody.

Table 3.6 shows the number of recipients and total claims, by date of service, for the two populations since program inception. It is clear that the significant growth in Impact Plus was in the population of children not in state custody, that was more directly managed by the two departments within the Cabinet for Health Services. The Secretary for the Cabinet of Families and Children reported to Program Review staff that she required that Cabinet’s staff to set internal Impact Plus spending targets and manage their cases to stay within that target.

Table 3.6
Impact Plus Recipients and Claims
By Cabinet

	Health Services			Families and Children		
Calendar Year	Recipients	Expenditures	Per Recipient	Recipients	Expenditures	Per Recipient
1998	848	$2,232,363	$2,633	450	$937,312	$2,083
1999	2,400	$11,138,016	$4,641	1,068	$3,289,776	$3,080
2000	3,426	$19,996,381	$5,837	1,274	$4,189,733	$3,289
2001*	2,130	$8,148,028	$3,825	640	$1,469,310	$2,296
		$41,514,787			$9,886,131	

*Partial Year - January 2001 - June 2001
Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

The program was supposed to be funded with “savings.”

Program Scope Not Defined. Staff reviewed all minutes and program folders from any meeting of the Budget Review Subcommittee on Human Resources and Subcommittee on Families and Children of the Committee on Health and Welfare in which Impact Plus was discussed. In testimony before legislative committees when implementation of Impact Plus was being proposed, Cabinet for Health Services officials asserted that the proposed program would be “budget neutral.” The assumption put forward was that the newly provided community wraparound services would replace more expensive residential care for children with severe emotional disturbance in the Medicaid population.

There was no explicit statement of the amount of expected savings, so the program scope was never defined.

While this assumption might sound logical, program designers did not specify the actual amount of money that might be involved. Thus, there was no explicit statement of the expected size of this program. Table 3.7 shows the 1997 Medicaid claims for various child behavioral health services, excluding pharmacy. It would be unlikely that the wraparound services included in Impact Plus would ever be expected to replace all acute inpatient, mental hospital, or psychiatric residential spending. Yet no one required program designers to state whether Impact Plus was intended to be a $5 million program, a $10 million program, or a $30 million program. Staff analysis of claims data indicates that while Impact Plus expenditures do appear to have replaced some existing Medicaid spending, a significant portion of the total $58.6 million allocated to Impact Plus to date represents net new spending.

Table 3.7
1998 Medicaid Behavioral Health Services for Children under 21

	Service	Recipients		Expenditures		Expenditures
		Number	Percent	Number	Percent	Per Recipient
01	Acute Inpatient	1,187	4%	$ 8,329,350	7%	$ 7,017
02	Mental Hospital	3,004	11%	$ 32,178,185	26%	$ 10,712
04	PRTF	209	1%	$ 7,333,443	6%	$ 35,088
28	Targeted Case Management	3,230	12%	$ 5,961,300	5%	$ 1,846
30	CMHC	22,185	81%	$ 25,760,917	21%	$ 1,161
45	EPSDT	1,299	5%	$ 41,433,668	34%	$ 31,897
64	Physician	6,820	25%	$ 2,564,290	2%	$ 376
	All Services	27,461	100%	$123,561,152	100%	$ 4,500

Source: LRC Staff analysis of claims extracted from Medicaid Management Information System (MMIS)

Without an explicit program scope, it was more difficult to tell when expenditures were exceeding expectations.

The lack of an explicit statement of expected program size had three major implications for program management. First, without assignment of a specific budget amount for which they would be held accountable, program managers had less incentive to rigorously evaluate and manage the cost effects of program implementation decisions. Conversely, lacking a specific spending plan, Cabinet officials were left without benchmarks to use in identifying and correcting inadequate fiscal management practices. Similarly, legislators were left without a means of recognizing early that the program was expanding beyond what they may have intended. Rather than having the opportunity to make policy decisions about spending priorities **before** new services were delivered to a new population, policy makers are now faced with the more difficult task of determining whether and how to reduce existing services to achieve a balanced budget.

Recommendation 3.1

The Secretary of the Cabinet for Health Services should immediately determine and report the target total budget for Impact Plus for the remainder of FY 2002 and should report explicit Impact Plus budget targets in the FY 2003-2004 requests to the Budget Review Subcommittee on Human Resources. The General Assembly should hold the Secretary accountable for requiring program managers to conduct operations so as to stay within the budget set for Impact Plus.

Recommendation 3.2

When considering any new program, legislative committees should require proponents to provide credible information about the expected total dollar cost of the program. This is particularly important where proposed funding is projected to come from "savings" of other expenditures. Rigorous estimates of expected savings should be documented, and details of how program implementation will limit spending to the "saved" amount should be required. Program implementation should not be allowed to proceed without legislators having the opportunity to make a policy decision about the net new scope of the program.

