REPORT OF THE VIRGINIA DEPARTMENT
OF MENTAL HEALTH, MENTAL RETARDATION
AND SUBSTANCE ABUSE SERVICES ON

The Effects of Managed Care and HMO Administration of Mental Health Benefits on Service Providers

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 44

COMMONWEALTH OF VIRGINIA
RICHMOND
1993

Preface

Authority

Senate Joint Resolution 107 requested the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the effects of managed care and HMO administration of mental health benefits on the utilization of public mental health providers and charity care of private mental health providers.

Study Group

A work group was convened that included representatives of:

- Virginia Association of Community Services Boards
- Virginians for Mental Health Equity
- Mental Health Association of Virginia
- Virginia Alliance for the Mentally Ill
- DMHMRSAS staff, and
- legislative liaisons for several licensed provider groups.

Staff

Rubyjean Gould, DMHMRSAS Director of Administration, and James Duffy, Assistant Director, Virginia Beach Community Services Board, principal researcher with invaluable data management assistance from Steve Yiuh, DMHMRSAS, Community Information Systems.

Study Approach

Surveys were developed with the concurrence of the study group and distributed to

- mental health and substance abuse professionals licensed by the Department of Health Professions,
- programs licensed under the auspices of the Department of Mental Health, Mental Retardation and Substance Abuse Services,
- members of the Virginia chapters of the Psychiatric Society,
- Employee Assistance Programs,
- United Way programs, and
- Family Services Agencies.

Two-Step Survey

Over 5,000 surveys were distributed to gauge -

- the number of managed care clients who had services denied or were forced to private charity or low cost care;
- mental health and substance abuse professionals' assessment of managed care trends;
- specific client dimensions about treatment type, why services were capped, and the clinical and financial impact.

Information and Data References

Additional information about the study methodology or data is available from Mr. Duffy at the Virginia Beach Community Services Board or Ms. Gould at the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

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Chapter 1

Executive Summary

Section 1

Findings and Recommendations

Findings

Managed Care has become a necessary means to control health care expenditures. Its report card is not definitive about cost savings beyond the ability to reduce use of certain types of health care services. Managed care's ability to provide the health care system with the cure is an evolving system that addresses only one dimension of the health care system. The literature suggests that there are many myths about managed mental health care, but there are definitely changing roles and realities. For the Commonwealth of Virginia, the SJR 107 study on Managed Care attests to the concern expressed by clinicians in both the private and public sectors, about the negative effects that managed care have had.

Effects of Managed Care: Cost Shifts

Managed Care, as a growing practice, contributes to the following:

- Increased Private Sector Charity and Low Cost Care
- Increased Capitation/Cost-Shifting
- Over $1 million Cost-Shifting to the Public CSBs Annually

Professional Concerns

- Professional Sentiment that It Affects the Quality of Care
- Major Professional Confidentiality Issues
- Intrusive Utilization Review
- Orientation of "Managed Reimbursement" versus Managed Care
- The Erosion of Extended Treatment Plans
- Reduced Access to Private Sector Care that shifts people to
  - Private Charity Care
  - Public Sector Waiting Lists
  - No Care at all and Deteriorated Mental Status

Part of the Solution

The above are realities and manifestations of the problem and <u>not</u> an indictment of Managed Care. Managed Care principles are needed in today's health care arena. The MH/SA community recognizes this reality and wants to partake in the system prescription. However, all parties will be needed to make it work with credibility and quality.

Recommendations

Managed care has been characterized as the responsibility of the many parties involved in the process. This framework is proper for recommendations engendered by the SJR 107 study.

General Assembly

Recommend that the Special Advisory Commission on Mandated Health Insurance Benefits work to ensure action on the following Managed Care related recommendations:

- Support Mental Health and Substance Abuse Services in the Essential Health Services Panel and 1993 General Assembly actions.

- Support the mental health services benefit conversion option approved by the Special Advisory Commission on Mandated Health Insurance Benefits. This conversion option provides flexibility in mandated mental health service coverage offered in insurance packages by providing a range of services in varied treatment settings.

  - Inpatient care: 20 days for adults and 25 days for children and adolescents under the age of 18 on the same terms and conditions as coverage for inpatient medical/surgical treatment.

  - At patient discretion, conversion of up to 10 days of inpatient benefits to partial hospitalization on the basis of one inpatient day for at least 1.5 days of partial hospitalization.

  - 20 outpatient visits with the first 5 on the same terms and conditions as medical/surgical outpatient visits, and the remaining 16 with no greater than a 50% coinsurance payment.

  - Medication management outpatient visits covered as medical/surgical outpatient visits and not against limits on mental health outpatient visits.

- Authorize the collaborative development by the SCC, DMHMRSAS, Department of Health Professions, and other involved agencies and governmental entities of a process for enabling Managed Care practice and the evaluation of their professional conduct.

Bureau of Insurance

- Require all Managed Care firms to comply with the developed criteria and assurances prior to conducting business in the Commonwealth.
- Monitor the conduct of Managed Care firms with the Department of Health Professions and DMHMRSAS through the administration of:
  - An Independent Case Disposition Appeals Panel
  - A Complaint Tracking and Disposition System
  - Requirement that all Managed Care firms advertise appeal and due process rights.

Managed Care Firms Doing Business in Virginia

- Comply with standards of care and confidentiality safeguards
- Implement equitable internal appeals procedures.
- Conduct quality of care assessments and long-term evaluations.
- Maintain and report performance data on service capitations and client prognosis and disposition.
- Abide by SCC Independent Review Panel Determinations.

DMHMRSAS and CSBs

- Track managed care trends and cost-shifting to State Hospitals and CSB programs.
- Ensure that Managed Care Standards of Care criteria produce appropriate levels of clinical services and full insurance benefit use.
- Report Managed Care practices that reduce access and cause cost-shifting to private sector charity care or public sector programs to SCC and the Secretary of Health and Human Resources for action.
- Work with Virginians for Mental Health Equity, Johns Hopkins, academic resources and consumer groups to study insurance mandates, utilization issues, and methods to track Managed Care trend data.

Practitioners and Institutions	▪ Cooperate, collaborate to make managed care work equitably for clients. ▪ Exercise all judicious appeals means. ▪ Assure confidentiality and professional ethics with respect to patient care and patient records. ▪ Recognize that Managed Care can reduce costs, but has the price of quality loss and cost-shifting to less effective and appropriate treatment. ▪ Educate consumers about the need for managed care and the consequence that if Managed Care is conducted too aggressively, the public will pay.
Employers and Businesses	▪ Insist that only reputable, credentialed Managed Care firms conduct business in Virginia. ▪ Evaluate Managed Care insurance packages based on quality performance and not just cost-savings. ▪ Recognize that mental health and substance abuse needs do not disappear, if not treated. When insurance per diems do not capture externalities, the private sector must allocate more charity care and the public sector cannot respond due to long-standing waiting lists. Business as a taxpayer will pay inordinately. Recognize that "we can pay now or pay more later."
Consumers	▪ Hold all parties responsible for Managed Care system effects on quality treatment. ▪ Exercise appeals procedures. ▪ Expect responsible performance by Managed Care firms and insist that the SCC report annually on the performance of Managed Care firms doing business in Virginia. ▪ Advocate for MH/SA insurance parity. ▪ Build alliances to assist all parties to make this prescription work.

Section 2

Summary of Survey Responses

Private Sector Survey Response

Private Sector Clients

Aggregate data indicate that 71,000 Virginians are adversely affected by managed care interventions denying them services or forcing them to private charity care. There is an astounding 29.44% of MH/SA managed care clients who bear negative effects.

- Reporting agencies served 241,033 MH or SA clients yearly
- 17,742 individuals reported to have been denied MH or SA services or forced to private charity care - this equates to some 71,000 Virginians in a calendar year.

Charity Care Impact

The study found that of survey respondents

- 47% provide some charity care
- 77% provide low-cost care with adjusted fees
- 92% saw an increase of working and insured clients with inadequate insurance or curtailed services
- 34% of low-cost caseloads now comprise working and insured individuals with inadequate coverage.

Responses

Private psychiatric hospitals and practices felt the greatest consequences for mental health cases.

- On average, there is a 37% rate of managed care enrollees.
- Capitation or cost-shifting rates were extremely high for
  - psychiatric hospitals,
  - EAPs,
  - Family Services, and
  - Private Practices.

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Responses, Continued

Attitudes about Managed Care Process

- 97% want to appeal review decisions and independent providers to be included in care review panels.
- 92% feel managed care referrals affect public and private charity care in cost shifting.
- 84% view managed care systems as reality for the foreseeable future and see that the MH/SA professional community must participate in a constructive fashion to forge well-defined standards of care.

Extrapolations

Capitation and cost-shifting rates were computed for each type of MH/SA provider.

- 85% of psychiatric hospital managed care clients were capitated in a manner that provokes a major difference of clinical opinion between hospital staff and Managed Care Utilization Reviewers or Case Managers.

High capitation or cost shifting rates were also noted as follows:

- Private Practices - 75%
- EAPs - 93%
- General Hospitals with MH/SA Inpatient Units - 37% and
- Residential Treatment Centers - 37%

Public Sector Survey Response

Public Sector

In urban areas, managed care plans cover a third of those seeking MH/SA treatment and the SJR 107 survey indicates that 29% of these enrollees are at risk of having their services capitated and consequently being shifted to another treatment sector - CSBs. Where managed care exists, the working and insured are cost shifted to the CSBs when:

1. They cannot afford private sector co-pays; and
2. Managed care has denied them further services.

Survey findings from the 40 CSBs from May 1 to May 15, 1992.

- 18 CSBs noticed managed care effects on their service system
- Fairfax, Hampton/Newport News and Virginia Beach had more pronounced effects
- 20 the CSBs increased admissions of citizens with insurance, but who couldn't afford the MH/SA co-pays
- 14 CSBs increased admissions of gainfully employed citizens who couldn't afford to participate in their company's health care package and, thus sought public services
- 71 managed care referrals were identified by the CSBs over the survey period equating to 1700+ annually.

CSB Client-Specific Responses

Treatment sought:
- 58% MH
- 36% SA,
- 6% MH/SA

CSB services sought
- 57% outpatient;
- 6% inpatient;
- 7% crisis intervention

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Survey Responses, Continued

CSB Managed Care Clients

CSB MC Clients/Individuals arrived at CSBs because:

- Further Services Denied 11%
- Non-available MC Service 11%
- Non-negotiable co-pay 28%

Previous care received ...

- Managed Care outpatient services 25.%
- Crisis intervention 6.%
- Inpatient 6.%
- No Services 48.5%

Clinical Prognosis and Cost

The Clinical Prognosis for those admitted due to managed care required:

- Short-term services 57.%
- Long-term services 23.%
- Inpatient or Residential with Day or Outpatient follow-up 9.%
- Less intense modality 3.%

- The cost-shifting associated with each of these cases totalled **$32,000** over the next 30 days

- Annualized cost shifting to CSBs can be projected conservatively at **$768,000** given the reality that many individuals will require extended treatment.

Managed care shifts at least **$1 million** annually to the public sector.

Chapter 2

Effects of Managed Care

Section 1

Overview

In this chapter This chapter covers the following topics:

Section 2

Organization of the Report

This report is organized to provide the history and Virginia study antecedents that were the precursors of the SJR 107 Study Process. It includes chapters on the survey findings from both the private and public sectors, analysis of the data, recommendations emanating from findings, and exhibits.

Section 3

History - Study Antecedents

Insurance Task Force

Convened

In May 1989, as requested by House Joint Resolution (HJR) 319, Howard M. Cullum, then Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, and Steven T. Foster, Commissioner, Bureau of Insurance, State Corporation Commission, convened a Task Force composed of

- service providers
- the insurance industry,
- advocates for individuals with mental disabilities, and
- university teaching hospital representatives.

Report

The Task Force met monthly from June, 1989 through October, 1990. Its final report was submitted to the Governor and the 1991 General Assembly in House Document No. 30, "Studying Insurance Coverage for Persons with Mental Disabilities.

House Document No. 30 Findings

In its report, the Task Force recommended that the General Assembly work toward an ideal service delivery system by considering the issues of

- parity coverage for mental health and substance abuse treatment,
- adequacy of funding to support treatment,
- increasing the insurance mandates to include outpatient treatment, and that
- managed care, including utilization review, being a reality of health care used increasingly to control costs and quality of care, should be well-structured with operational standards that would include a neutral appeals system.

Managed Care Effects

The study determined that the effects of managed care on mental health and substance abuse services were substantial and controversial and would require a broader review of managed care and public policy to address public anxiety about health care issues in general.

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Insurance Task Force, Continued

Public Perception of Gatekeepers

For the public to perceive managed care gatekeepers as responsible and objective, the report recommended that they

- be liable for the consequences of their decisions,
- be independent of insurance companies and providers, and
- have no financial interest in the outcome of their decisions.

Mental Health Just One Care Component

Mental Health is a small component of Managed Care. For a managed care systems study to be useful, it would have to extend beyond mental health and substance abuse services and be undertaken on a broad basis because managed care systems do not limit their review solely to mental health and substance abuse services. Thus the Task Force's recommendation embodied in House Joint Resolution 399 passed by the 1991 General Assembly, charged the Board of Health Professions with the task of studying the standards and ethics of managed care systems.

HJR No. 399: Managed Care Study

Special Task Force on Managed Care

On receipt of HJR No. 399, the Chairman of the Board of Health Professions invited eight members to participate on a special Task Force on Managed Health Care.

One member from each of the following boards:

- Medicine,
- Nursing,
- Pharmacy,
- Nursing Home Administrators,
- Social Work, and
- Board of Health Professions - two citizen members.

To give special expertise and balance to the study, consultation was sought from a broad array of forty-seven public agencies and private organizations.

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Study Process

The study process included

- a comprehensive literature review,
- meetings and a public hearing,
- solicitation and review of "position and perspectives" statements from each consultant agency or organization,
- site visits, and
- reaction to an exposure draft by all advisory groups.

Report

In its report to the Commission on Health Care for All Virginians, the Task Force on Managed Health Care devoted a section to "Mental Health and Substance Abuse Treatment Issues"[1] due to the substantial expression of concerns by businesses, the insurance industry, providers, and clients.

Principles Endorsed

The Task Force endorsed six principles for the evaluation of mental health and substance abuse treatment benefits. Two principles applied to managed care.

