

FINANCING BRIEF

Environmental Scan on the Alignment of Managed Care Organizations with the System of Care Approach for Children's Behavioral Health

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The National Technical Assistance Center for Children's Mental Health at Georgetown University (TA Center) conducted an environmental scan of managed care organizations (MCOs) that manage behavioral health services to children, youth, and young adults with behavioral health conditions and their families. The goal was to explore how the policies and services provided or purchased by MCOs are aligned with the system of care approach. For purposes of the survey, an MCO was defined as an organization that manages both physical and behavioral health services, or a behavioral health organization (BHO) that manages only behavioral health services. The term "MCO" was used in this scan to be inclusive of both types of organizations and is the term used in this financing brief.

This scan is considered to be exploratory, and was designed as a first step in gathering baseline information from MCOs about their implementation of the system of care approach. The results of the scan will be used to strengthen partnerships among MCOs and all system of care stakeholders to ensure that comprehensive, effective, home- and community-based services and supports are available to improve the lives of youth and families.

Potential respondents were identified by state children's behavioral health directors from 49 states who participated in a previous scan on the implementation of health reform and home- and community-based services in their states (Stroul, Safer-Lichtenstein, Henderson-Smith, & Le, 2015; Stroul, Henderson-Smith, Safer-Lichtenstein, & Le, 2015). Through that survey, they were asked to provide the names of organizations responsible for managing children's behavioral health services in their states and contact information for a representative of each organization. Children's directors in 20 states submitted information for a total of 43 MCOs. After extensive follow-up, responses were received from 13 MCOs, a 30% response rate. Despite the low response rate, the results provide preliminary information and set the stage for future collaboration with these and other MCOs on implementation of the system of care approach.



Available at: http://gucchd.georgetown.edu/products/FinanceBrief_MCO_SOC_Alignment.pdf

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THE SYSTEM OF CARE APPROACH

The concept of a system of care was introduced in the mid-1980s to improve the quality and outcomes of services for children, youth, and young adults with mental health challenges and their families (Stroul & Friedman, 1996). Since then, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been investing in the development of comprehensive systems of care in states, communities, tribes, and territories. Systems of care are comprised of an array of home- and community-based services and supports, supported by an infrastructure, and guided by a well-defined philosophy. System of care principles call for services that are individualized, family driven and youth guided, culturally and linguistically competent, and coordinated across child-serving systems.

Extensive evaluations of systems of care have provided a strong evidence base documenting their positive impact on children and families. In addition, a positive return on investment has been demonstrated by shifting resources to home- and community-based services. Systems of care result in:

- **Improved Lives for Children and Youth:** Decreased behavioral and emotional problems (depression, anxiety, aggression), suicide rates, substance use, involvement with juvenile justice, and improved school attendance and grades
- **Improved Lives for Families:** Decreased caregiver strain, increased capacity to handle their child’s challenging behavior, and increased ability to work
- **Positive Return on Investment:** Redeployment of resources from higher-cost, restrictive services to lower-cost, home- and community-based services and supports; decreased admissions and lengths of stay in psychiatric hospitals, residential treatment, and out-of-home placements in child welfare and juvenile justice systems

(Stroul, Goldman, Pires, & Manteuffel, 2012; Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014).

Based on these findings, SAMHSA determined that the approach was ready for widespread expansion, and is now providing resources to states, tribes, territories, and communities to take systems of care to scale. This system of care expansion initiative was originally comprised of one-year planning grants and four-year implementation grants (SAMHSA, 2014a; 2014b). In 2015, these were combined into a single, four-year grant entitled, Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children and Their Families Program, referred to as “System of Care Expansion and Sustainability Cooperative Agreements” (SAMHSA, 2015).

Achieving SAMHSA’s goal of bringing systems of care to scale is dependent on the engagement of all stakeholders involved in behavioral health service delivery—policy makers across child-serving systems, providers, MCOs, family and youth organizations and leaders, and others. MCOs play a pivotal role as managers of care and costs, purchasers of services from a provider network, and providers of some services. As such, it is important to engage MCOs as partners in improving services and outcomes for children and families.