The original design was modeled after Kentucky Impact, which allocated funds to Regional Interagency Councils for their management.

Original Capitation Approach Abandoned. Even though no explicit initial budget amount was identified for Impact Plus, it was originally designed to operate in a manner very similar to the Kentucky Impact Program. In FY 1998, Kentucky Impact was fully funded with $4.8 million of state General Fund dollars. In Kentucky Impact, the total $4.8 million was allocated to the Regional Interagency Councils (RIACS). Each RIAC was then responsible for prioritizing the mental health wraparound services that could be funded within its budget allocation. This was a *non risk-bearing capitation* arrangement because RIACS were only required to provide the services that could be funded within the capitation amount.

Provider Reimbursement Structures

There are two basic approaches for structuring a provider reimbursement program. These are **fee-for-service** and **capitation**. The primary management tasks for each are discussed.

1. **Fee-for-service** arrangements reimburse providers for each unit of service delivered to the eligible population. In this type of arrangement there is a financial incentive for providers to deliver as many services as possible to as many people as allowed. Therefore, the primary task of program managers is to monitor and manage eligibility and utilization to control costs. The major tools in this effort are well-defined and rigorously enforced criteria for program eligibility and service access. If program costs exceed budgeted amounts, then the only means for cutting costs is to restrict program eligibility, reduce access to services, or both.

2. In **capitated** arrangements, an identified entity is given a lump-sum allocation to pay for services for the eligible population. There are two types of capitation agreements.

   Risk-bearing capitation imposes all financial risk on the capitated organization by specifying that all agreed services must be delivered to the eligible population. If total costs exceed the capitation fee the organization must absorb the excess costs, but it also gets to keep the difference if total costs are less than the fee. In this type of capitation arrangement, the capitated organization has a financial incentive to underprovide services; therefore, the primary task of program managers is to monitor and enforce quality standards.

   Non- risk-bearing capitation also allocates a total amount to an organization for the provision of defined services to an identified population but allows the organization to curtail service delivery once the allocated amount is gone. In effect, this arrangement transfers responsibility for prioritizing and managing services from central program managers to the capitated organization; however, central managers retain responsibility for ensuring that program funds are utilized efficiently to provide services of acceptable quality.

Reviews of the program by R.E.A.C.H. of Louisville, Inc. indicate that the Kentucky Impact program was successful in reducing the use of residential facilities by children with severe emotional disturbance, yet the program was facing budget constraints that limited its coverage. At the same time, Medicaid expenditures on residential mental health services for children were increasing rapidly and over 400 children had been in out-of-state placements during the previous year.

Impact Plus was to merge Medicaid dollars with the Kentucky Impact model.

The concept in creating Impact Plus was to keep the Kentucky Impact model and simply use the Title V agreement as a mechanism to allow Medicaid dollars to be accessed as a new funding stream to address both of these problems. The model was described as

Kentucky Impact + Medicaid dollars = Impact Plus

Kentucky Impact could refuse children if expenditures exceeded the funds allocated.

Unfortunately, there was a fatal flaw in this equation that caused the whole to greatly exceed the sum of the parts. Because Kentucky Impact was funded through a non-risk-bearing capitation arrangement, the local RIACs were able to turn children away (or put them on a waiting list) when funds were exhausted. Yet, federal Medicaid rules require that medically necessary mental health services be provided to Medicaid-eligible children as an *entitlement.* Further, as described more fully in Chapter One, the Cabinet was in the process of negotiating settlement of a class action lawsuit brought by the Division of Protection and Advocacy regarding Medicaid's legal responsibility to provide mental health services to Medicaid-eligible children.

Medicaid services must be provided as an entitlement to the eligible recipients; they cannot be withheld due to lack of funds.

The Title V agreement between the Department for Mental Health/Mental Retardation Services, the Department for Medicaid Services (both within the Cabinet for Health Services) and the Cabinet for Families and Children did allow access to Impact Plus services to be restricted to only those Medicaid-eligible children who met the established criteria for program eligibility. However, following the Kentucky Impact model, those criteria had been kept relatively broad to facilitate local flexibility.

Thus, a more accurate description of the original Impact Plus model might be

Kentucky Impact + Medicaid dollars = Impact Plus
[broad eligibility] + [entitlement] = [rapid growth]

By the summer of 1999, the problems resulting from implementation of this model were becoming apparent in two ways. First, the quality concerns common to capitated arrangements were starting to appear. Testimony before the State Interagency Council indicated that there was great variation in the implementation of Impact Plus eligibility criteria among the Regional Interagency Councils, and the Department for Mental

Health/Mental Retardation Services and the Department for Community Based Services had to remind service providers that quality case management was expected.

The approach of Regional Interagency Councils to manage funds within a budget was abandoned.