1. ***The payment system should be consistent with managed care techniques that have been shown to be effective.***

   Managed care, including utilization review, is useful in the promotion of cost-effective treatment in some instances, when judiciously applied without undue interference in patient care or professional judgment. Its qualified success prevents recommending universal managed care/utilization review for all mental health, substance abuse, or general medical treatment and care.

   The task force concurs with the authors that "[L]ike the health field it claim to manage, the intervention of managed care itself should be subject to the test of cost-effectiveness."

2. ***In mental health and substance abuse treatment -- and in all health care practice -- it is incumbent upon the purveyors of managed care and utilization review systems and strategies to demonstrate contemporary empirical support for case decisions.***

   Liability for decisions to decline payment for services is not equivalent to liability for treatments performed or withheld, but payers as "third parties" in medical care decision making must share appropriately in the assignment of liability. Their share of liability risk should increase commensurate with their increasingly prominent role in deciding who receives care and who renders care.

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Objectives of Findings and Recommendations

The findings and recommendations of the report were intended to accomplish the following objectives:

- improve the cost-effectiveness of managed care;
- improve coverage and assure continuity of care;
- promote disclosure and due process as alternatives to regulation;
- identify regulatory barriers ot cost-effective care;
- increase public protection in the insurance marketplace;
- locate accountability in managed care systems; and
- address specific, unresolved concerns.

Section 4

Study Process

Study Purpose

Anecdotal Information

In earlier public meetings and hearings about insurance benefits for mental health and substance abuse treatment services, there was overwhelming testimony about the inequities caused by the arbitrary application of managed care systems on patients and onerous cost-shifting to the overburdened public sector.

Empirical Information Sought

While there was an abundance of anecdotal information, there was a dearth of empirical information available about the effects of managed care systems on mental health delivery systems. Senate Joint Resolution No. 107 sought to rectify that absence by requesting that the Department of Mental Health, Mental Retardation and Substance Abuse Services study the effects of managed care and HMO administration of mental health benefits on the utilization of public mental health providers and charity care of private mental health providers.

Impact of Managed Care

SJR 107 provided the opportunity to broadly ask the question: "What impact has the rapid introduction and practice of 'Managed Care' procedures had on the provision of mental health care service delivery?"

As a health care system intervention, "Managed Care" was hypothesized to impact mental health care delivery systems in the following domains:

- Treatment Care Access
- Treatment Care Quality and Continuity, and
- Administrative Burden on MH Care Providers.

SJR No. 107: Managed Care Study

Defining Terms

Managed care is generally used to refer to forms of health benefits coverage and health service delivery that are alternatives to traditional fee-for-service medicine. The array of care options, most notably HMOs and PPOs, may rely on capitation risk incentives and selective contracting affiliations.

The literature defines "Managed Care" as a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision.

Examples

Examples may range from

- delivery systems such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) to -
- utilization review procedures exercised by payers, insurers or providers, to
- hybrid forms of insurance, service delivery and utilization management.

Critical Variables

Critical variables in the delivery of care

- treatment care,
- access,
- quality,
- program,
- clinical and administrative management,
- costs and externalities.

Managed fee-for-service plans typically incorporate

- pre-admission certification,
- concurrent utilization review,
- case management, and
- other coordination protocols.

Key Variables

To operationalize SJR 107, the key variables of managed care and their effects needed to be hypothesized from the onset. Thus, "Managed Care" was broadly labelled as the independent variable.

Managed Care Procedures

Procedure Administration

In practice, managed care involves the administration of the procedures below.

Pre-Admission Certification

Pre-Admission Certification - requires
- initial assessment,
- symptomatology, and
- treatment protocol consistent with the desired modality.

Terms often used interchangeably with pre-admission certification are:
- prior review,
- predetermination,
- pre-certification and
- prior authorization

The approval of benefits in advance of service provision may be contingent rather than final.

Concurrent Utilization Review

Concurrent Utilization Review - reviews stays assessing length of stay for both urgent and non-urgent admissions.

Case Management

Case Management - focuses on few beneficiaries in a group who generate or are likely to generate very high expenditures.

Retrospective Review

Retrospective Review - reviews health treatment information retrospectively and may result in the denial of claims.

Selective Contracting

Selective Contracting - limits patient choice by restricting access to providers who meet
- network standards;
- requisite credentials and qualifications;
- treatment style and philosophy; and
- negotiated fee schedules.

The provider network includes:
- psychiatrists,
- psychologists,
- social workers, and
- hospitals.

Broadening the Scope

Substance Abuse

SJR 107 examines the effects of managed care on the public and private mental health care systems. While SJR 107 did not explicitly address substance abuse services, it referenced a Pennsylvania study of managed care centered on substance abuse. Consequently, it appeared reasonable that the study design include the substance abuse service delivery system as well.

Time Lines

SJR 107 was approved by the 1992 General Assembly and was in final form in early March. DMHMRSAS and the VACSB learned shortly thereafter that the SJR 107 would not have the traditional deadline of early fall for completion and presentation to the 1993 General Assembly. It became apparent that the SJR 107 study would have to be presented to the Special Advisory Commission on Mandated Health Insurance Benefits on May 18, 1992 for the Commission to incorporate SJR 107's findings into its deliberations. The Mandates Commission stated that mental health mandates were one of the more complex, yet pressing agenda issues and thus, remained committed to its 1992 schedule.

Postponement Request

On April 6, 1992, Russell Petrella, Ph.D., DMHMRSAS Director of Mental Health Services, testified before the Mandates Commission requesting an extension on the SJR 107 study until July 13, 1992.

Postponement Issues

The extension request was based on the following factors:

- There were no prior studies.
- To design the study, staff did an extensive literature search and enlisted the aid of leaders in health care economics. This study would be the first of its kind nationally and economists from academic institutions such as Johns Hopkins were very interested in it.
- The study's uniqueness underscored the importance of designing a reliable survey instrument that would yield authoritative results.

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Postponement Issues, Continued

Postponement Factors

- To assess the impact of managed care on private sector providers more than 5,000 surveys were sent to
  - professional mental health and substance abuse providers licensed by the Department of Health Professions,
  - mental health and substance abuse programs licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services,
  - United Way agencies,
  - employee assistance programs, and
  - members of Virginia's psychiatric societies.

Further Factors

The impact on public sector service use would be gauged by similar instruments distributed to programs operated under the aegis of the community services boards system.

- Researchers projected that the report of the analysis of survey data would be ready for the Commission use by its July 13, 1992 meeting.
- Therefore, it would be premature to present in May, only to have subsequent findings lead to different conclusions in July. It would be more expeditious to present the findings and testimony in July and provide Commission members with ample time to study the material so important to their deliberations about these issues.

Awesome Logistics

Mr. Jim Duffy, Assistant Director of the Virginia Beach Community Services Board and principal researcher of the SJR 107 study, testified that the study's scope and logistics demanded ample time.

Time Table Relaxed

The Mandates Commission appreciated the concerns of the SJR 107 researchers, but its timetable could not be altered and said that mental health testimony would be needed for the May 18 hearing. The Commission anticipated extensive mental health professional and consumer group testimony at both the May 18 and July 13 hearings. This would allow additional findings at a later date.

Thus, the SJR 107 study was clearly on a fast track to meet the Commission's expectations.

Study Methodology

Study Methodology Approved

A draft study methodology was presented to DMHMRSAS and Virginians for Mental Health Equity (VMHE) on March 13, 1992. Initially, point in time surveys were considered to reduce the administrative burden of requesting data. The private sector survey instruments were modified and presented to the Executive Committee of the Virginians for Mental Health Equity at its March 14, 1992 meeting. The approach was endorsed by VMHE on behalf of the private mental health sector and it elected to capture data for a full calendar quarter (3 months).

Mailing and Target Group

DMHMRSAS mailed surveys with a response return date of April 8, 1992 to:

- licensed facilities,
- psychiatric hospitals,
- private practice professionals,
  - MDs,
  - psychologists,
  - LCSWs,
  - Licensed counsellors, etc.
- family service agencies.

The SJR 107 survey was accompanied by:

- A letter from DMHMRSAS Commissioner King E. Davis explaining the managed care phenomena and study intent
- A copy of SJR 107
- Individual client specific and aggregate client data surveys.

Client Specific Data

Data Collection

When possible data should be collected at the individual client level to integrate independent variables with dependent variable effects. Such individualized data analysis allows a more flexible and revealing description of the issue. The SJR 107 study depended on gathering source data from agencies and professionals in the mental health community that have differing capabilities of producing such data. Example: some agencies might have highly sophisticated automated systems to collect the data for managed care referrals. More often, private practice professionals rely on manual clinical charts and memory to extract data on cases matching the profile of managed care referrals. Given this reality, the study design enabled the collection of both aggregate and individualized data for a good response. Individualized data yield a more definitive picture of the affected mental health or substance abuse clientele and service impacts.

Treatment Sensitive Responses

The client specific survey was designed to isolate responses by type of mental health or substance abuse provider with respect to the type of managed care services received prior to admission to the responding agency and the services sought or needed on arrival. In this manner, the data should yield some sense of which agencies were experiencing particular service modality problems with managed care firms.

Reasons for Service Cap

The client specific survey would indicate why clients' services were capped and why the client sought charity care from a private or public agency. Jargon, semantics and multiple meanings are endemic to the managed care field and, at the risk of over-complicating the survey, alternative service cap reasons were listed for respondents to check the reason the client was referred or capped. Other reasons came from interviews with case managers from managed care firms, private and public sector clinicians.

Clinical Impact

An experimental research design would attempt to view "Managed Care" as the independent variable in a random sample of clinical cases and isolate the clinical impact across complex quality of care measures. The study did not have the luxury of time nor the availability of well tested, reliable and valid service quality instruments to yield the differential efficacy of treatment plans. The need for such an elegant research design has been reported in the literature. The October 1990 edition of the professional journal: "Hospital and Community Psychiatry" contained several articles on the role of managed care in mental health and the need for research on Managed Care's impact on care accessibility and clinical outcome. Longitudinal studies are necessary to compare various managed care techniques.

Quality of Care Dimension

Research would promote attention to the quality of care dimensions of managed care and not just its efficiency, if effects were studied for

- client satisfaction,
- clinical status,
- course of disorder,
- role performance, and
- post-discharge use of medical, mental health, and social services.

SJR 107 conveys the perceived sentiments of certain professionals and consumers that Managed Care is inextricably tied to the quality of care. Indeed, its premise is anchored in a continual pursuit of treatment plan efficiencies that may be at odds with short-term and long-term clinical benefits for consumers. Recognizing the need for longitudinal research and trying to respond to the legislative charge requires some determination that managed care and service capping has a negative impact on quality client care. Consequently, the SJR 107 surveys boldly ask whether managed care referrals

- were professionally or clinically appropriate,
- caused cost-shifting, and
- affected client prognosis.

Reasons for Charity Care and Low Charge Care

In tandem with reasons for service caps principally brought about by utilization review or case manager decisions, the survey sought reasons for charity or low charge care based on pre-study interviews and discussion with DMHMRSAS and VMHE. Anecdotal data produced many permutations on this theme.

Trends and Anecdotal Information

Trends

The explosion of managed care practices and techniques is accompanied by different understandings by

- organizations,
- providers, and
- consumers.

Thus a section of the study explored whether there was a convergence of thought when professionals are independently asked about managed care statements. Given their experiences, the hypotheses were that convergence of professional groups is a valid predictor of the presence or absence of the managed care attribute and causal relation.

Anecdotal Information Encouraged

The abundance of anecdotal data is addressed resoundingly by

- managed care literature,
- the absence of research studies on managed care effects, and
- previous testimony about insurance trends in mental health and substance abuse.

Recognizing the semantics and varied interpretations about the growth of managed care, researchers saw the need for anecdotal data. Commissioner Davis' letter encouraged anecdotal responses. The survey response and anecdotes were poignant in capturing issues from the standpoint of mental health and substance abuse service providers faced with the reality of managed care.

Distribution and Response

Distribution

In March 1992, 6,748 surveys were mailed to private sector agencies and professionals. In addition to the 438 licensed psychiatric and residential treatment MH/SA facilities in the Commonwealth, surveys were mailed to:

- Virginia Clinical Psychologists
- Virginia Family Service Agencies
- Virginia Licensed Clinical Social Workers
- Virginia Licensed Professional Counselors
- Virginia Psychiatric Society - both Virginia chapters
- Virginia United Way Counseling Agencies

Response

Responses were received from:

- 547 Private Practices
- 49 Family Service Agencies
- 45 General Hospitals with MH Inpatient
- 29 Residential Centers
- 28 Psychiatric Hospitals
- 16 Employee Assistance Programs
- 8 United Way Agencies

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Distribution and Response, Continued

CSB Participation	All 40 CSBs participated in surveys conducted from May 1 to May 15, 1992 in two stages: 1. Managed care trend observations and 2. Managed care client specific admission information.
CSB Pre-Test	The public sector Community Services Board network is inundated with data requests from federal, state, Medicaid, and local sources. Consequently, the VACSB system has an elaborate process to pre-screen surveys for existing data sources and to refine survey instruments. The study's importance induced survey refinements and a two-week pre-test in Virginia Beach and Fairfax. The pre-test generated feedback from clinical and reimbursement staff to improve the survey instrument for use by all CSBs.

Chapter 3

Findings

Section 1

Overview

In this chapter This chapter covers the following topics:

Section 2

Private Sector

General Description: Client Population

Working and Insured The common assumption is that private sector mental health and substance abuse service consumers are working and have group health insurance coverage. The Insurance Task Force Report of two years ago showed the range of mental health and substance abuse coverage, and HJR 206 calls for a study of insurance parity between mental health and physical health. The prevalence of mental health and substance abuse disorders is not decreasing. Treatment does not carry the stigmatized vignette of the past. Econometric studies have proven that mental health and substance abuse service use is quite responsive to insurance plan designs and particularly, cost-sharing.

Consequently, the past decade has witnessed that most insurance plans require $20-25 co-pays per session for mental health and substance abuse outpatient coverage.

Therefore, the composition of private sector clients entails people who can afford co-pays for their treatment plans. To the extent that insurance plans are modified or managed care adjudicates service levels, the actuarially reimbursed level of private mental health and substance abuse services is directly correlated.