SYSTEM OF CARE DEFINITION

“A spectrum of effective community-based services and supports for children, youth, and young adults with or at risk for mental health and related challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, in school, in the community, and throughout life”

SYSTEM OF CARE PHILOSOPHY

Values:

- Community Based
- Family Driven, Youth Guided
- Culturally and Linguistically Competent

Principles:

- Broad Array of Effective Services and Supports
- Individualized, Wraparound Practice Approach
- Least Restrictive Setting
- Family and Youth Partnerships
- Service Coordination
- Cross-Agency Collaboration
- Services for Young Children
- Services for Youth and Young Adults of in Transition to Adulthood
- Linkage with Promotion, Prevention, and Early Identification
- Accountability

(Stroul, Blau, & Friedman, 2010)

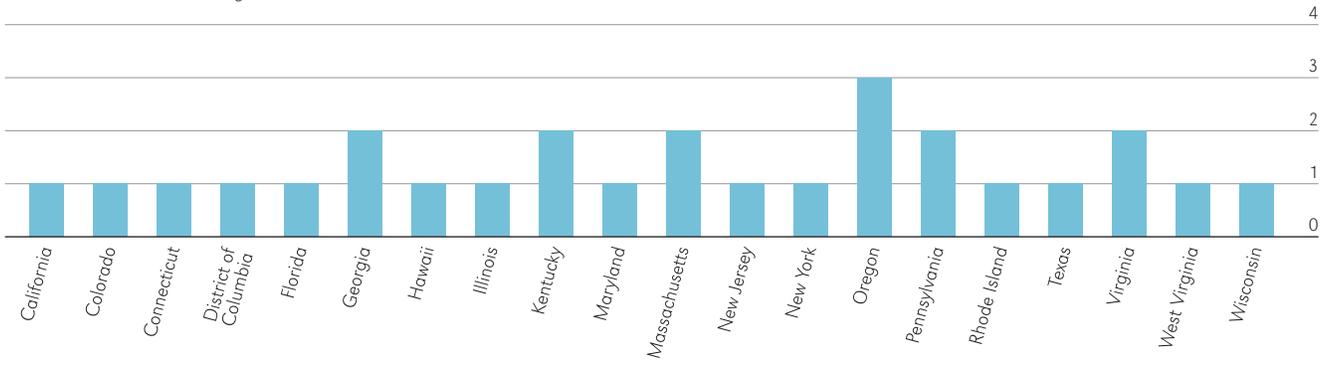
PROFILES OF THE MCOs

States Served

The 13 MCOs reported serving a total of 20 states. As shown in **Figure 1**, more than one MCO reported serving some states. Two MCOs serve Georgia, Kentucky, Massachusetts, Pennsylvania, and Virginia, and three MCOs serve Oregon. Only one MCO reported serving each of the other states.

Figure 1 States Served by MCOs

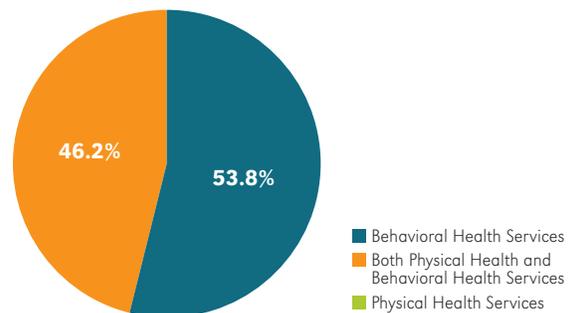
Number of MCOs Serving State



Services Managed

The MCOs were asked if they manage physical health services, behavioral health services, or both in most of their contracts. **Figure 2** shows that slightly more than half of the MCOs manage behavioral health services only, and slightly less than half manage both behavioral health and physical health services. None of the MCOs included in this scan manage only physical health services.