Second, the pattern of increasing claims (which would be expected at the beginning of any new program) showed no signs of abating, and by July 1999 was in the neighborhood of $1.25 million per month. On July 8, 1999, the use of capitated arrangements with the Regional Interagency Councils was discontinued and their official association with the program ended.

Thus, while it may have seemed logical to couple the successful Kentucky Impact model with the Medicaid funding stream, program designers apparently did not fully appreciate that Medicaid is not just a pool of dollars but is a program governed by complicated federal rules. It is clear that Impact Plus designers did not adequately understand the fiscal and programmatic implications of federal Medicaid requirements.

Recommendation 3.3

The Secretary of the Cabinet for Health Services should designate one or more individuals who are knowledgeable about federal Medicaid rules and analysis of Medicaid claims data and require those individual(s) to regularly monitor and evaluate the fiscal performance of Impact Plus, its compliance with federal and state Medicaid rules, and the implications of those rules for fiscal management of the program. To avoid the difficult situation in which staff of one Department (Medicaid Services) has fiscal responsibility for a co-equal Department (Mental Health/Mental Retardation), the individual(s) assigned to this task should report directly to the Secretary on all matters related to Impact Plus.

No effective utilization controls were in place when the local management of budgets was discarded.

No Effective Utilization Controls. Extensive discussions with Impact Plus program designers indicate that there were four major reasons that adequate utilization controls were not incorporated in the original program design. First is that under the planned capitation arrangement, utilization management would be primarily left to the Regional Interagency Councils responsible for local implementation of the program. The Department for Medicaid Services did hire benefit coordinators for each region, who had responsibility for prior authorization of every service included in any child's service plan. Benefit coordinators were not effective utilization managers. As a group, they did not have the professional stature to effectively question service recommendations made by clinicians on service teams. Also, much of their time in the early period was spent enrolling providers and negotiating the individual provider reimbursement rates that had been allowed by program managers.

Impact Plus was expected to be a temporary program to be included in managed care networks.

A second reason for the absence of early utilization controls was that Impact Plus was created as a temporary program. In 1997 and 1998, the Cabinet for Health Services was in the process of planning state-wide adoption of managed care partnerships for the provision of Medicaid services. Managed care partnerships for physical health services were either in operation (Jefferson County and Fayette County) or in development. The Cabinet had decided to carve out the behavioral health component and develop it as a separate managed behavioral health organization (MBHO) program. The Cabinet's request for proposals for the MBHO stated

> *IMPACT Plus Services are currently covered services that shall be the responsibility of the MBHO. The MBHO must continue to provide services that have been authorized through the program, and must continue to provide the program as an individualized, flexible response to the needs of child Members who have complex service needs* (Page 96).

Thus, Impact Plus managers focused their primary attention on getting the program in full operation for hand-off to the MBHO, who would have long-term responsibility for its management. It would have been left to the MBHO to develop utilization controls.

The managed behavioral health care initiative was abandoned.

The Medicaid managed behavioral health initiative never came to fruition and was officially discarded by the Cabinet in November 1999. When the managed care initiative was abandoned, Impact Plus was left to operate as an entitlement program with ill-defined eligibility criteria and an absence of effective controls on service provision by a new group of providers, many of them private for-profit firms who had negotiated individualized reimbursement rates. Under these conditions it is little wonder that costs exploded.

Impact Plus managers did not think providers or recipients would take advantage of poor utilization controls.

A third reason given by early Impact Plus managers for not establishing utilization control and monitoring of providers was that they expected providers would always act in the best interests of the children in the program, and not provide services that were unneeded, much less bill for services they had not provided. Such naivete is unfortunately not substantiated by actual experience, either within Impact Plus or in other provider reimbursement programs. Recent site reviews of providers by Impact Plus staff have identified numerous instances of unacceptable performance, including one case in which a provider had billed for approximately $40,000 worth of individual therapy sessions for which no documentation or case notes could be produced. The program has since recouped those payments.

Previous studies of state provider reimbursement programs (Kentucky Kare, First Steps, the Underground Petroleum Storage Tank Program, the Non-emergency Transportation Program) have all demonstrated that enough individual decision makers (both providers and recipients) associated with a program will take advantage of insufficient utilization and quality controls to significantly undermine program integrity. It is unreasonable to expect that providers and recipients uniformly put the interests of the program ahead of their own self-interest. It is the responsibility of management to protect the interest of the program. It is also true that failures of management in this regard tend to ultimately result in budget shortfalls that become the concern of the State Budget Director.

Recommendation 3.4

A provider reimbursement program is defined to have the following two characteristics.