Treatment Received

Private sector mental health and substance abuse treatment provide a broad array of behavioral and treatment methodologies in accordance with client need. Insurance reimbursement heavily influences the type of treatment programs offered by the private sector and these are:

- Crisis Intervention
- Day Treatment/Partial Hospitalization
- Inpatient
- Medical Detoxification
- Outpatient - Individual and Group
- Residential Treatment

Mental health and substance abuse clients who require other modalities or extended long term treatment after their insurance coverage runs out typically come to the public treatment sector.

Impact Numbers

Analysis of the private sector aggregate data yields some extremely interesting data. Annualized data indicates that 71,000 Virginians are adversely affected by managed care interventions that deny services or force them to private charity care. The annualized percentage of MH/SA managed care clients with negatively affected services to total admissions was an astounding 29.44%

- Reporting agencies served 241,033 MH or SA clients yearly

- 17,742 individuals reported to have been denied MH or SA services or forced to private charity care - this equates to some 71,000 Virginians in a calendar year.

Provider Characteristics

Program Setting

SJR 107 Respondent data was categorized by groupings as follows:

- Psychiatric Hospitals
- General Hospitals with MH/SA Inpatient Unit
- Residential Treatment Centers
- Employee Assistance Programs
- Outpatient Practices - Solo or Major, Multi-Discipline Group
- Family Service Agencies
- United Way Agencies

Provider Discipline

Listed in alphabetical order:

- Clinical Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- MH/SA Educators
- Psychiatric Nurses
- Psychiatrists
- Psychologists
- Qualified Mental Health Professionals

Charity and Low Cost Care

The study found that of survey respondents

- 47% provide some charity care for indigent clientele.
- 77% provide low-cost care involving adjusted fees
- 92% saw an increase in clientele who are working and insured and have inadequate insurance coverage or a curtailment of covered services.
- 34% of low-cost caseloads involve working and insured individuals whose coverage proved inadequate.

In short, private sector mental health and substance abuse treatment needs and rendered services exceed insurance reimbursement and co-pay revenues.

Continued on next page

Provider Characteristics, Continued

Impact Numbers

- Private psychiatric hospitals and practices felt the greatest consequences for mental health cases.
- The majority of respondents provided charity care. 40% for practices.
- 77% provided low cost care.
- 92% noted increases among their clientele who are working and insured and have inadequate or curtailed insurance coverage.
- On average, there is a 37% rate of managed care enrollees.
- Capitation or cost-shifting rates were extremely high for
  - psychiatric hospitals,
  - EAPs,
  - Family Services, and
  - Private Practices.

Attitudes about Managed Care

- 97% want to appeal review decisions and want independent providers to be included in care review panels.
- 92% feel managed care referrals affect public and private charity care in cost shifting.
- 84% view managed care systems as reality for the foreseeable future and see that the MH/SA professional community must participate in a constructive fashion to forge well-defined standards of care.

Continued on next page

Provider Characteristics, Continued

Extrapolations

Capitation and cost-shifting rates were computed for each type of MH/SA provider. As expected, psychiatric hospitals were profoundly affected by managed care.

- 85% of psychiatric hospital managed care clients were capitated in a manner that provokes a major difference of clinical opinion between hospital staff and Managed Care Utilization Reviewers or Case Managers.

High capitation or cost shifting rates were also noted as follows:

- Private Practices - 75%
- EAPs - 93%
- General Hospitals with MH/SA Inpatient Units - 37% and
- Residential Treatment Centers - 37%

Provider Observations and Views

Scarce Resources Understood

Most MH/SA providers understand today's health care environment and its challenge for insurers, health providers, professionals and consumers to develop reasoned solutions to the problem of unchecked health care expenditures. Balancing resources with attentiveness to health care coverage and quality of care represents society's tightrope. Given their basic understanding and appreciation of health care economics, MH/SA providers have proven their interest in being a part of the solution.

Process Frustrating

The SJR 107 managed care survey response clearly speaks to provider frustration in dealing with an adjudicative process that challenges professional protocols in far too many ways.

Discriminatory Coverage

Discriminatory coverage for MH/SA benefits continues to be a major inequity in our nation's effort to promote accessible mental health and substance abuse care. Managed care practices reinforce this discrimination concern, and are akin to punishing providers when positive clinical outcomes are not dramatically swift.

Continued on next page

Observations and Views, Continued

Accountability Factors	MH/SA professionals recognize the need for accountability. Many would argue that managed care has taken on a professional accountability role which oversteps appropriate bounds. Mental Health and Substance Abuse professionals are ethically and legally bound and accountable to consumers first.
Managed Reimbursement?	Managed care represents "managed reimbursement for many professionals. The MH/SA profession must interact and play within today's reimbursement realities, and managed care techniques are used to hold down costs as part of a marketable group insurance plan for businesses and employers. Managed care is viewed as symptomatic of insurance industry and businesses that do not have all the facts about MH and SA treatment. Subsequently, MH/SA services struggle with credibility when needs far exceed private and public professional resource capacity. Professionals recognize that the impact of managed care requires the collaboration of others to balance the resource and employer sides of the triage process within established standards and thresholds of care.
Informed Participation	Professionals want to participate in the managed care phenomenon with assurances that clinical standards and appeal processes are in place and that the *voice of quality* is always at work. Most importantly, MH/SA professionals recognize that managed care is the dominant avenue for individuals to access care. Insurance plan designs and MH/SA coverages require more informed decision-making by employers and employees about MH and SA service quality so that health plans respond to need, not just bottom lines.

Client Specific Data

This section highlights client specific data on over 2,000 individuals impacted by managed care. The preponderance of data was from private outpatient practices.

Treatment Type

- 63% involved MH treatment
- 21% involved SA treatment
- 15% involved MH and SA treatment

Age and Gender

- 31% involved youth under 18
- 56% involved adults
- 13% involved elderly

- 53% female
- 47% male

Non-Inpatient Data

Isolating non-inpatient data,

- 34% had received crisis intervention services, and
- 44% received individual outpatient therapy prior to admission to the reporting agency.

Need for more extended care

People needed more extended service. The distribution of services needed upon admission shifts from

- 34% to 10% for crisis intervention, and
- 44% to 60% for outpatient

Reasons for Service Cap or Charity Care

Reasons as to why services were capped or the client sought charity care were categorized as follows:

• Pre-certification	15%
• UR/Case Management	23%
• Service Not Available through MC	12%
• Client could not afford Co-pay	20%
• MC Procedures	30%

Continued on next page

Client Specific Data, Continued

Client Prognosis

Client Prognosis

• Needs additional short-term services	58%
• Needs inpatient/residential	11%
• Will receive less intensive service than required	29%

Next 30 Day Cost of Services

Cost of Services Client Needs in Next 30 Days. The average costs associated with a client's needs over the next 30 days were reported by MH/SA providers as follows:

• Residential Treatment Centers	$10,821
• Psychiatric Hospitals/General Hospitals	$7,819
• Family Service Agencies	$2,453
• Employee Assistance Programs	$1,993
• Private Outpatient Practices	$1,639

Outpatient estimates seem high because costs are based on a client's needs that involve more intense modalities such as inpatient, residential or day treatment. This finding is consistent with prognosis data.

Anecdotal Data Themes

Private sector respondents provided ample anecdotal data which has been categorized as indicated below.

Process

Unequivocally, MH/SA providers do not embrace the managed care review process. The following quotes capture the prevailing sentiment.

- *"Managed Care is an 'intrusive' process that doles out treatment in increments . . . Let third parties dispense with doubletalk like 'cost-effective' and simply acknowledge that they cannot or will not pay for long-term therapy, and set limits on the annual 'allotment' for Mental Health services they can live with, and leave it to the therapist and client what to do after the money runs out. JUST STAY OUT OF THE PROCESS."*

- *"The formidable process entailed in some review and pre-admission certification will cause clients to postpone treatment, resulting in more serious long-term needs later."*

Staff Qualifications

Often reported in the literature, is the professional concern of what qualifications a managed care reviewer brings to the clinical matter. The second-guessing stage and reliance on phone and 800 numbers predictably causes conflict.

- *"Managed Care reviews are often done by poorly qualified individuals using arbitrary checklists which vitiate the individual circumstances, needs, and treatment plan designs. If review must occur, it must be done by an equally-trained specialist of the same discipline (i.e., psychologist to psychologist, psychiatrist to psychiatrist.)"*

Confidentiality

MH/SA professionals render treatment under the utmost respect and ethical concern for client confidentiality. Managed care review mechanisms open up a whole new arena beyond traditional insurance reimbursement. Professionals question the level, quantity and specificity that managed care assumes to be subject to review. Professionals argue that clinical records' confidentiality must be upheld and that wholesale disclosure to managed care personnel defies the realities of maintaining the strictest confidential practices.

- *"Managed Care poses serious confidentiality issues, as well as privacy and freedom of choice."*

Extended Treatment

Anecdotal data was consistent with client specific data reports where many individuals' prognosis included denial of present services or a more intense modality. Projected costs over the next 30 days clearly support this theme as managed care deters the opportunity for extended treatments.

- *"Some Mental Health problems require extended treatment and Managed Care reviews often deny continued treatment coverage."*

Reimbursement vs. Quality

The literature points out that reimbursement plan designs influence the utilization of MH/SA services. In fact, MH/SA services use is very responsive to economic adjustments in insurance coverage and co-pays. The SJR 107 survey found reports of individuals who abandon treatment when coverage is capped. This phenomenon raises obvious questions about quality.

- *"Clients who are in need of continuing treatment are electing to withdraw from treatment when insurance coverage runs out."*
- *"In the long run quality care is more cost-effective than short-term cost containment systems."*

Where Do They Go? Cost Shifting to the Public Sector

The SJR 107 private sector survey in all forms (aggregate findings, client specific, and anecdotal) begs the question: "If so many individuals are capped and cannot access continued or more intensive services - where are they?"

Answers: Some individuals...

- Access some private charity care.
- Drop out of treatment entirely -
  - decompensate, and
  - are dealt with in crisis often in a more expensive setting.
- Wind up in the State Hospital.
- Continue to confront and baffle the criminal justice system and courts.
- Approach CSBs and "get in line" as most CSBs have waiting lists.

- *"Cost-shifting is a covert agenda which will further burden an already over-burdened public system."*
- *"Usually the more difficult problems are 'dumped' on the public sector with no/little regard to ethical issues or professional responsibility to client."*

Managed Care Practices

Anecdotal data specifically cited larger and well-known managed care firms that were considered unscrupulous in their handling of MH/SA case reviews. There appeared to be major concerns about the fair and consistent practice of utilization review and pre-certification in relation to published criteria.

Layers of Administration

Administrative burdens on MH/SA professionals and provider organizations are another resounding theme. This issue is often cited in the literature and attributed to managed care firms strong self-interest in instituting measures that will decrease their expenditures and reduce their costs -

- computerization,
- expanded treatment protocols, and
- greater targeting of reviews for high pay-off.

Managed care firm administrative efficiencies can reduce administrative burdens on MH/SA providers and clients.

- *"Managed Care adds administrative costs and layers of bureaucracy that would be better allocated to more treatment."*

On Balance

Most Mental Health professionals recognize the need for cost containment. Managed Care as the intervention poses major problems of:

- confidentiality
- treatment continuity
- treatment planning flexibility
- too much paper, process, and "clinical review"
- liability for treatment decisions
- lack of MH professional community involvement in establishing treatment standards - government regulatory role

- *"Managed Care should be directed primarily toward inpatient treatment for mental health . . . open access to outpatient mental health care is extremely cost-effective, and should not be aggressively managed."*

- *"Managed Care is here to stay and cost containment will reduce utilization. Diversity of Mental Health problems necessitates assurance that individuals and professionals can confidently pursue treatment in accordance with the clinical needs."*

Section 2

Public Sector - Community Services Boards

General Description: Client Population

Working and Insured

Where working and insured individuals make up the majority of the private MH and SA sector clientele, CSBs have vastly different experiences based on the availability of private sector services in the CSB area and the level of public funding support. In many areas of the Commonwealth, private MH/SA care is minimally available and certain treatment modalities may be totally absent. Therefore, CSBs are the principal MH/SA service provider in that area and serve many working and insured individuals which generates fee revenue to support the CSB budget.

Managed Care Prevalence

Managed care is more prevalent in

- Northern Virginia,
- Greater Richmond, and
- Hampton Roads.

No One Denied Access

Similarly, these areas have large CSBs who look to the private sector to respond to the MH/SA needs of the working and insured. As public entities, CSBs do not deny services to anyone based on ability to pay. However, clients with other means are advised of private sector treatment options.

Decrease Projected from Insurance Revenues

CSBs have diversified their revenue base over the past two years as State General Funds were reduced and Medicaid funding was substituted. Together with State and local budget cuts, CSBs have witnessed a greater emphasis on serving those "most in need." The working and insured populations seen by CSBs are in MH/SA outpatient units who can afford the private sector co-pays (often $20-$25 per session). Hence, many individuals may have mental health insurance, but economic realities preclude their use of it privately. **Today, half the CSBs see an increase in this segment of their caseloads.**

Continued on next page

General Description, Continued

Managed Care Impact on Client

As a significant majority of working and insured individuals seeks MH/SA treatment in the private sector, managed care impacts about one-third. This proportion grows daily.

In urban areas, managed care plans cover a third of those seeking MH/SA treatment and the SJR 107 survey indicates that 29% of these enrollees are at risk of having their services capitated and consequently being shifted to another treatment sector - CSBs.

In short, in CSB areas where managed care exists, the working and insured are cost shifted to the CSBs when:

1. They cannot afford private sector co-pays; and
2. Managed care has denied them further services.

Treatment Available

CSBs provide the same services as the private sector, although most CSBs purchase inpatient services from local psychiatric hospitals [2]. CSBs also provide an array of services that are not traditionally available in the private sector because insurance does not cover them. CSBs design unique programs tailored to the needs of severely impaired MH/SA clientele who may require lifelong services.

Examples of unique CSB services include:

- Day Treatment
- Emergency - Court Liaison Services
- In-Home Intensive
- Psychosocial Rehabilitation
- Residential Supportive Living/Case Management
- Respite Care
- Social Detoxification, and
- Collaborative Models with Schools, Social Services, Health, Juvenile Courts, and other human service agencies.