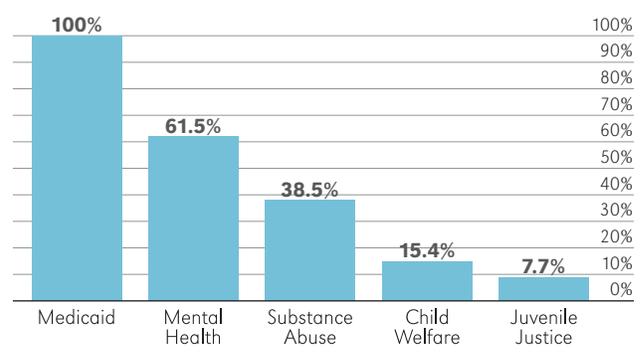
Figure 2 Services Managed by the MCOs



Purchasing Agencies

The scan explored the government agencies that purchase services from the MCOs to manage behavioral health services. Medicaid and behavioral health agencies are the primary purchasers of services from these MCOs. As shown in **Figure 3**, all the MCOs reported having contracts with state Medicaid agencies, over 60% reported contracts with state mental health agencies, and nearly 40% have contracts with state substance abuse agencies. Child welfare and juvenile justice agencies rarely purchase services from these MCOs—only two MCOs reported contracts with child welfare and one with juvenile justice.

Figure 3 Purchasing Agencies



Populations Covered in Contracts

Most of the MCOs (83%) serve a total population of children and youth that includes those with serious behavioral health conditions (Figure 4). Many fewer (25%) serve exclusively children and youth with the most serious and complex behavioral health conditions. The majority serves the child welfare population and youth with substance use disorders, and half of the MCOs also serve children and youth with developmental disabilities.

Figure 4 Populations Covered by the MCOs

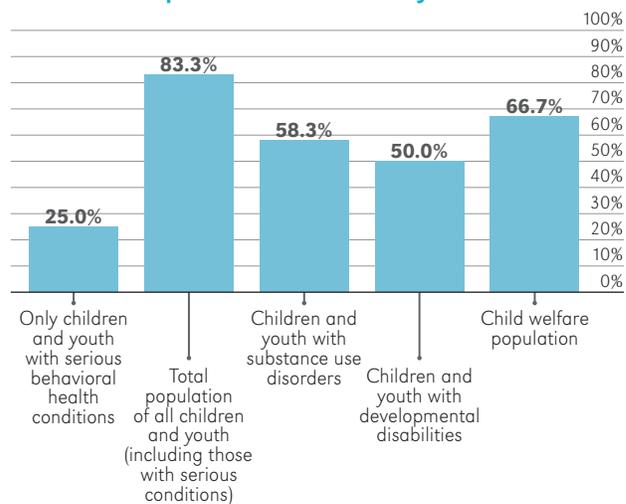
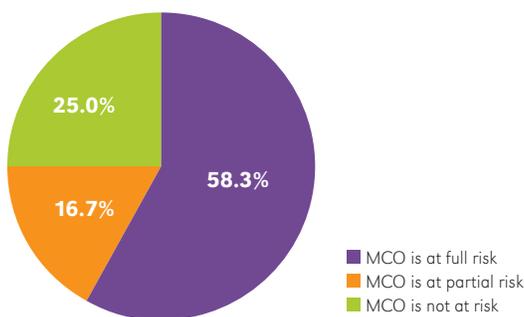


Figure 5 Risk in MCO Contracts



Risk in Contracts

As shown in Figure 5, most of the MCOs' contracts are risk based—more than half (58%) reported they are at full risk in most of their contracts. Only three of the MCOs are not at risk in their contracts, and two are at partial risk.

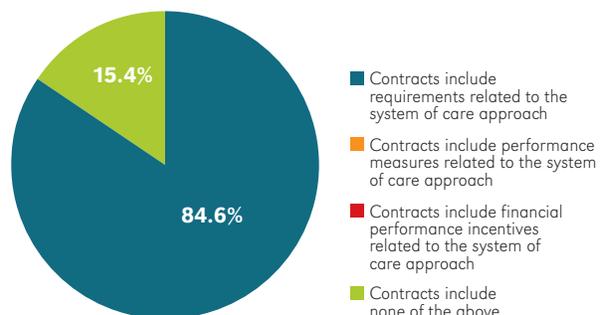
ALIGNMENT WITH THE SYSTEM OF CARE APPROACH

Inclusion of System of Care Requirements in Contracts

All of the respondent MCOs reported that most of their contracts with purchasers include language or requirements that are related to the system of care approach, even if the term “system of care” is not used. Despite contract requirements, none of the MCOs indicated that their contracts include either performance measures or financial performance incentives related to the system of care approach.

Similarly, most of MCOs (about 85%) include language or requirements related to the system of care approach in their contracts with the providers in their provider networks (Figure 6). However, none of them include performance measures or financial performance incentives related to these requirements.