1. *A state agency uses funds appropriated by the General Assembly to reimburse non-governmental entities for the provision of services directly to a citizen who has been determined eligible for state provision of the services; and*

2. *The recipient has some control over the selection of the provider or how often services will be accessed.*

Prior to the implementation of any new provider reimbursement program, or significant expansion of an existing one by an Executive Branch agency, the agency should be required to submit detailed utilization control and quality assurance plans to the State Budget Director. Before state funds are allotted to the program by the Governor's Office of Policy and Management, the State Budget Director should certify in writing to the Interim

Joint Committee on Appropriations and Revenue that the plans presented have a high probability of achieving adequate utilization control and quality assurance. The utilization control and quality assurance plans should be evaluated in terms of existing law at the time the plans are filed, and in terms of major changes that may be anticipated. The State Budget Director should utilize any expertise necessary to evaluate the plans but is strongly encouraged to seek the counsel of the Commissioner of Insurance.

Program managers were advocates for the population they served.

A final reason for initial weak control of the number of eligibles and provision of services was not directly offered to Program Review staff but seemed apparent in discussions with Impact Plus officials. As they should, program managers appeared to believe strongly in the need for additional mental health services for children and in the ability of the Impact Plus program to offer a significant improvement in the lives of families of children with severe emotional disturbance. Comments from parents and their representatives indicate that many were desperate to receive such assistance.

Managers may have tipped the necessary balance between advocacy and fiscal responsibility.

Some of the Cabinet employees involved in the design of Impact Plus appeared ambivalent about whether the rapid growth of the program's budget was a positive or a negative occurrence. There was common agreement that Medicaid cannot continue to absorb annual costs that grew from just over $5 million to nearly $25 million in three years. It was also generally acknowledged that providers should be better monitored to preserve scarce dollars for the benefit of a greater number of children. However, there was also clearly some satisfaction expressed that a significant number of state dollars had come to be allocated in a manner believed to be critically needed and long overdue.

While it is essential that agency staff care about the populations they serve and believe in the programs they offer, it is management's fundamental responsibility to balance the roles of advocacy and stewardship of resources. From an advocacy standpoint it may be desirable that a program was created that delivered new dollars to behavioral health services for children. However, from a management standpoint, it is unacceptable that this occurred without the decision having been made by the policy makers elected to make those decisions.

Recommendation 3.5

Impact Plus managers should be reminded that their job is to achieve the policy goals of the program within the budget priorities set by elected officials.

There was substantial demand for Impact Plus services.

Demand for Program Services. Since the number of Impact Plus recipients did grow at such a rapid rate, it is clear that there was substantial demand for the services it offered. This demand is likely a function of several factors. First, Impact Plus offered a new set of services from a new group of providers. These would have attracted new Medicaid-eligible recipients, particularly those who had been unable to obtain the desired services through existing Medicaid programs. This could have been because they did not care to use the existing Medicaid providers, could not use them because of waiting lists, or did not know about service availability through EPSDT.

Those familiar with Impact Plus say the services provided are beneficial to the children who receive them.

Program Review staff heard from parents, clinicians, and officials of state agencies who deal with troubled children that the services offered by Impact Plus were very beneficial to the children who received them. There is strong support among these groups for continuing the program. At one point there were internal discussions at the Cabinet for Health Services about the possibility of dropping the Impact Plus program because of its escalating costs. The Cabinet for Families and Children was in the process of designing its own version of Impact Plus in that eventuality. That program would have been funded totally with state dollars.

More parents were able to access services for their children without having to relinquish custody.

The policy decision to use Impact Plus as a vehicle to allow parents to receive certain residential behavioral health services for their children without having to commit them to state custody also likely increased demand for services. Also, officials familiar with both systems told Program Review staff that some schools may have directed a substantial share of the students who might have qualified for special education services to Impact Plus instead.

Impact Plus served many more children with conduct disorders than did EPSDT.

An examination of the claims of children who received EPSDT services (with or without Impact Plus services) indicates that there were twice as many children receiving services for mood disorders, such as depression or anxiety, than for conduct disorders. Conversely, not only were there many more children who received Impact Plus services, they were two and a half times as likely to receive treatment for conduct disorders than for mood disorders. This indicates that Impact Plus was being accessed by a different group of children than was EPSDT.

Practitioners reported that more children are having more serious problems at a younger age.

A final comment about general demand for behavioral health services is in order. No matter what decisions are made by policy makers regarding the nature and amount of behavioral health services for children that will be funded in the future, it is likely that demand for those services will continue to grow. A universal comment Program Review staff heard from practitioners involved with emotionally disturbed children was that more children are having more severe problems and at an earlier age.

Impact Plus is serving a higher proportion of children with developmental disorders, particularly children with autism.

Children with Developmental Disorders. Another group of children that has received new levels of service through Impact Plus are children with developmental disorders. Most of the children in this category are autistic. Since the program's inception, over four times as many children with developmental disorders have received services from Impact Plus (211) than from EPSDT (46) during the same period. In calendar year 2000, children with developmental disorders represented three percent of recipients in Impact Plus, and eight percent of expenditures. At $13,477 per recipient, the average cost of services for this group is nearly 2.5 times larger than the average for all recipients.