Cost Shifting Predicted

CSBs respond to the realities of their environment and client needs relative to private sector capacity and total funding capacity. In 1985, the Virginia Association of Community Services Boards issued a position paper entitled: "HMOs: An Opportunity For Cost-Effective Mental Health Care." This paper advocated a collaborative role for mental health inclusive services as HMOs evolved to become a primary health care plan in the Commonwealth. The VACSB position statement predicted that the administration of HMO benefits, service caps and co-pays would initiate a cost-shifting process to the public CSB sector. While empirical data is not available to attest to this trend, large, urban CSBs have experienced cost-shifting trends since the early 1980s. Managed care and HMOs combined cover more enrollees and the cost-shifting pool has dramatically enlarged.

Fiscal Year 1991 Budgets

CSB budgets of fiscal year 1991 reflect the effects of this shift.

The table below shows the Mental Health Outpatient and Substance Abuse Treatment Budgets.

Service	Total	Fees/ Insurance	Public Funding	Per Client Subsidy
Mental Health Outpatient	$42 Million	$8.7 Million	$33.3 Million	$505 per client (65,899 clients)
Substance Abuse Care	$66.4 Million	$6.5 Million	$59.8 Million	$792 per client (75,516 clients)

Impact Numbers: CSB-Specific

The SJR 107 survey yielded the following findings from the 40 CSBs about managed care during the study period from May 1 to May 15, 1992.

- 18 CSBs noticed managed care effects on their service system
- Fairfax, Hampton/Newport News and Virginia Beach had more pronounced effects
- 20 CSBs increased admissions of citizens with insurance, but who couldn't afford the MH/SA co-pays

Continued on next page

General Description, Continued

Impact Numbers: CSB-Specific

- 14 CSBs increased admissions of gainfully employed citizens who couldn't afford to participate in their company's health care package and, thus sought public services
- 71 managed care referrals were identified by the CSBs over the survey period equating to 1700+ annually.

Impact Numbers: Client Data

- 31% were youth under 18

Treatment sought:
- 58% MH
- 36% SA,
- 6% MH/SA

CSB services sought
- 57% outpatient;
- 6% inpatient;
- 7% crisis intervention

Reasons for Seeking CSB Services

Individuals arrived at CSBs because:

• Further Services Denied	11%
• Non-available MC Service	11%
• Non-negotiable co-pay	28%

Pre-CSB Care

Previous care received ...

• Managed Care outpatient services	25.%
• Crisis intervention	6.%
• Inpatient	6.%
• No Services	48.5%

Clinical Prognosis

The Clinical Prognosis for those admitted due to managed care required:

• Short-term services	57.%
• Long-term services	23.%
• Inpatient or Residential with Day or Outpatient follow-up	9.%
• Less intense modality	3.%

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Next 30 Days Cost of Services (Cost-Shifting)

- The cost-shifting associated with each of these cases totalled **$32,000** over the next 30 days
- Annualized cost shifting to CSBs can be projected conservatively at **$768,000** given the reality that many individuals will require extended treatment.

Managed care shifts at least **$1 million** annually to the public sector.

Provider Characteristics:CSBs

CSBs are the local public MH/MR/SA authority with Code of Virginia responsibility to plan, evaluate, and organize service delivery for the community's mentally handicapped. CSBs provide an array of "core services" pursuant to existing licensure rules and regulations established by DMHMRSAS.

One of the responsibilities of CSBs relative to their daily interactions with citizens, local governments, and DMHMRSAS is to assess service delivery trends as affected by changing client needs and shifting funding patterns, e.g. the transition to Medicaid reimbursed services. In general, CSBs have waiting lists for most services.

CSBs and Managed Care

HMOs and managed care trends have escalated in the past year due to more aggressive managed care strategies. It is a trend that urban CSBs know influences who and why individuals seek public services; a trend that adds more clients to the overburdened system without the prospect for additional insurance revenues, nor additional public funding. Managed care capitated clients cannot be denied CSB services and it is a rare client who can contribute to the full treatment charge. CSB charges do not reflect total costs and most individuals require adjusted fees.

In short, CSBs are "the end of the line" without other options for individuals with capitated insurance coverage. CSBs are in the unenviable position of having the community expect that all needs will be accommodated despite shrinking budgets and HMO/Managed Care cost-shifting.

Provider Discipline

Like the private sector, CSBs employ or contract with a wide range of mental health and substance abuse professionals including:

- Licensed Clinical Social Workers
- Licensed Professional Counselors
- MH/SA Educators
- Psychiatric Nurses
- Psychiatrists
- Psychologists
- Qualified Mental Health Professionals

Insured Caseloads

As noted, "CSB Clientele - Working and Insured," CSB service configurations are designed to meet the needs of the community environment including the extent of private MH/SA services. In large urban CSBs where managed care has more of a presence, CSBs have very low percentages of insured clientele. Again, as pressure builds to serve those most in need, waiting lists, those individuals with insurance are usually advised of their private sector options.

Example:

In Virginia Beach, caseloads with insurance (not including Medicaid):

Mental Health Outpatient	13.%
Substance Abuse	5.%

Typically, these insured individuals cannot afford the co-pays required to exercise their insurance coverage privately and, consequently can be considered "medically indigent."

Chapter 4

Analysis

Section 1

Overview

In this chapter

This chapter covers the following topics of analysis from the study survey response.

Prevalence Figures

Nation: Commonwealth

In testifying before the Health Mandates Review Commission on May 18, 1992, Commissioner King Davis described MH/SA Prevalence Rates as applied to Virginia's population. The table below displays the ramification of the national statistics for Virginia's citizens.

DISORDER	Rate	Virginians
Alcohol, Drug Abuse or Other Mental Disorder Individuals Over 18 Years of Age	15.4%	798,000
Serious Mental Health Problem: Children or Adolescents	5.0%	75,000

Health Insurance

In Virginia, health insurance availability has been characterized as

- one-third of Virginians having group health insurance,
- one-third are self-insured and
- one-third are uninsured.

Of the one-third having group health coverage, probably 50% are enrollees in plans with managed care components which translates to over one million Virginians. Charts in Appendix I on page 72 portray insurance types and prevalence rates. Prevalence rates are then compared to treatment sector data utilizing statewide CSB and facility data, and SJR 107 survey data.

Unmet Need

It is clear that there is a significant unmet need above and beyond CSB waiting lists and Managed Care cost-shifting.

- 38% of the projected prevalence figures do not show up in either the public or private MH/SA sector.

The literature confirms that a large proportion seek out services from the general health care system.

Continued on next page

Prevalence Figures, Continued

Cost-Offset: General Medical Services

Many speakers at the Special Advisory Commission on Mandated Health Insurance Benefits cited findings from literature that mental health services offset the need for some medical services. To paraphrase, the use of mental health services decreases the use of general medical services. Thus, the investment of increasing access to mental health care is offset by the corresponding decrease in the use of general medical services.

Quality A Factor

As Managed Care systems grow and become the vehicle through which more and more Virginians access mental health care services, it is critical that cost containment strategies be balanced judiciously within professionally accountable treatment standards. The quality of MH/SA care is very much at stake, as are the well-being of clients and their families. The private sector response to SJR 107 strongly spells out concerns about quality.

Cost-Shifting

All other things being equal, the growth of Managed Care Systems create algebraic changes in the care pie charts. If fewer people can access MH/SA benefits or remain assured that coverage will handle their personal treatment plan, the pie shifts more people to:

- Private Charity Care
- Public Sector Waiting Lists or
- No care and deteriorated mental status.

Managed Care is a fundamental shift in how we are going to finance and access health care and what services will be available. Improved management and tough cost/benefit questions can promote better care. The charge to manage costs will not abate, although simply limiting services is not sufficient. Persons who receive inadequate or no care do not disappear.

Chapter 5

Recommendations

Section 1

Overview

In this chapter This chapter covers the following topics:

Introduction

Managed Care has become a necessary means for the country to attempt to control health care expenditures. Its report card is not definitive about cost savings beyond the ability to reduce utilization of certain types of health care services. In total, managed care's ability to provide the health care system with the cure that the country seeks is an evolving system to address one dimension of the health care system. The literature suggests that there are many myths about managed mental health care, but there are definitely changing roles and realities. For the Commonwealth of Virginia, the SJR 107 study on Managed Care attests to the concern expressed by clinicians in both the private and public sectors, about the negative effects that managed care have had.

Effects of Managed Care: Cost Shifts

Managed Care, as a growing practice, contributes to the following:

- Increased Private Sector Charity and Low Cost Care
- Increased Capitation/Cost-Shifting
- Over $1 million Cost-Shifting to the Public CSBs Annually

Professional Concerns

- Professional Sentiment that It Affects the Quality of Care
- Major Professional Confidentiality Issues
- Intrusive Utilization Review
- Orientation of "Managed Reimbursement" versus Managed Care
- The Erosion of Extended Treatment Plans
- Reduced Access to Private Sector Care that shifts people to
  - Private Charity Care
  - Public Sector Waiting Lists
  - No Care at all and Deteriorated Mental Status

Part of the Solution

The above are realities and manifestations of the problem . It is not an indictment of Managed Care. Managed Care principles are needed in today's health care arena. The MH/SA community recognizes this reality and wants to partake in the system prescription.

Managed Care - The Responsibility of Many

Managed Care is characterized as the responsibility of the many parties involved in the process. This framework is proper for recommendations engendered by the SJR 107 study.

The General Assembly

Recommend that the Special Advisory Commission on Mandated Health Insurance Benefits work in tandem to ensure action on the following Managed Care related recommendations:

- Support the inclusion of adequate Mental Health and Substance Abuse Services within the Essential Health Services Panel and 1993 General Assembly actions.

- Support the mental health services benefit conversion option approved by the Special Advisory Commission on Mandated Health Insurance Benefits. This conversion option provides flexibility in mandated mental health service coverage offered in insurance packages by providing a range of services in varied treatment settings.

  - Inpatient care: 20 days for adults and 25 days for children and adolescents under the age of 18 on the same terms and conditions as coverage for inpatient medical/surgical treatment.

  - At patient discretion, conversion of up to 10 days of inpatient benefits to partial hospitalization on the basis of one inpatient day for at least 1.5 days of partial hospitalization.

  - 20 outpatient visits with the first 5 on the same terms and conditions as medical/surgical outpatient visits, and the remaining 16 with no greater than a 50% coinsurance payment.

  - Medication management outpatient visits covered as medical/surgical outpatient visits and not against limits on mental health outpatient visits.

- Authorize the State Corporation Commission, Bureau of Insurance to aggressively undertake the responsibilities listed below.

- Authorize the collaborative development by the SCC, DMHMRSAS, Department of Health Professions, and other involved agencies and governmental entities of a process for enabling Managed Care practice and the evaluation of their professional conduct.

State Corporation Commission: Bureau of Insurance

- Require all Managed Care firms to comply with developed criteria and assurances prior to conducting business in the Commonwealth.
- Monitor the conduct of Managed Care firms in concert with DMHMR-SAS and the Department of Health Professions through the administration of:
  - An Independent Appeals Panel on Case Dispositions
  - A timely Tracking System of Consumer and Provider Complaints and prompt Reporting of their Disposition
  - Requiring all Managed Care firms to clearly advertise that enrollees have appeal rights and can file complaints up to SCC level.

Managed Care Firms

- Comply with behavioral inclusion and exclusion standards of care and confidentiality criteria safeguards to provide coverage for enrollees.
- Implement internal appeals procedures.
- Routinely conduct internal quality of care assessments and long-term evaluations.
- Maintain and report performance data on service capitations and client prognosis and disposition.
- Abide by SCC Independent Review Panel Determinations.

Department of Mental Health, Mental Retardation and Substance Abuse Services and Community Services Boards

- Track managed care trends and cost-shifting to State Hospitals and CSB programs.
- Ensure that Managed Care Standards of Care criteria uphold the expectation that clients can fully utilize their insurance benefits and receive appropriate levels of clinical services.
- Monitor Managed Care practices that reduce access and cause cost-shifting to private sector charity care or public sector programs; report findings to SCC and the Secretary of Health and Human Resources for evaluation and action.
- Work with Virginians for Mental Health Equity, Johns Hopkins, and consumer groups and academic resources to study insurance mandates, utilization issues, and methods to track Managed Care trend data.

Practitioners and Institutions

- Cooperate, collaborate and try to make managed care work equitably on behalf of clients.
- Exercise all judicious appeals means.
- Assure confidentiality and professional ethics with respect to patient care and patient records.
- Recognize that Managed Care can reduce costs, but has the attendant price of quality loss and cost-shifting to less effective and less appropriate treatment and settings.

Practitioners and institutions must educate consumers about the necessity of managed care and the adverse economic externalities that the public will pay if Managed Care is allowed to be conducted too aggressively.

Employers and Businesses

- Insist that the Commonwealth ensure that only reputable, credentialed Managed Care firms conduct business in Virginia.
- Evaluate Managed Care insurance packages based on quality care and not just cost-savings.
- Recognize that mental health and substance abuse needs do not disappear if not treated. If insurance per diems do not capture externalities, the private sector must allocate more charity care and the public sector gets "dumped" on and cannot respond due to long-standing waiting lists. Business as a taxpayer will pay inordinately.

Consumers

- Hold all parties responsible for the conduct of Managed Care system effects on quality treatment.
- Exercise appeals procedures.
- Expect responsible performance by Managed Care firms and insist that the SCC report annually on Managed Care firms' performance.
- Advocate for MH/SA insurance parity.
- Build alliances to assist all parties to make this prescription work - too many lives are at stake.

Chapter 6

Appendices

Overview

In this section

This chapter includes the following exhibits:

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
Mental Health, Mental Retardation and Substance Abuse Services

KING E. DAVIS, Ph.D., LCSW
COMMISSIONER

MAILING ADDRESS
P.O. BOX 1797
RICHMOND VA 23214
TEL (804) 786-3921

MEMORANDUM

TO: Mental Health and Substance Abuse Professional

FROM: King E. Davis, Ph.D.
Commissioner

SUBJECT: **Senate Joint Resolution 107 - Study of Managed Care and HMO Affects on Public Sector and Private Sector Charity Care**

DATE: March 16, 1992

Senate Joint Resolution No. 107 (enclosed) was passed during the last session of the General Assembly. This resolution charges the Department of Mental Health, Mental Retardation and Substance Abuse Services to conduct a study of the effects of managed care and HMO administration of mental health benefits on the utilization of charity care services of private providers of mental health services in the Commonwealth of Virginia. In addition, the study will examine the effects of managed care systems on Virginia's public mental health and substance abuse system of community services boards and state hospitals.