Figure 6 Inclusion of System of Care-Related Requirements in Contracts with Provider Networks



Implementation of System of Care Principles

As noted, the system of care approach is based on a set of principles that guide service delivery to children and families, including:

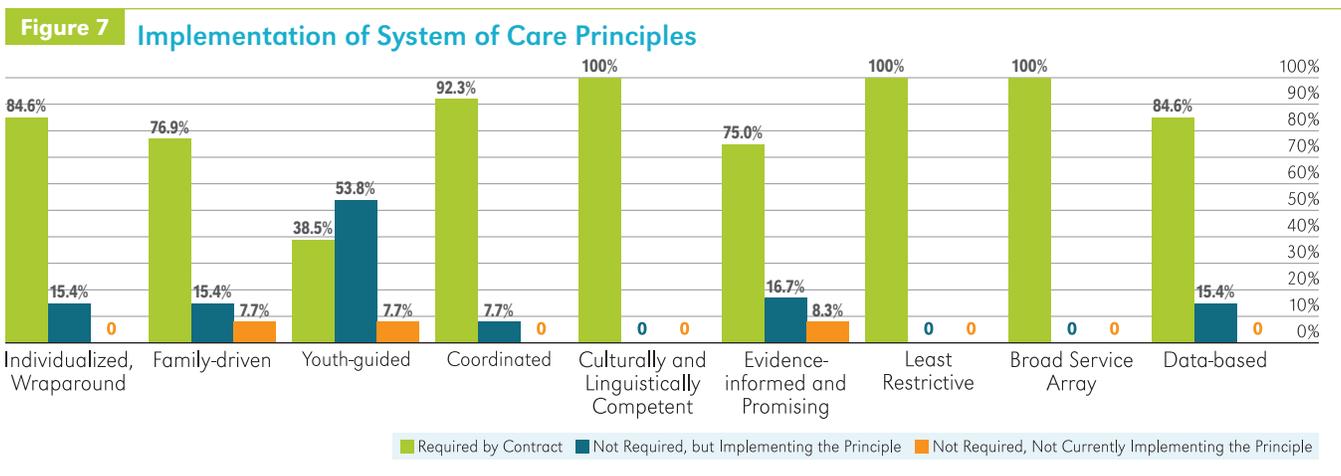
- Individualized, Wraparound approach to service planning and delivery (e.g., individualized child and family teams, individualized service plans)

- Family-driven approach (e.g., families have decision making role, included in child and family teams, have choices, parent/caregiver peer support is provided)
- Youth-guided approach (e.g., youth are active partners in services, included in child and family teams, have choices, youth peer support is provided)
- Coordinated approach (e.g., intensive care management for youth with serious and complex conditions, basic care coordination, coordination across agencies)
- Culturally and linguistically competent approach (e.g., culture-specific services, diverse providers, interpretation)
- Evidence-informed and promising practice approach (e.g., evidence-informed interventions, training for providers, best practice guidelines and protocols)
- Least restrictive approach (e.g., high utilization of home- and community-based services, decreased utilization of inpatient and residential treatment)
- Broad service array (e.g., comprehensive array of home- and community-based services and supports)
- Data-based approach (e.g., routine data collection on children’s behavioral health service utilization, quality, and outcomes)

Figure 7 depicts the implementation of these principles across the MCOs, indicating if each principle is:

1. Required by contract with their purchasers,
2. Not required by contract but they are implementing the principle anyway, or
3. Not required by contract and they are not currently implementing the principle at this time.

Figure 7 shows that all of the MCOs are required by contract to have a broad array of services and approaches that are culturally and linguistically competent and use the least restrictive home- and community-based settings. More than 75% of the MCOs are subject to requirements for all of the other principles, with the exception of a youth-guided approach which only about 39% of the MCOs are required to implement. However, more than half (54%) of the MCOs reported implementing the youth-guided principle even though it is not required.



Customization of Services for Youth with Serious Behavioral Health Conditions

The MCOs were asked if they tailor services and supports to children and youth with serious and complex behavioral health conditions. All of the MCOs indicated that services are customized for youth with serious conditions.