One third of autistic children access Impact Plus because they are eligible through the Home and Community Based Waver.

For most recipients, Medicaid eligibility depends on family income and resources. A number of families who would not be financially eligible for Medicaid have obtained Medicaid cards for their children through the Home and Community Based Waiver program. The Home and Community Based Waiver program provides community services to persons who need nursing home level of care to prevent them from being institutionalized at a higher expense for Medicaid. It has higher income standards and those who would normally not qualify for Medicaid may be qualified under this program. Just over one third of the families with children with autism who receive Impact Plus services qualified for Medicaid eligibility provided through the Home and Community Based waiver. Impact Plus services most often provided to these children and families are therapeutic child support services, case management, and collateral services.

Parents of autistic children want the Impact Plus services. Professionals question whether the program is the most appropriate vehicle.

In discussions with parents, clinicians, and researchers familiar with autism, two specific issues were raised. First, it is clear that parents of autistic children feel strongly that their children need the services they receive from Impact Plus, particularly compared to the level of services they had received before the program's creation. However, professionals familiar with successful interventions to improve the functioning of individuals with autism have questioned whether the services provided by Impact Plus are the most beneficial that could be offered and whether Impact Plus is the most appropriate vehicle for delivering services to this population.

Individuals with developmental disorders may need life-long interventions different from those appropriate for children with mood, conduct, or adjustment disorders.

A review of the professional literature and discussions with staff of the Kentucky Autism Training Center indicates that early evaluation, diagnosis, and treatment planning are key to successful outcomes that may permit children and adults with autism to remain in their communities. "State of the art" intervention methods continue to evolve based on professional research standards. The individualized nature of autism and the degree of individual impairment make it difficult to prescribe a standard regime of treatment. Some of the behaviors demonstrated by autistic children may resemble the behavior of children with severe emotional disturbance; however, the reasons for the behaviors are quite different so the successful interventions are also different. The system of services offered through Impact Plus seems to be designed for children with mental health conditions rather than for children with a developmental disability.

A workgroup is drafting a document to guide service planing for individuals with autism.

The State Interagency Council convened a workgroup of mental health professionals, parents of autistic children, and professionals from the Kentucky Autism Training Center to develop a "clinical pathways" document as a guide to evaluation and service planning for children with autism. The document is a work in progress, and demonstrates efforts to refine and define services available to families with autistic children.

One model that might be considered is Maryland, which is now implementing a Medicaid Home and Community Based Services Waiver for Children with Autism Spectrum Disorder. The state department of education operates the program through local school systems and through local early intervention programs for infants and toddlers.

Recommendation 3.6

A directive should be issued to the Kentucky Autism Training Center of the Weisskopf Center for the Evaluation of Children to convene a group of professionals representing the Child Evaluation Center at the University of Louisville, the Bingham Child Guidance Clinic at Norton-Kosair Hospital, Louisville, the Infant/Toddler Evaluation Center at the University of Kentucky, or other similar university or hospital-based program offering an appropriate, multi-disciplinary assessment. This group should consult with the Department for Mental Health/Mental Retardation, the Department for Medicaid Services, the Department of Education, and representatives of families with autistic children to produce a "best practices" manual to specify the types of services and provider qualifications reasonable for payment with public funds. The "Clinical Pathways" document that is now being drafted could be used as a guide for these discussions.

Recommendation 3.7

Quality training and supervision should be required for case managers and community service providers involved with autistic children, particularly for schools and those involved in developing Individual Education Plans. A pilot program of travelling specialty teachers may be helpful.

Recommendation 3.8

Consideration should be given to delivering services for children with autism through the service system for individuals with mental retardation and other developmental disabilities, including early intervention systems.

Utilization Control Measures Instituted to Date

Managers instituted changes to slow program growth.

Impact Plus managers instituted four major changes in an attempt to bring fiscal accountability to the program. Impact Plus managers have promulgated emergency regulations to tighten program definitions and require prior authorization of all requests for services, undertaken site reviews of provider operations and documentation, and begun to develop outcomes measurement protocols. This section will summarize each of those efforts and make recommendations regarding utilization management.

New regulations attempted to tighten eligibility and service practices.

Regulations Tighten Program Definitions. In July 2000, the Department for Medicaid Services filed an emergency regulation, 902 KAR 3:030E, to institute immediate programmatic changes to Impact Plus. The original regulation had been in effect since December 1997 with no changes from program inception to the filing of the emergency regulation in July 2000.

Under the original regulation:

- Any "licensed practitioner of the healing arts" could be a service provider;
- A very general category of "rehabilitative" services was instituted for maximum reduction of a behavioral disability and restoration and maintenance of a recipient to his "highest possible functional level";
- Services had to meet the requirements of the Title V Agreement and included:
    - targeted case management;
    - "rehabilitative services";
- Eligibility was defined as children who were:
    - in custody of the state or at risk of being in custody of the state;
    - under the supervision of the state; or
    - in an institution or at risk of being in an institution;
- Service types were listed but not defined; however, a program manual with further detail was incorporated into the regulation and included the same general requirements as the amended regulation.