A study of the effects of managed care is timely because 82% of employer-sponsored health insurance plans offer some form of managed care -- managed fee for service 49%, HMOs 17%, and PPOs 16%. Managed fee-for-service has increased its market share nationally by 50% between 1987 and 1989 and continues to grow.

The words "managed care" evoke many concepts and involves an array of care options, most notably HMOs and PPOs, which rely on capitation risk incentives and selective contracting affiliations. Obviously, treatment care, access, quality, program and clinical and administrative management, costs and external factors are all critical variables in the delivery of care. Managed fee-for-service plans typically incorporate pre-admission certification, concurrent utilization review, case management, and other coordination protocols.

Health care issues are clearly on the national and state agendas. MH/SA managed care constitutes a major chapter that the Virginia Special Advisory Commission on Mandated Insurance Benefits will be studying in May and the Commission on Health Care for All Virginians will be examining in the fall and reporting to the 1993 General Assembly.

Studies to date with respect to cost savings and adverse impact have been anecdotal. The fact remains, however, that managed care will continue to be a major component in most health insurance plans. Mental health and substance abuse treatment access, care and quality are fundamental tenets and ethics that professionals support. The dramatic evolution of managed care strategies will continue to be the pathway through which most Virginians access mental health and substance abuse treatment. Managed care, with its emphasis on cost containment and high use, will continue to challenge the mental health community. We need to assess and articulate our findings on the impact of managed care on community-based services, State facilities, and private practices to State legislators. To do so and to promote a factual dialogue, we need your input by participating in the attached surveys.

The first survey is "client specific" intended to be used for examining "managed care" factors and issues which precipitate admissions to "charity or reduced cost care." The survey may be duplicated to capture data regarding all managed care clients for your most recent calendar quarter. Data may be aggregated on one form and returned. If your practice is not in a position to produce client specific data, we would appreciate your cooperation in responding to the second survey. The second survey is a "managed care trends survey." It is retrospective and requests your assessment of managed care trends. Your response should reflect your broad experience with managed care, rather than individual or specific cases. The survey materials include more specific instructions regarding questions, assistance, survey returns, etc.

Please respond to the questions and return the individual or aggregated client specific surveys together with the managed care trends survey by April 8, 1992. If you have already completed and returned these surveys, do not complete another set. If you prefer to fax your response, our fax number is (804) 786-4146. If you have questions or would like a copy of the final study, you may contact Rubyjean Gould, Director of Administrative Services, at (804) 786-3915. Thank you for your assistance.

KED/yz

Attachments

cc: Rubyjean Gould

1992 SESSION

LD4107661

SENATE JOINT RESOLUTION NO. 107

Offered January 21, 1992

Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the effects of managed care and HMO administration of mental health benefits on the utilization of public mental health providers and charity care of private mental health providers.

Patrons—Howell, Benedetti, Gartlan, Holland, E.M., Lambert and Scott; Delegates: Bloxom, Callahan, DeBoer, Hall, Jennings and Scott

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Referred to the Committee on Rules

WHEREAS, an increasing number of health insurers and self-insured employers in the Commonwealth of Virginia are utilizing various forms of managed care and health maintenance organizations (HMOs) to administer mental health insurance benefits to the citizens of the Commonwealth; and

WHEREAS, testimony before the Insurance Task Force of the Bureau of Insurance and the Department of Mental Health, Mental Retardation and Substance Abuse Services indicated a need to develop strategies to strengthen coordination and cooperation between the public and private mental health providers to achieve maximum utilization of appropriate mental health treatment in the most cost-effective manner; and

WHEREAS, the Governor's Drug Policy Council Staff of the Commonwealth of Pennsylvania conducted a recent inquiry into managed care of mental health insurance benefits and found that "it appears that cost shifting of HMO subscribers to the public sector is standard practice by some HMOs and drug and alcohol treatment providers"; and

WHEREAS, many private (both for profit and not-for-profit) providers of mental health services who render services to the indigent and the uninsured at little or no cost are finding that their charity care is increasingly utilized by the working and insured whose insurance benefits are being managed in such a manner as to deny them insurance coverage for adequate mental health care; and

WHEREAS, the Special Advisory Commission on Mandated Insurance Benefits has announced its intent to study the mandated mental health insurance benefit in the fall of 1992; and

WHEREAS, there is a lack of information available about the effect of the administration of mental health insurance benefits by managed care agents and HMOs on the utilization of public providers and charity care services of private providers of mental health services in the Commonwealth of Virginia; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services be requested to study the effects of managed care and HMO administration of mental health insurance benefits on the utilization of public providers and charity care services of private providers of mental health services in the Commonwealth of Virginia. The Department shall report to the Special Advisory Commission on Mandated Insurance Benefits prior to its public hearings on the mandated mental health insurance benefit; the Governor; the Commission on Health Care for All Virginians; and the 1993 Session of the General Assembly pursuant to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

VIRGINIA DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES

Effects of Managed Care and HMO Administration of MH and SA Benefits on the Utilization of Public (CSB) and Private Sector Charity Care Study
Senate Joint Resolution 107, 1992 General Assembly

PRIVATE SECTOR SURVEY

INSTRUCTIONS: Please provide one response on behalf of your practice.

- Type of Mental Health or Substance Abuse Program (check as applicable):

1 ___ Private Psychiatric Hospital
2 ___ General Hospital with Inpatient Wing
3 ___ Residential Treatment Center
4 ___ Employee Assistance Program
5 ___ Private Mental Health / Substance Abuse Practice
6 ___ Family Service / Counselling Center
7 ___ United Way Affiliate

	MH	SA	Total
Total MH and SA Clients Served Per Year	1 ____	2 ____	3 ____
Working and Insured Individuals in your system during your most recent calendar quarter, whose insurance has denied coverage or effectively forced individual to private charity care (Managed Care Referrals)	1 ____	2 ____	3 ____

- Our practice provides charity care for indigent clientele. 1 ☐ Yes 2 ☐ No
- Our practice provides low cost care for indigent clientele. 1 ☐ Yes 2 ☐ No
- During the last year, I have noted an increase among our clientele who are working and insured and have inadequate insurance coverage or a curtailment of some HMO services. 1 ☐ Yes 2 ☐ No
- If yes to the previous question, I would estimate that the percentage of our charitable and low cost care caseload that represents working and insured individuals whose insurance coverage for services has been reduced or have experienced a curtailment due to HMO services is: _____ %
- I would estimate that the percentage of our practice that is managed care is _____ %

	Strongly Agree	Agree	No Opinion Neutral	Disagree	Strongl Disagre
1. Managed care referrals to public and private charity care are likely to decrease.	1 ____	2 ____	3 ____	4 ____	5 ____
2. Managed care systems increasing share of the health insurance marketplace effectively increases the proportion of the population who can be mental health/ substance abuse indigent.	1 ____	2 ____	3 ____	4 ____	5 ____

	Strongly Agree	Agree	No Opinion Neutral	Disagree	Strongl Disagre
3. In practice, managed care tools rarely force choice for service continuation in public or private charity care systems.	1 _____	2 _____	3 _____	4 _____	5 _____
4. Managed care systems' requirement for covering only voluntary vs court ordered treatment due to the availability of 24 hour pre-authorization is reasonable.	1 _____	2 _____	3 _____	4 _____	5 _____
5. Opportunities should be provided for clients and mental health and substance abuse professionals to appeal review decisions, and for independent providers to be included in managed care review panels.	1 _____	2 _____	3 _____	4 _____	5 _____
6. Managed care referrals affect public and private charity care systems in direct and indirect cost-shifting.	1 _____	2 _____	3 _____	4 _____	5 _____
7. Managed care system private inpatient coverage/ concurrent review systems effectively increase State hospital admissions.	1 _____	2 _____	3 _____	4 _____	5 _____
8. Managed care systems have seriously constrained Juvenile Court System treatment alternatives.	1 _____	2 _____	3 _____	4 _____	5 _____
9. Managed care systems in Virginia largely share the perception that individuals who cannot benefit from short-term treatment belong in the public sector.	1 _____	2 _____	3 _____	4 _____	5 _____
10. The managed care approach to mental health and substance abuse treatment with its emphasis on cost outcome and treatment efficacy is a valid and necessary regulator on the "consumption" of private MH/SA services.	1 _____	2 _____	3 _____	4 _____	5 _____
11. Managed care systems are a reality for the forseeable future and the MH/SA professional community must partake in a constructive role to forge well-defined standards of care or consensus regarding alternative treatment.	1 _____	2 _____	3 _____	4 _____	5 _____

■ Comments or Anecdotal Information:

Survey Completed By: _____

Title: _____

Agency: _____

Please Return by April 8, 1992 to:

Rubyjean Gould
Virginia Department of Mental Health,
Mental Retardation, and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23214

FAX (804) 786–4146

VIRGINIA DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES

Effects of Managed Care and HMO Administration of MH and SA Benefits on the Utilization of Public (CSB) and Private Sector Charity Care Study
Senate Joint Resolution 107, 1992 General Assembly

CLIENT SPECIFIC SURVEY

INSTRUCTIONS: Please duplicate this form as needed. Use a separate form to check off the characteristics of each managed care client in your practice during your most recent calendar quarter. You may aggregate data for all managed care clients on one form and return.

■ **Type of Mental Health or Substance Abuse Program (check as applicable):**

1 ___ Private Psychiatric Hospital
2 ___ General Hospital with Inpatient Wing
3 ___ Residential Treatment Center
4 ___ Employee Assistance Programs
5 ___ Private Mental Health and/or Substance Abuse Practice
6 ___ Family Service / Counselling Center
7 ___ United Way Affiliate

■ **For these Managed Care Clients, please provide the following characteristic data (check relevant category):**

Treatment Type:		Age:		Sex:	
1 Mental Health Treatment	_____	1 < 18	_____	1 Male	_____
2 Substance Abuse Treatment	_____	2 18 - 64	_____	2 Female	_____
3 Mental Health & Substance Abuse Treatment	_____	3 65+	_____		

"Managed Care" Services (HMO, PPO, IPA, EAP) received by this client PRIOR TO admission to your practice:

1 Crisis Intervention _____
2 Individual Outpatient Therapy _____
3 Group Outpatient Therapy _____
4 Day Treatment _____
5 Residential _____
6 Inpatient _____
7 Intensive Outpatient _____

■ **Services Sought/Needed in Public or Private Sector Low Cost/Charity Care:**

1 Crisis Intervention _____
2 Individual Outpatient Therapy _____
3 Group Outpatient Therapy _____
4 Day Treatment _____
5 Residential _____
6 Inpatient _____
7 Intensive Outpatient _____

■ **Individual was previously receiving services through this type of managed care organization:**

1 Employee Assistance Program (EAP) _____
2 Health Maintenance Organization (HMO) _____
3 Preferred Provider Organization (PPO) _____
4 Individual Practice Association (IPA) _____

■ **Why client's services were effectively capped and he/she sought public or private low cost/charity care:**

1 Pre-certification for more intensive service denied _____
2 Utilization Review/Case Management Decision _____
3 Referred due to non-availability of recommended modality through managed care _____
4 Client could not afford co-pay and managed care affiliate not allowed to negotiate other arrangement _____
5 Managed Care Procedural Constraints effectively forced family choice to seek other services _____
6 Other (please explain): _____ _____

■ **Was the managed care referral/capitation of services:**

- clinically appropriate? 1 ☐ Yes 2 ☐ No
- ethically and professionally sound? 1 ☐ Yes 2 ☐ No
- decided by managed care firm overturning private professionals' treatment plan? 1 ☐ Yes 2 ☐ No

■ **The cost of services that the client will require in the next 30 days will amount to the following estimate:** $ _____

■ **Client Prognosis (check one):**

1 . Individual requires and will benefit from additional short-term services _____
2 . Individual will benefit from needed inpatient/residential services and then require follow-up day treatment or outpatient services _____
3 . Individual will not be able to obtain the necessary service modality and will have to be accommodated through a less intensive modality _____
4 . Individual is not "invested" nor has clear treatment goals and additional services are of dubious value _____

■ **Comments or Anecdotal Information:**

_____

_____

_____

_____

Survey Completed By: _____

Title: _____

Agency: _____

Please Return by April 8, 1992 to:

Rubyjean Gould
Virginia Department of Mental Health,
Mental Retardation, and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23214

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

KING E. DAVIS, Ph.D., LCSW
COMMISSIONER

MAILING ADDRESS
P.O. BOX 1797
RICHMOND, VA 23214
TEL. (804) 786-3921

MEMORANDUM

TO: Community Services Board Executive Directors

FROM: for King E. Davis, Ph.D.
Commissioner

SUBJECT: **Senate Joint Resolution 107 - Study of Managed Care and HMO Effects on Public Sector and Private Sector Charity Care**

DATE: April 24, 1992

Senate Joint Resolution No. 107 (enclosed) was passed during the last session of the General Assembly. This resolution charges the Department of Mental Health, Mental Retardation and Substance Abuse Services to conduct a study of the effects of managed care and HMO administration of mental health benefits on the utilization of charity care services of private providers of mental health services in the Commonwealth of Virginia. In addition, the study will examine the effects of managed care systems on Virginia's public mental health and substance abuse system of community services boards and state hospitals.

A study of the effects of managed care is timely because 82% of employer-sponsored health insurance plans offer some form of managed care -- managed fee for service 49%, HMOs 17%, and PPOs 16%. Managed fee-for-service has increased its market share nationally by 50% between 1987 and 1989 and continues to grow. You may be aware that State employees are about to embark into a managed care system effective July 1, 1992.

The words "managed care" evoke many concepts and involve an array of care options, most notably HMOs and PPOs, which rely on capitation risk incentives and selective contracting affiliations. Obviously, treatment care, access, quality, program and clinical and administrative management, costs and external factors are all critical variables in the delivery of care. Managed fee-for-service plans typically incorporate pre-admission certification, concurrent utilization review, case management, and other coordination protocols.

