



Transition of Fort Bragg Demonstration to Capitated Behavioral Health

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Much has been written about the Fort Bragg Child and Adolescent Mental Health Demonstration, which provided a comprehensive continuum of care to military children in North Carolina from 1990 to 1995. Yet relatively little information exists about the current status of Fort Bragg. This recent article presents research on the impact of transition from the demonstration to a capitated behavioral health care contract. Using a case study approach, the authors reviewed a range of written materials and conducted semistructured interviews with a variety of current and past personnel, as well as phone surveys with families and a network analysis comparison between the demonstration and managed health care systems.

Comparing service utilization rates between the demonstration and managed health care systems was difficult, because the two contractors used different methods for counting unduplicated youth. To compensate, the authors estimated the number of unduplicated youth under the capitated contractor, although it is unclear how this estimation was calculated. Results revealed that under the capitated contractor, the utilization rate increased slightly in 1996 and then dropped sharply in 1997. Furthermore, inpatient, residential, and intermediate services all decreased dramatically from the demonstration to the capitated contractor. Two reasons presented as explanations for low service utilization were "the managed care contractor's stated wish to reduce the use of intermediate services" (p. 395) and the additional cost to families under the managed care system in the form of both a copayment and a deductible that placed access to care outside the reach of many lower income families.

Although the capitated contract specified that outpatient services were to be available to all beneficiaries without preauthorization, the authors found that the contractor encouraged providers to have all contacts preauthorized and those who did not were not being reimbursed for services. However, a later dispute required the contractor to reimburse providers for denied sessions that should have been included in the unmanaged eight visits.

Other results showed that the capitated service system successfully implemented contract provisions enabling individuals to access care by either visiting an authorized provider, through a walk-in at the contractor's office, or through a 24 hour phone line. "Communication between army personnel and the contractor was described as dramatically and positively improved from the previous [demonstration] contractor" (p. 399), although other military personnel voiced dissatisfaction on availability of information, ease of referrals, and collaboration with telephone-line clinicians.

Network analysis indicated that community-wide planning and relationships between community agencies decreased under the capitated managed care system. Using multiple measures, all analyses revealed a decline in service coordination among community providers after the transition from the demonstration grant. The authors note, "This decrease meant that providers in this community were coordinating their activities around the target children's behavioral health services with others, in general, less often... at a time when the professional literature was urging

Recommendations for Future Managed Health Care Contracts

1. Monitoring needs to shift from prevention of fraudulent overuse of services to prevention of fraudulent underuse of services due to cost-savings measures in managed care.
2. Accountability-focused written provisions of contract are necessary for ensuring quality of care.
3. Resources are needed to monitor the implementation of contracts and impact on beneficiaries.
4. More incentives are needed for prevention and early intervention activities.
5. Clinical needs should not be displaced by financial concerns.
6. Change is needed so that there are not incentives to underserve those with long-term needs.



DATA TRENDS: December, 2000 #20

Summaries of research on mental health services for children and adolescents and their families



more coordination of effort” (p. 401). Additionally, rating scales completed by community service providers and service agency representatives indicated that under the capitated system, problems in service delivery experienced by youth and families increased significantly, quality of services and service system performance decreased significantly, and “the extent to which goals of an effective mental health service system were being attained was also rated as significantly decreased” (p. 401).

Another interesting finding was that the contractor’s emphasis on cutting costs resulted in a shift of service provision to other community programs, indicating that costs were reallocated rather than saved. The authors note that, “these costs are passed on to the taxpayer so that limiting costs in one sector is an artificial cost-reduction method” (p. 404). Additionally, despite the premise that money savings in the reduction of costly services can be used to provide supportive and preventive services, little was offered besides the dissemination of a community resource directory, advertisement of courses on family issues, and a breast cancer awareness and support project.

As a result of their findings, the authors made several recommendations to ensure appropriateness and quality of care in future managed health care contracts; these are available in the table above.