The July 2000 emergency regulation made significant changes to the program. Among the most important changes for utilization control were the following.

- Eligibility criteria were tightened by defining "at risk of institutionalization" to include only cases:
    - where a child was certified by a clinician to need short-term crisis stabilization services; or
    - where a child has a severe, persistent Axis 1 diagnosis with documentation of severe behavioral health problems during the past six months, and requires a coordinated plan of medically necessary community mental health services to avoid institutionalization.
- A specific list of the providers allowed to provide services was adopted.
- Requirements for prior authorization for each service and shortened time periods of authorization were imposed.

- Changes were made in the membership of the child's treatment team.
- Independent case management requirements were imposed whereby providers were prohibited from performing both case management and any other type of services. This action was taken to reduce the incentive for a case manager to unnecessarily recommend services provided by his or her own agency.

These changes were to be in effect by October 2000. Additionally, in September 2000, enrollment of new providers ceased, existing providers were prohibited from expanding their service areas, and rates were frozen.

Active resistance caused some of the changes to be dropped.

There was active resistance to many of these changes from service providers and parents/consumers. Those opposed to the changes presented testimony at public hearings on the administrative regulation, spoke at legislative committee hearings, held meetings with individual legislators, and engaged in letter writing campaigns to Cabinet officials and legislators.

The concerns by those opposed to the changes were varied. Testimony was presented that:

- Specification of mandatory members of every child's service team was creating administrative problems for providers and causing delays in development of service plans; was causing some team members not to be compensated for participation in service team meetings; and was inefficient by requiring a fourth "unrelated" person to be included in the team.

- Many providers said they would leave the program altogether if the independent case management requirement remained because they wanted to be able to supervise both case management and the provision of services. They also said payments for case management services helped maintain the financial viability of their involvement in the program.

- Requirements for prior authorization by the peer review organization would limit eligibility and services for children in need.

Many families with children who were receiving services under Impact Plus were very active with their legislators. Through a series of meetings among family members, legislators, and agency staff, the Cabinet for Health Services developed a new emergency regulation that was promulgated in March 2001. The Cabinet acquiesced on many of the service delivery requirements, including dropping the requirement for independent case management and a fourth member of the service team. According to Impact Plus staff, no providers have voluntarily left the program to date.

Eligibility and service requests are now subject to prior authorization by the Healthcare Review Corporation (HRC).

Prior Authorization by Healthcare Review Corporation. Two of the most significant changes in the emergency regulation promulgated in July 2000 were the new requirement that all eligibility functions and all approval for services be managed by Medicaid's peer review organization, Healthcare Review Corporation (HRC), and that all services meet the requirements of the definition of "medical necessity." The new requirements also stipulated that every service had to have prior authorization from HRC.

As of October 2000, all eligibility determinations and authorizations of services are provided by HRC. These new duties were covered under the existing contract between HRC and Medicaid, with no contract amendment. It was explained that HRC could take on the Impact Plus responsibilities at no additional cost because there had been less demand for long-term care review than had originally been negotiated in the contract. Without the Impact Plus tasks, the contract would have been reduced.

HRC has recently added three new positions to the existing 5.5 dedicated to Impact Plus reviews.

HRC has approximately 8.5 full-time equivalent positions devoted to prior authorization reviews for Impact Plus. About half of these positions are staffed by registered nurses and half are staffed by licensed clinical social workers, although three of these have only been recently hired and may not yet have affected the timing or quality of reviews. These employees can only approve requests for services. Denials must be made by HRC physicians after communication with the clinician making the request. HRC receives a copy of each child's service plan and evaluates specific service requests in the context of the overall plan.

When the move to HRC review was under discussion, opponents of the change argued before legislative committees that placing eligibility and service approval with HRC was simply a way to provide fewer services to fewer children to save money. They argued that the result would increase the possibility that more children would end up in institutions in the future and that more children would end up being committed to the state to access services.

Between 10/00 and 7/01, HRC denied 145 eligibility requests, most for lack of documentation.

Program Review staff requested documentation of all denials of eligibility and services since HRC assumed that responsibility for Impact Plus. As detailed in Table 3.8, between October 2000 and July 2001, HRC disapproved Impact Plus eligibility for 145 children, most for lack of documentation of a required criterion, such as a six-month history of behavioral problems. Fifteen appeals of these decisions were filed. Ten denials were upheld, three were overturned, and two denials remained in effect because the appeal request was not received by the required date.