Health care issues are clearly on the national and state agendas. MH/SA managed care constitutes a major chapter that the Virginia Special Advisory Commission on Mandated

VOICE/TDD (804) 371-8977
FAX (804) 786-4146

Managed Care Survey
April 24, 1992

Insurance Benefits will be studying in June and July and the Commission on Health Care for All Virginians will be examining in the fall and reporting to the 1993 General Assembly. Studies to date with respect to cost savings and adverse impact have been anecdotal. The fact remains, however, that managed care will continue to be a major component in most health insurance plans. Mental health and substance abuse treatment access, care and quality are fundamental tenets and ethics that professionals support. The dramatic evolution of managed care strategies will continue to be the pathway through which most Virginians access mental health and substance abuse treatment. Managed care, with its emphasis on cost containment and high use, will continue to challenge the mental health community. We need to assess and articulate our findings on the impact of managed care on community-based services, State facilities, and private practices to State legislators. To do so and to promote a factual dialogue, we need your input by participating in the attached surveys.

The first survey is a "CSB Managed Care Admissions Survey" to determine whether or not your CSB is experiencing any changes due to "managed care" factors. If you have been impacted by managed care admissions, you are requested to complete the "CSB Client Specific Survey" for clients referred from managed care services seeking admissions from May 1st through May 15th. The surveys were piloted in Fairfax-Falls Church and Virginia Beach. The VACSB MIS Committee has reviewed and approved these surveys.

Please respond to the questions and return the first survey by May 5th and, if you are experiencing the "managed care" phenomenon, the Client Specific Survey by May 20, 1992. If you prefer to fax your response, our fax number is (804) 786-4146. If you have questions or would like a copy of the final study, you may contact Rubyjean Gould, Director of Administrative Services, at (804) 786-3915. Thank you for your assistance.

KED/yz

Attachments

cc: James Bumpas
Jacqui Ennis
Robert Shackelford
Rubyjean Gould
Paul Gilding
Jo Powell

1992 SESSION

LD4107661

SENATE JOINT RESOLUTION NO. 107

Offered January 21, 1992

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VIRGINIA DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES

Effects of Managed Care and HMO Administration of MH and SA Benefits on the Utilization of Public (CSB) and Private Sector Charity Care Study
Senate Joint Resolution 107, 1992 General Assembly

CSB MANAGED CARE ADMISSIONS FOR MAY 1st – 15th 1992

1. Is Managed Care and HMO administration of MH and SA benefits impacting on your CSB? For instance, does your CSB experience "managed care admissions" (from Health Maintenance Organizations, Employee Assistance Programs, Preferred Provider Organizations, CHAMPUS Demonstration Project), or insured individuals whose insurance has NOT been exhausted but insuror will not cover further services? ☐ Yes ☐ No

   NOTE: If your CSB has been impacted by "managed care admissions" please participate in the Client Specific Survey during May 1 – 15, 1992. In addition, please respond to question 2 and 3 and return this form immediately.

2. Our CSB has experienced increasing admissions of clients with health insurance who cannot afford co-pays to utilize private sector services. ☐ Yes ☐ No

3. Our CSB has experienced increasing admissions of clients who are employed but cannot afford their company's insurance plan. ☐ Yes ☐ No

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Executive Director: _____

Community Services Board: _____

Please return this form by May 5, 1992 to:

Rubyjean Gould
Department of Mental Health,
Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23214

VIRGINIA DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES

Effects of Managed Care and HMO Administration of MH and SA Benefits on the Utilization of Public (CSB) and Private Sector Charity Care Study
Senate Joint Resolution 107, 1992 General Assembly

CSB CLIENT SPECIFIC SURVEY

PART I – Intake/Reimbursement Data **CSB Client ID:** _____ _____

INSTRUCTIONS: Please duplicate this form as needed. Use a separate form to check off the charac tics of each managed care (HMO, EPA, PPO, IPA) admission to your agency during the od of May 1st – May 15th, 1992. Managed care admissions refer to insured individual whose insurance has not been exhausted, but insuror will not cover further service

■ For these Managed Care Referrals, please provide the following characteristic data (check relevant category):

V1 Age:

1) < 18 _____
2) 18 – 64 _____
3) 65+ _____

V2 Sex:

1) Male _____
2) Female _____

Individual was previously receiving services through this type of managed care organization:

1) Employee Assistance Program (EAP) _____
2) Health Maintenance Organization (HMO) _____
3) Preferred Provider Organization (PPOO) _____
4) Individual Practice Association (IPA) _____
5) CHAMPUS/FHC Choices _____
6) Referred by HMO having received no previous services _____
7) Other (Explain) _____

V4 Why was client referred?

1) Further services denied _____
2) Referred due to non-availability of recommended service through managed care _____ _____
3) Client could not afford co-pay and not allowed to negotiate other arrangement per agency managed care contract _____
4) Don't know why _____
5) Other (please explain): _____

PART II – Clinical Data

CSB Client ID: _____

V5 For these Managed Care Referrals, please provide the following characteristic data (check relevant category):

Treatment Type:
1) Mental Health Treatment _____
2) Substance Abuse Treatment _____
3) Mental Health & Substance Abuse Treatment _____

V6 "Managed Care" (HMO, EAP, PPO, IPA) Services received by this client IMMEDIATELY PRIOR TO CSB admission:

1) Crisis Intervention _____
2) Individual Outpatient Therapy _____
3) Group Outpatient Therapy _____
4) Day Treatment/Intnsv Outpatient _____
5) Residential _____
6) Inpatient _____
7) None _____
8) Other _____

V7 Reason For Referral: Services Sought/Needed through your CSB

1) Crisis Intervention _____
2) Individual Outpatient Therapy _____
3) Group Outpatient Therapy _____
4) Day Treatment/Intnsv Outpatient _____
5) Residential _____
6) Inpatient _____
7) Court Involved/Legal _____
8) None _____
9) Other - specify _____

V8 What is the clinical impact of managed care services being discontinued and the client being referred to CSB?

_____

_____

_____

_____

V9 The financial impact of services the client will require in the next 30 days will amount to the following estimate (i.e. based on full fee/charge for anticipated services): $ _____ (total charges)

_____ Outpatient Sessions @ _____/hour
_____ Inpatient Days @ _____/day
_____ Group Therapy @ _____/hour
_____ Residential @ _____/day
_____ Day Treatment Days @ _____/day
_____ Other

V10 Client Prognosis (check one):

1) Individual requires and will benefit from additional short-term services _____
2) Individual will benefit from additional long-term outpatient services _____
3) Individual will benefit from needed inpatient/residential services and then require follow-up day or outpatient services _____
4) Individual will not be able to obtain the necessary service modality and will have to be accommodated through a less intensive modality _____
5) Individual is not "invested" nor has clear treatment goals and additional services are of dubious value _____
6) Other: _____

■ Comments or Anecdotal Information:

_____

_____

_____

Survey Completed By: _____

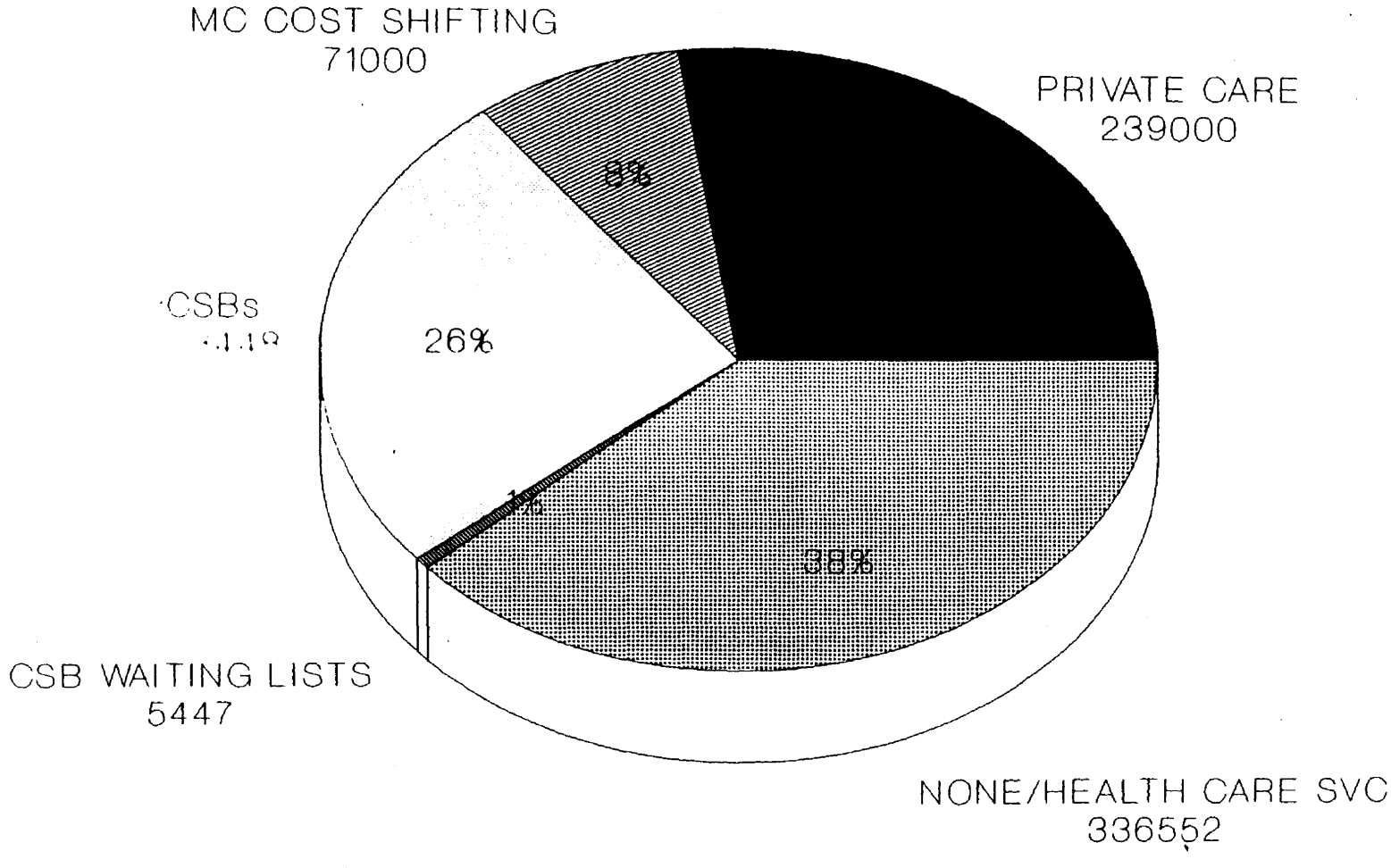
Title: _____

Community Services Board: _____

Please Return by May 20, 1992 to:

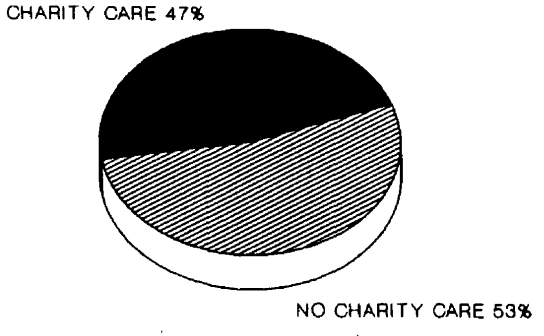
Rubyjean Gould
Department of Mental Health,
Mental Retardation and Substance Abuse Services
Post Office Box 1797