Table 3.8
Reasons for Impact Plus Eligibility Denials by HRC
October 2000 - July 2001

Denial Reason	Number	Percent
No six-month history	63	43%
Insufficient information supplied	27	19%
No Axis I diagnosis	22	15%
Does not meet established criteria	13	9%
At risk status not clearly defined/ documented	9	6%
Other	4	3%
Custody Issues	3	2%
Lacks medical necessity	2	1%
Chemical dependency based diagnosis/problems	2	1%
Total	**145**	**100%**

During the same period, HRC denied 488 requests for Impact Plus services on behalf of 277 children. Most were for non-residential services.

During the same period, 488 requests for Impact Plus services on behalf of 277 children were denied by HRC, as shown in Table 3.9. Nearly ninety percent of the denials were for non-residential services such as therapeutic child support and individual therapy. Of these denials, thirty were appealed. Sixteen denials were overturned, and five were modified so services could be approved. Eight denials were upheld on appeal, and one remained in effect because the appeal request was not received by the required date.

Table 3.9
Number of Denials for Impact Plus Services by HRC
October 2000 - July 2001

Service	Number	Percent
Therapeutic Child Support	181	37%
Collateral Services	86	18%
Individual Service	82	17%
Case Management	67	14%
Therapeutic Foster Care/Group Residential	26	5%
After School/Summer Programs	19	4%
Evaluation	6	1%
Partial Hospitalization	6	1%
Children's Day Treatment	4	1%
Crisis Stabilization	4	1%
Intensive Outpatient Services	4	1%
Group Services	3	1%
Total	**488**	**100%**

HRC has been averaging 53 eligibility and 339 service requests per week for Impact Plus.

Since it began reviewing Impact Plus claims, HRC received an average of 53 eligibility requests and 339 service requests each week. Thus, it does not appear that, to date, HRC denials have significantly limited participation in Impact Plus.

Providers feel HRC is delaying requests simply to cut costs.

In interviews with Program Review staff, Impact Plus providers have also complained about the shortened length of service periods that will be approved by HRC and the slow turnaround for service requests. The complaint was made that a slow approval process caused children to go without needed services and lose scarce placements. There were also complaints that HRC reviewers do not understand children's behavioral health needs and the community services that Impact Plus is designed to give them.

Providers also say that slow authorizations have created a financial burden for them.

Another major issue for providers was the financial burden they attribute to slow service approval by HRC. One small provider told about having to repeatedly borrow from a local bank to cover payroll because of slow processing of service requests. A site review of the provider indicated that it had followed all Impact Plus rules and was delivering exemplary service to the children treated. In Chapter 2, Program Review staff recommended that the Title V agreement be maintained largely because the new pool of providers is believed to represent an opportunity to expand and improve the state-wide quality of behavioral health services delivered to children with severe emotional disturbance. Inadequate operational performance by HRC should not be allowed to drive good providers out of the system.

Review indicates that eligibility requests are normally decided in the week they are received.

HRC staff acknowledged that the transition to strict prior authorization was initially difficult. They assert that the problems are being reduced over time as transition problems are addressed. In an attempt to determine the average turnaround time, and whether it has declined over time, Program Review staff requested copies of the weekly reports HRC sends to Medicaid on the status of eligibility and service requests. Staff received copies of the eligibility and service request spreadsheets for twenty-seven of the weeks between December 2000 and August 2001 (records for some weeks could not be found by Medicaid). For these weeks, all eligibility decisions were rendered within the week they were received.

Data submitted to Medicaid by HRC was inadequate to evaluate turnaround time for service requests; providers complain it is lengthy.

Prior to February 2000, weekly service request reports included the date of the request and the date the service decision was made, if it occurred during that week. For decisions not made during the week the request was received, no additional entry was made to indicate the actual date the decision was made. Therefore, it is not possible to use the reports provided to Medicaid to calculate an average number of days that it took HRC to make decisions on service requests. Starting in February 2000, some data on the decision date were entered for cases in which the decision fell outside the week the request were received. However, staff review of this data found them to be inconsistently entered and validated. For example, there were some cases in which the date approved was entered as a date prior to the date requested. Unless Medicaid receives data that were not provided to Program Review staff, it is not possible to track the average HRC turnaround time for Impact Plus service requests. However, many providers complain that turnaround has been slow, to the point of seriously compromising their financial stability.

Recommendation 3.9

Given that Impact Plus is an entitlement program for those who meet the eligibility criteria, the Department for Medicaid Services should continue to impose centralized eligibility determinations and prior authorization of service requests. These decisions should not revert to the Regional Interagency Councils.

Recommendation 3.10

The Department for Medicaid Services should require HRC to submit data on the date of all eligibility and service requests, the initial decision date for all eligibility and service requests, and the final status of denied requests. The Department for Medicaid Services should monitor these data and use them to develop benchmarks for HRC performance. Procedures should be put into place to effectively address instances in which HRC responses to Impact Plus service requests fall outside an allowable time frame, both on average and in individual situations. Poor performance by HRC should not be allowed to cost Impact Plus the new provider pool for children's behavioral health services that it has worked so hard to develop.