VIRGINIA MH/SA TREATMENT SECTORS

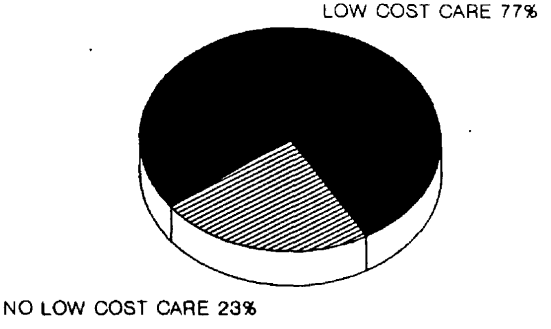


Assumes 15.4% prevalence

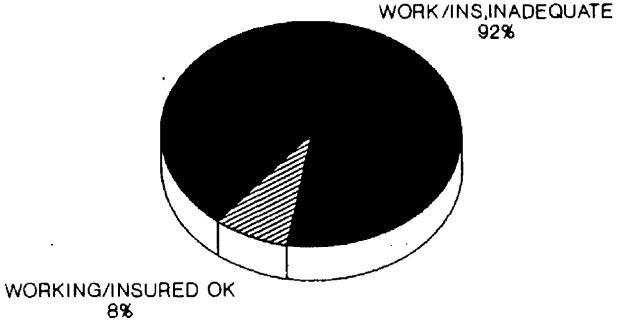
PRIVATE SECTOR MH/SA FIRMS PROVIDING CHARITY CARE



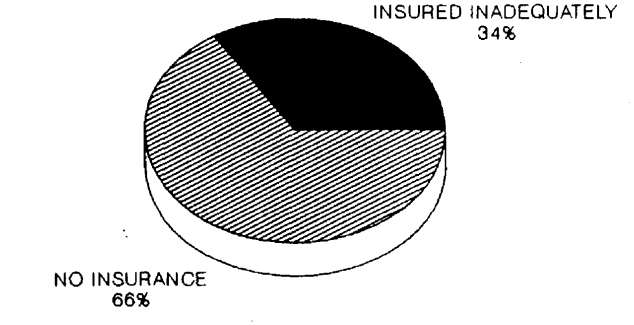
PRIVATE SECTOR MH/SA FIRMS PROVIDING LOW COST CARE



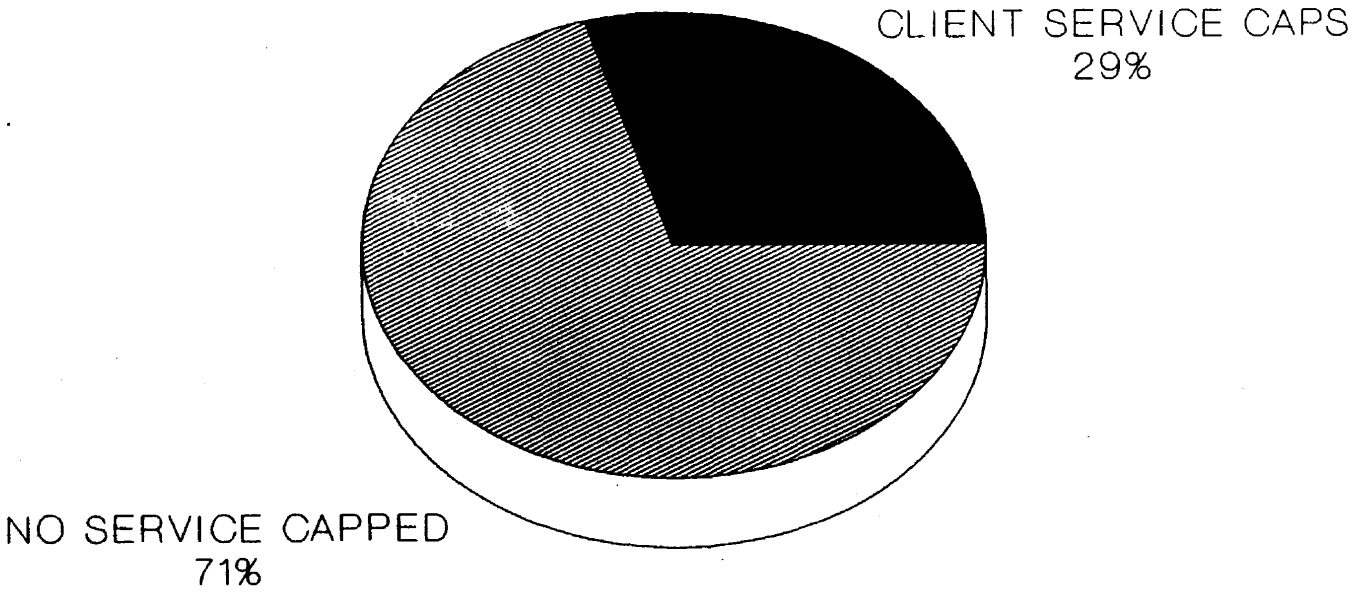
PRACTICES WITH INCREASE OF WORKING INSURED-INADEQUATE COVERAGE



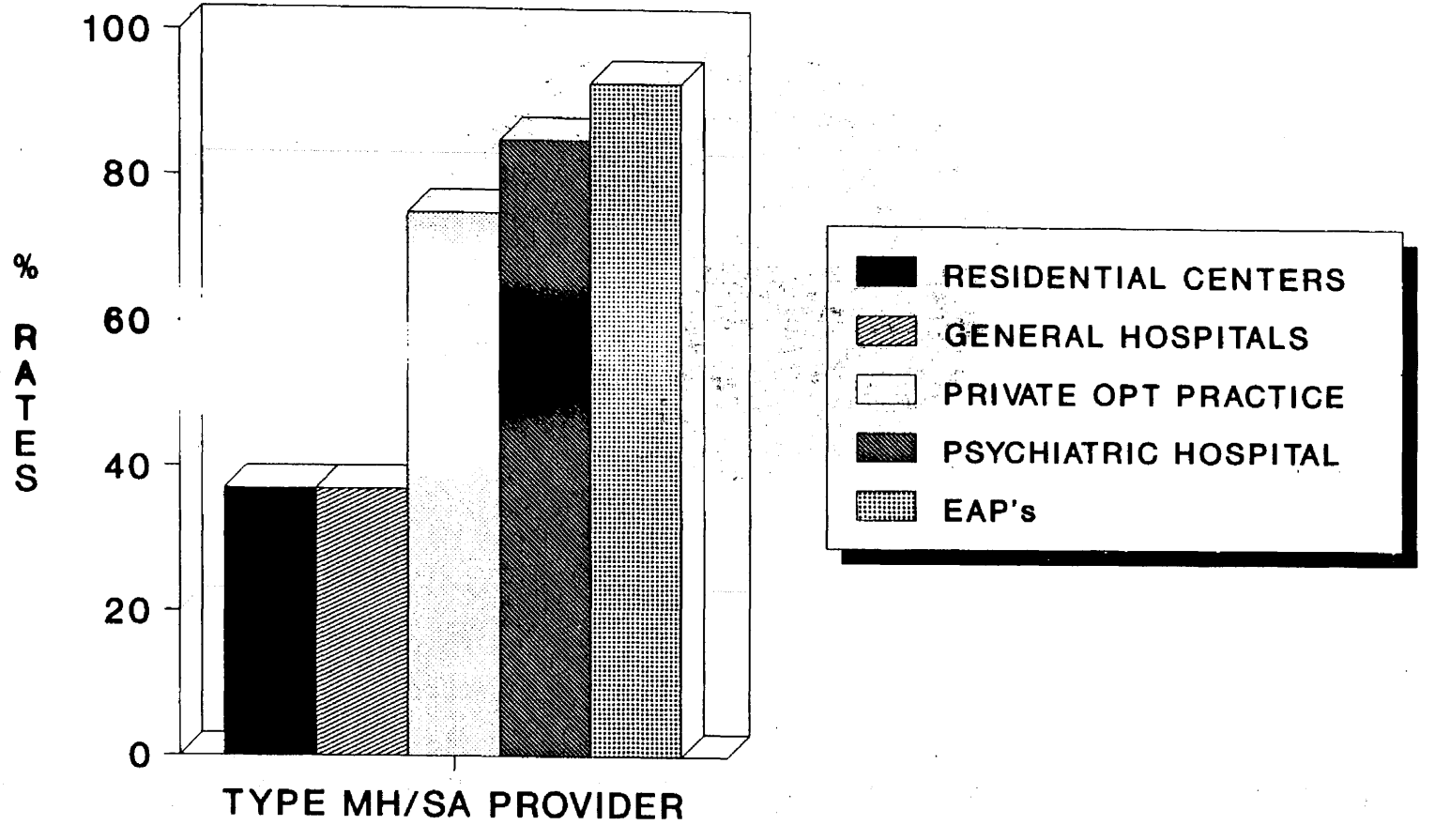
CHARITY & LOW COST CARE CASELOAD WORKING & INSURED--INADEQUATELY



PRIVATE MH/SA SECTOR
MANAGED CARE CAPITATIONS TO ADMISSIONS

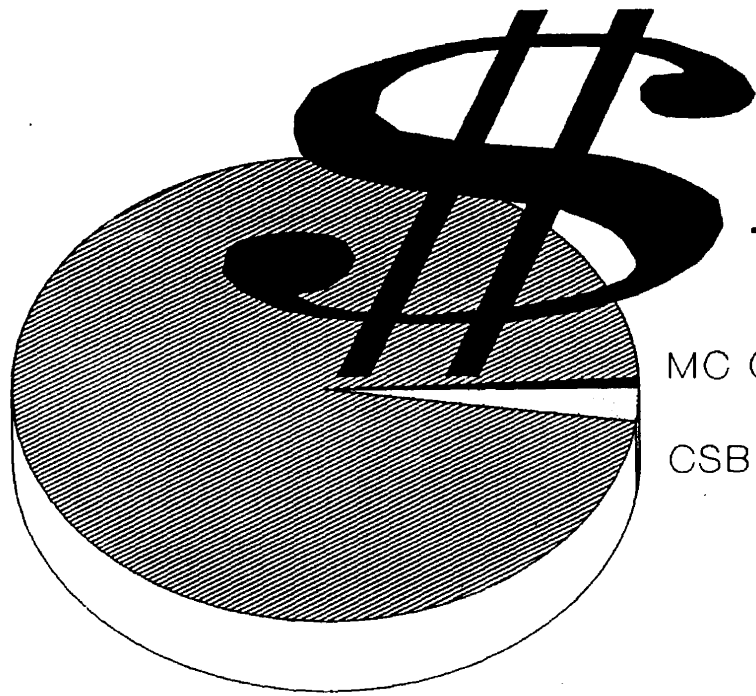


CAPITATION/COST SHIFTING RATES BY TYPE OF MH/SA PRIVATE PROVIDER



MANAGED CARE COST SHIFTING TO CSBs

LIH SA CSB CLIENTS
223448



1 MILLION

MC CASES TO CSBs
1700

CSB WAITING LISTS
5447

MANAGED CARE EFFECTS

ON PUBLIC MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

PROVIDED BY VIRGINIA COMMUNITY SERVICES BOARDS

COMMUNITY SERVICES BOARD	MANAGED CARE EFFECTS		INCREASED ADMISSIONS WHO CANNOT AFFORD PRIVATE CO-PAYS		INCREASED ADMISSIONS WHO CANNOT AFFORD COMPANY INSURANCE PLAN	
	Yes	No	Yes	No	Yes	No
ALEXANDRIA	*		*		*	
ALLEGHANY		*		*	*	
ARLINGTON						
CENTRAL	*					
CHESAPEAKE		*		*		*
CHESTERFIELD						
COLONIAL	*		*			*
CROSSROADS		*	*		*	
CUMBERLAND		*				
DANVILLE		*		*		*
DICKENSON		*		*		*
DISTRICT 19		*	*			
EASTERN SHORE		*		*		*
FAIRFAX	*		*		*	
GOOCHLAND		*		*		*
HAMPTON/NEWPORT NEWS	*		*		*	
HANOVER						
HARRISONBURG		*		*		*
HENRICO	*		*			*
HIGHLANDS		*				
LOUDOUN						
MIDDLE PENNINSULA		*	*		*	
MT. ROGERS		*	*		*	
NEW RIVER	*		*		*	
NORFOLK	*		*		*	
NORTHWESTERN		*	*		*	
PIEDMONT		*	*			*
PD I		*		*		*
PORTSMOUTH	*		*			*
PRINCE WILLIAM	*		*		*	
RAPPAHANNOCK	*			*		*
RAPPAHANNOCK/RAPIDAN	*		*		*	
REGION TEN		*	*		*	
RICHMOND	*		*		*	
ROANOKE	*		*			
ROCKBRIDGE		*	*			*
SOUTHSIDE		*		*		*
VALLEY		*				
VIRGINIA BEACH	*		*		*	
WESTERN TIDEWATER		*				

Virginia Department of Mental Health,
Mental Retardation and Substance Abuse Services
Office of Community Information Systems and Data Management

Effects of Managed Care and HMO Administration of MH and SA Benefits on the Utilization of Public(CSB) and Private Sector Charity Care Study

PRIVATE SECTOR SURVEY

Report Date: 29 May 1992

PROGRAM TYPE:			
1. Private Psychiatric Hospital	28	5. Private MH and/or SA Practice	547
2. General Hosp. w/ Inpatient Wing	45	6. Family Service/Counselling Center	49
3. Residential Treatment Center	29	7. United Way Affiliate	8
4. Employee Assistance Programs	16	TOTAL (Program Types 1-7)	722

	MH	SA	TOTAL
1. Total MH and SA clients served per year:	183,977	57,056	241,033
2. Working and Insured Individuals in your system the days of March 26 & 27, 1992, whose insurance has denied coverage or effectively forced individual to private charity care (Managed Care Referrals):	14,154	3,588	17,742

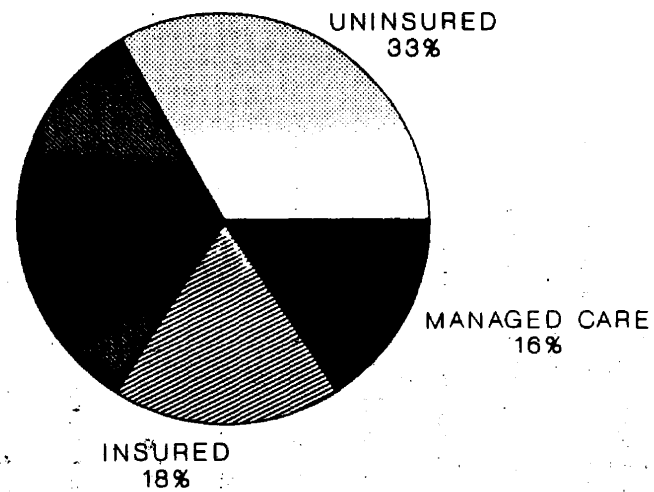
	YES	NO
3. Our practice provides charity care for indigent clientele:	317	353
4. Our practice provides low cost care for indigent clientele:	527	156
5. During last year, I have noted an increase among our clientele who are working & insured & have inadequate insurance coverage or a curtailment of some HMO services:	629	55

6. If yes to previous question, estimated percentage of charitable/low cost caseload that represents working individuals whose insurance coverage has been reduced/curtailed due to HMO services:	34% (1% - 100%)
7. Estimated percentage of practice that is managed care:	37% (1% - 100%)

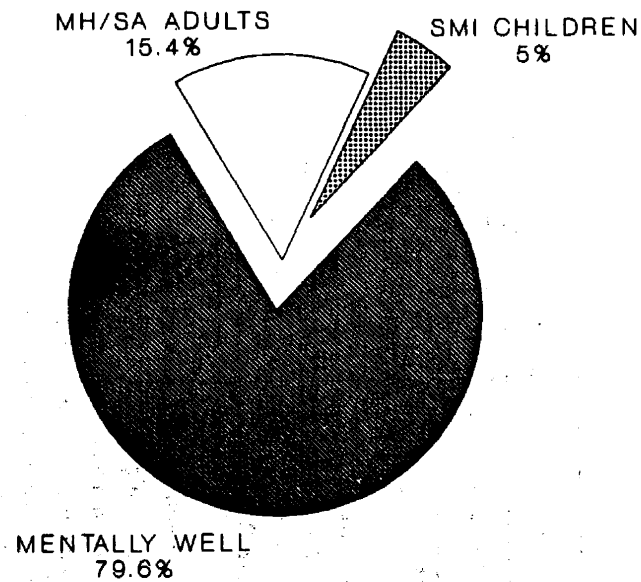
**** Answers to the following 11 questions are based on a scale from "Strongly Agree" to "Strongly Disagree". ****

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
8. Managed care referrals to public & private charity care are likely to decrease.	113	69	31	156	351
9. MCS' increasing share of health insurance marketplace effectively increases proportion of population who can be MH/SA indigent.	435	165	41	24	29
10. In practice, managed care tools rarely force choice for service continuation in public or private charity care systems.	37	45	65	217	292
11. MCS' requirement to cover only voluntary vs. court-ordered treatment due to availability of 24 hr. pre-authorization is reasonable.	14	46	128	227	252
12. Clients & MH/SA professionals should have appeal rights for review decisions. Independent providers should be in review panels.	559	121	9	2	7
13. Managed care referrals affect public and private charity care systems in direct and indirect cost-shifting.	469	168	36	7	11
14. MCS' private inpatient coverage/concurrent review systems effectively increase State hospital admissions.	274	232	157	15	10
15. MCS have seriously constrained Juvenile Court System treatment alternatives.	260	167	236	15	4
16. MCS in Virginia share the perception that individuals who can't benefit from short-term treatment belong in the public sector.	369	221	68	21	5
17. Managed care approach to MH/SA treatment w/ emphasis on cost treatment efficacy is a valid regulator of private MH/SA services.	14	135	42	233	266
18. MCS are a reality for the future & MH/SA community must forge well-defined standards of care regarding alternative treatment.	243	333	33	45	35

VIRGINIA'S HEALTH COVERAGE & MH/SA PREVALENCE



INSURANCE TYPE



MH/SA PREVALENCE

Based on 1990 census:6,187,358

Endnotes

1. "Report to the Commission of Health Care for All Virginians - In Response to House Joint Resolution No. 399 (1991)," November 1991, pp. 68-73.