Impact Plus staff have begun site reviews of providers.

Site Reviews. Impact Plus staff began conducting site reviews of provider records in January 2001 as a measure to reduce unnecessary utilization and improve quality of provider documentation and service provision. As of August 2001, site reviews had been conducted for twelve of the 214 providers enrolled in the program. According to Impact Plus staff, providers were selected for the initial review either because they had a large dollar volume of Impact Plus claims, or because concerns had been raised about the quality of the services they provided. The stated intention is to schedule a review of every provider at least every two years.

According to Impact Plus staff, in a site review, they review all personnel to make sure they are qualified. To review claims, they select some high-volume, middle-volume, and low-volume files and check for appropriateness of services, whether they tie back to the service plan, adequacy of service coordination, and whether there is evidence that freedom of choice was allowed parents. They review a minimum of ten percent of the cases for each provider and check against claims reports provided by Medicaid. They focus on quality and ask for performance improvements as they deem appropriate.

Overall Findings from Site Review of Provider Exhibiting Good Practice Protocols

1. Files were well organized.
2. It was evident that (name deleted) provides comprehensive supervision of staff.
3. Staff supervision occurs on a frequent and regular basis.
4. All treatment notes were recorded in a clinically appropriate format and related directly back to each client's service plan.
5. Provider continually offers in-house training which improves the quality of care for the children and raises the level of staff professionalism.

In closing, the site review team found the agency to operate in a professional manner and provide quality services to the families and children they serve.

Overall Findings from a Site Review of a Provider Exhibiting Poor Practice Protocols

1. Recoupment is necessary in all three categories of services the agency has been authorized to provide.
2. Services are not being provided in accordance with individual goals and objectives in client service plans.
3. The person providing a large portion of the agency's clinical services has failed to document any of the services claimed.
4. Agency documentation overall does not support the quantity of services claimed.
5. Many staff throughout the agency have not and do not meet minimum qualifications to provide the services claimed.

In summary, it is the recommendation of the site review team that, based on the above findings, efforts be made to pursue the recoupment of payments for undocumented services and services that were not provided according to regulations. In addition, it is recommended that the Provider Contract between the Provider Departments and this agency be terminated. (A recoupment in the amount of $40,000 was received from this agency.)

The site reviews are an important step in quality assurance.

The site review activities bring an important element of utilization and quality control to the management of Impact Plus. HRC staff reported that they see improvements in the documentation submitted by providers as a result of the site reviews and training sessions. This can have a significant effect on improving HRC's timely response to service requests.

Currently, the site review efforts suffer from two major limitations. First, sufficient staff resources have not been allocated to this important central management task. Second, the site review team does not include a child behavioral health clinician who could more adequately assess the appropriateness of the nature, frequency, and duration of services included in the reviewed cases. Because of that, much of the site review attention is focused on matters related to documentation and staff qualifications without fully addressing the quality of services.

Recommendation 3.11

Impact Plus site review activities should be continued and expanded. At least two additional staff positions should be allocated to this effort. One of the positions should be filled by a child behavioral health clinician who is qualified to assess the appropriateness of the nature, frequency, and duration of the services included in the reviewed cases.

Development of outcomes monitoring is underway.

Outcomes Measurement. A final utilization control effort under way in the program is the development of regular monitoring of outcomes for children who receive Impact Plus services. The plan is to administer two child behavioral health-screening questionnaires to Impact Plus children on intake, at six-month intervals, and upon exit from the program. The screening instruments to be used are the Child Behavior Checklist and the Ohio Screening Tool for Children. As the proposed screening is not yet underway, it is too early to determine what effect it might have on quality and utilization. However, adequate collection and evaluation of outcome measures would generally be expected to improve program quality.

Overall Conclusion

The overall conclusions of this report are as follows. Program proponents argued for the creation of Impact Plus by asserting that it would be a budget neutral program that would deliver more appropriate community-based services to children with severe emotional disturbance. The costs of those services were to be funded by an associated reduction in the costs of institutionalization for those children. Parents, clinicians, and agency officials who deal with troubled children uniformly reported that the services received by children have been beneficial for them.

However, the review of Medicaid behavioral health claims for children does not support the conclusion that Impact Plus was budget neutral. Instead, it appears that program design flaws, particularly an initial misunderstanding of federal Medicaid requirements and the absence of effective utilization controls early in the program, have resulted in significant new services being delivered by a new group of providers to new groups of children. It appears that a significant share of these services were funded with net new dollars.

Thus, the major conclusion is that the early program design flaws have created a situation where policy makers must face the difficult decision of whether to continue funding the new services for an unanticipated population, which has expressed strong desire for those services, or whether to reduce program scope to relieve pressure on a Medicaid budget that is already facing serious deficits.

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