2. Note: Due to 1990's severe State and local budget cuts, most CSBs now have no funding for inpatient care.

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
Mental Health, Mental Retardation and Substance Abuse Services

KING E. DAVIS, Ph.D., LCSW
COMMISSIONER

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April 29, 1993

Steven Foster, Commissioner
Bureau of Insurance
P. O. Box 1157
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Dear Commissioner Foster:

Senate Joint Resolution 107 requested the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the effects of managed care and HMO administration of mental health benefits on the utilization of public mental health providers and charity care of private mental health providers. The study findings led to several recommendations that concern your bureau.

We appreciated your thorough review and detailed response to the report and recommendations bearing on your agency's operations. Below is our response to your comments.

1. *The Report states that a study pertinent to mental health and substance abuse was undertaken. However, the recommendations do not pertain only to mental health and substance abuse managed care. Instead, the recommendations, as written, pertain to all managed care. Consequently, in addition to mental health and substance abuse managed care, the recommendations would apply, for example, to dental managed care, chiropractic managed care, managed care engaged as a result of an automobile accident (and covered through automobile insurance), the medical/surgical managed care.*

Response: This observation is accurate. The recommendation is consistent with the Board of Health Professions' Task Force on Managed Health Care report to the Commission on Health Care for All Virginians, HJR 399 (1991), as well as its precursor, the House Document 30; Final Report of the Insurance Task Force Studying Insurance Coverage for Persons with Mental Disabilities, HJR 42 (1990) that deemed it futile and too restrictive an exercise to examine managed care just as it pertains to mental health care and substance abuse treatment.

2. *The Report's recommendations that pertain to the SCC would be expensive to implement. The costs of implementation were not considered in the report. Costs would include the cost of regular staff, physicians and other professional consultants to serve on the appeals panel, office space, equipment (including computer systems, work stations, and telephones), and supplies. The Bureau is unable to*

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determine the costs associated with the recommendations because the Report does not provide adequate information to permit such an estimate. However, with respect to regular staff, it appears that even five (5) regular staff members (in addition to the appeals panel consultants) may not be sufficient. Staff would be needed for authorizing "Managed Care Firms" to conduct business, for handling and tracking complaints, for conducting investigations, for criteria development and maintenance, for appeals panel administrative functions, and for other normal office functions.

Response: Expensive is a relative term. Additional resources would be required and are deemed justified in light of the benefits to be derived. Only the SCC, Bureau of Insurance would be able to identify the resources necessary to be responsive to public complaints in the context of its current organizational structure and resource allocation.

3. *The study did not indicate how much of the shifting of the mental heath and substance abuse care to the public sector and to private sector charity and low cost care is caused by self-insured plans. Self-insured plans are exempt from state regulation because of ERISA preemption. It is probable that the shifting discussed in the Report is caused to some extent by these self-insured plans. If this is the case, then the recommendations would not improve the problems to the extent that they are caused by self-insured plans (because the recommendations would not impact self-insured plans).*

Response: Generally, it is accepted that one-third of Virginians are covered by some form of a self-insurance program. The study could not isolate this variable within the allowable study schedule and resources. Nonetheless, the recommendation is warranted and would be beneficial to those not covered by self-insurance programs.

4. *The Report states that managed care caused some mental health and substance abuse care to be shifted to the public sector and to private sector charity and low cost care. However, the data do not demonstrate how much of the shifting was caused by "managed care". Rather, it appears that other factors that are not "managed care" (such as co-payments, the inability of some individuals to afford to participate in their company's health care package, limitations on benefits, and the exclusion of certain services from insurance coverage) caused much of the shifting the Report is attributing to managed care. Therefore, the effects of "managed care" appear to be somewhat less than that alleged in the Report. For example:*

a) Page 7 of the Report which discusses the public sector survey response states "71 managed care referrals were identified by the CSBs over the survey period equating to 1700+ annually" ("CSB" is the acronym for Community Services Board). Page 8 of the Report shows that of these "managed care" clients,

- *11% arrived at CSBs because further services were denied*
- *11% arrived at CSBs because services were not available through managed care*
- *28% arrived at CSBs because of non-negotiable co-pays*

The Report did not explain why the other 50% of "managed care clients" arrived at CSBs. Of the 50% of CSB managed care clients whose reasons for arrival at a CSB were explained, 39% (28% + 11% = 39%) arrived because of non-negotiable co-pays or because service was not available through managed

*care. However, non-negotiable co-pays are not an effect of "managed care" but are an accepted cost control technique of health insurance. In addition, it appears that unavailability of the service through managed care means that the plan did not offer the needed service, in which case it would be an excluded benefit. Excluded benefits, like co-pays, are not germane to managed care, but are common to health insurance. The remaining 11%, those who arrived because further services were denied, may represent services denied by utilization review and hence by managed care. On the other hand, although it does not appear to be the intent of the survey (see "Instructions" on page 63 of the Report), this 11% may also include individuals whose insurance has been exhausted. However, it appears that 11% of those referred to CSBs may have been referred due to managed care. If that is the case, then instead of the 1700 managed care referrals alleged on page 7 of the report, the data identifies only 187 (1700 * 11% = 187) managed care referrals to the CSBs annually. Taking this a step further, instead of the $768,000 annualized cost shifting to CSBs reportedly caused by managed care, the data would indicate only an $84,480 ($768,000 * 11% = $84,480) annual cost shift to CSBs caused by managed care.*

b) Page 25 of the Report which discussed the private sector survey response states that "Annualized data indicates that 71,000 Virginians are adversely affected by managed care interventions that deny services or force them to private charity care." It appears that the figure of 71,000 is an annualization of responses to the third question of the "Private Sector Survey" (page 54 of the Report). It also would appear from the wording of this survey question that the 71,000 may include individuals affected by things other than "managed care" as "managed care" is defined on page 16 of the Report. This survey question asks private sector mental health and substance abuse professionals for the number of "Working and Insured Individuals in your system during your most recent calendar quarter, whose insurance has denied coverage or effectively forced individuals to private charity care (Managed Care Referrals)." Individuals can be denied coverage or effectively forced to private charity care for reasons other than managed care. Consequently, it appears that this 71,000 figure may include, for example, individuals who insurance benefits have run out.

Response: SJR 107's language specifically requested a study of "the effects of managed care and HMO administration of mental health benefits on the utilization of public mental health providers and charity care of private mental health providers". The study is consistent with the definition of managed care found in material from the Institute of Medicine and managed care literature. The survey instrument and the Commissioner's cover letter to study participants solicited data consistent with SJR 107's intent. The data does not overstate the effects of managed care which are very real and increase daily.

5. *Although the report does not specifically define "Managed Care Firms", if we assume that a "Managed Care Firm" is an entity involved in any managed care procedure as these procedures are defined on page 16 of the Report, then "Managed Care Firms" would appear to include health insurers, health maintenance organizations, preferred provider organizations, property/casualty insurers, private review agents, and various other entities involved in managed care pursuant to self-insured plans and consequently exempt from state regulation. The Bureau of Insurance currently regulates health insurers, health maintenance organizations, preferred provider organizations, property/casualty insurers, and private review agents. The Report does not address how the recommendations pertaining*

to regulation and monitoring of "managed care firms" would integrate with the current legal framework. Perhaps instead of creating an entirely new regulatory framework under the nebulous heading of "managed care", we should identify specific problems and corresponding solutions and amend the existing laws and procedures accordingly. For example, if copayments are determined to be a problem, then we should address copayments for all insurance, not just insurance administered via managed care. The same would apply to "inadequate insurance", services not covered/provided, and utilization review.

Response: The study reported real effects and problems and consumer and public accountability driven recommendations. The study supports the need for a collaborative response by public agencies to assure care, due process, and responsible corporate behavior on the part of managed care firms.

6. *With respect ot the recommendation that "the SCC report annually on Managed Care Firms' performance" (page 49 of the Report), conversations with DMHMRSAS staff revealed that this reporting would be based on complaints received. It appears that attempting to capture and report "managed care complaints" by "managed care firm" would present several difficulties for the Bureau. First, since managed care is a technique utilized by many entities regulated by the Bureau, a "managed care firm" may also be, for example, an insurance company, a private review agent, a health maintenance organization, or a preferred provider organization. Consequently, although we would be able to capture the complaint data in our computer system in a manner which would permit the recommended reporting, the new method for categorizing complaints may impact the other complaint data statistics of the Bureau. Second, we may be confronted with difficulties in determining which entity should be assigned any given complaint. To elaborate, a complaint may be made to the Bureau against an insurer because the insurer did not pay full benefits for a physician visit. Subsequent follow-up may reveal that insurer is limiting payment because he is not a network provider. If the preferred provider organization is a separate entity from the insurer, who would we record the complaint against - the insurer or the preferred provider organization? Third, it may be difficult in some cases to determine whether the complaint is a managed care issue or not and to therefore assign the complaint appropriately. These potential difficulties would reduce the meaningfulness of any complaint reporting.*

Furthermore, reporting the number of managed care complaints against a given firm would not indicate whether the firm is performing well or poorly. A firm with a high volume of managed care activities would understandably have a greater number of complaints than a firm with a low volume of managed care activities.

Response: The implementation of such an automated complaint monitoring system does have its challenges. The development of any information system effort requires decision rules. Based on their complaint tracking experience, Bureau staff should be uniquely qualified to determine the appropriate assignment and explanation of complaint data. Should Bureau staff not feel equipped to handle this endeavor, DMHMRSAS staff will be happy to provide assistance. We believe that the public interest would be best served with this effort and will work closely with SCC staff to assist in the design or incorporate such features into an automated system.

7. *With respect to the recommendation that "Managed Care Firms" have internal appeal procedures, this recommendation appears to overlap with the Bureau's recommendation in the SJR 120 Report. In the SJR 120 Report, the Bureau recommends that insurers, health services plans, and health maintenance organizations that make prospective or concurrent utilization review denials should be required to have an appeals process for the appeal of these denials if the insurer, health services plan, or the health maintenance organization makes the utilization review determination for its own insured, member, subscriber, or enrollee. If an entity external to the insurer, health services plan, or health maintenance organization makes the utilization review determination, then Insurance Regulation Number 37, Rules Governing Private Review Agents, requires that the private review agent provide an appeals process. In SJR 120, the Bureau did not recommend requiring an appeals process for retrospective review. Since retrospective review would not result in withheld or delayed care, other mechanisms, such as the court systems, already exist to handle disagreements of this nature.*

Response: The SJR 120 Report recommendations are consistent with the findings of the SJR 107 Report with one significant exception. In mental health and substance abuse emergencies there is a need for an immediate appeals process to resolve differences between the treatment professional and the managed care firm for individuals with potential for suicide or degrees of dangerousness. The Board of Health Professions also recognized this important distinction in appeals procedures for MH/SA care.

8. *The Report does not address how criteria for managed care firms would be developed or by whom. Conversation with DMHMRSAS staff revealed that the criteria would be developed by staff from the Bureau of Insurance, DMHMRSAS, and the Department of Health Professions. It is important to note that the Bureau does not have staff with the medical expertise necessary to assist in the clinical criteria development.*

Response: Models from national organizations and the experience of other states prove the positive outcome of criteria-setting processes for managed care firm business conduct.

9. *The Report recommends that the Bureau of Insurance, Department of Health Professions, and DMHMRSAS jointly monitor the conduct of managed care firms. This "joint" monitoring could pose organizational problems.*

Response: There is successful precedence for interagency licensing and cross-secretariat programs that offer more performance monitoring input and public protection. The Comprehensive Services Act and several other broad-reaching and cross-secretariat efforts come to mind. DMHMRSAS has enjoyed good working relationships and successful collaboration efforts with Bureau of Insurance staff in the past and would welcome future working relationships.

10. The Report acknowledges on page 20 that much of the data extracted from private practice professionals was based on manual clinical charts and memory.

Response: True and astounding, when one considers the magnitude of the S. R study survey response. The original study design called for a two-day sample because most private professionals do NOT have sophisticated MIS systems to retrieve data. The Virginians for Mental Health Equity (representing professional mental health providers, psychiatrists, psychologists, social workers, counselors) voted to conduct a full calendar quarter survey, recognizing that MH/SA professionals would have to manually retrieve data. The intensity of the response portrays a conservative estimate of the effects of managed care and the pronounced professional concerns about the quality of care rendered.

I hope that this information is helpful in clarifying some of the recommendations. We look forward to working with the Bureau in providing this welcome public service. If you have any questions, please do not hesitate to give me a call.

Sincerely,

King E. Davis, Ph.D.
Commissioner

KED/yz

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

KING E DAVIS, Ph D , LCSW
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April 29, 1993

Bernard L. Henderson, Jr., Director
Department of Health Professions
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Dear Bernie:

Senate Joint Resolution 107 requested the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the effects of managed care and HMO administration of mental health benefits on the utilization of public mental health providers and charity care of private mental health providers. The study findings led to several recommendations that concern your department.

We appreciated your review and response to the report and recommendations bearing on your agency's operations. Below is our response to your comments.

1. *We have no objection to the recommendation relative to the participation of the Department of Health Professions in the development of criteria which may be used to evaluate professional conduct.*

Response: We welcome the opportunity to work with the Department of Health Professions in developing professional conduct criteria.

2. *The second recommendation pertinent to the Department of Health Professions proposes the monitoring of managed care firms in administration of an appeals panel on case disposition and a complaint tracking system. ...We may need additional resources or authority to effectively engage in this activity. This may also be the type of recommendation where "the devil is in the detail" and a complete draft of implementing legislation is necessary to respond to a request for comment.*

Response: Additional resources or authority that might be required are deemed justified in light of the benefits to be derived for the public.

Sincerely,

King E. Davis, Ph.D.
Commissioner

KED/yz

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