PROVISION OF HOME- AND COMMUNITY-BASED SERVICES

In addition to exploring the implementation of system of care principles, the scan examined the implementation of specific home- and community-based services by the MCOs. These services and supports are typically provided by systems of care as part of their comprehensive array of services. The scan focused on those services and supports specified in the joint bulletin issued by SAMHSA and the Centers for Medicare and Medicaid Services in 2013 detailing home- and community-based services for children’s behavioral health that are effective. The bulletin outlines authorities that can be used to cover these services under Medicaid.

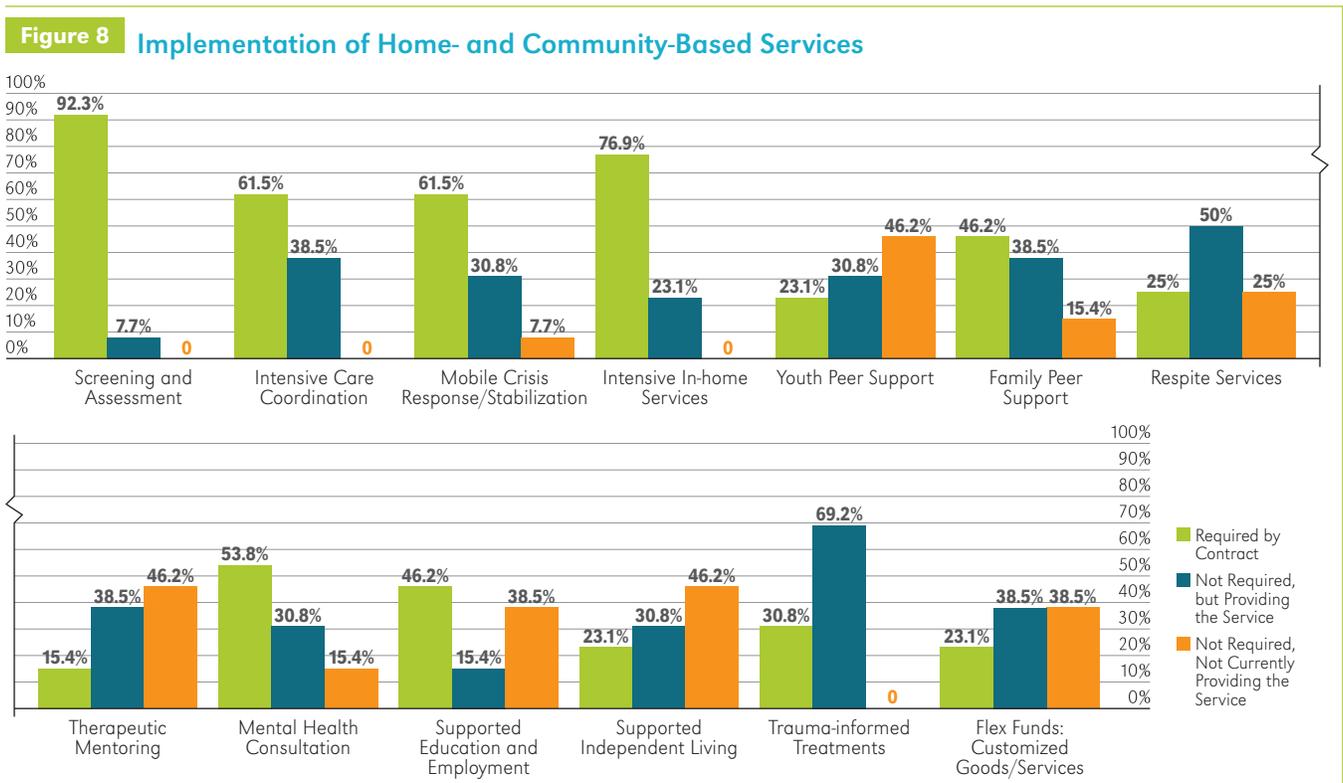
Figure 8 shows whether each service is:

1. Required by the purchaser in most of the MCO’s contracts,
2. Not required by contract but the MCO is providing the service anyway, or
3. Not required by contract and the MCO is not providing the service at this time.

The services most frequently included in MCO contracts are screening and assessment with standardized tools, which was reported as a requirement by over 90% of the MCOs, and intensive in-home services, reported as a requirement by 77% of the MCOs. Over 60% of the MCOs are required to purchase or provide intensive care coordination with a Wraparound approach and mobile crisis response and stabilization services. All of the other services reportedly are not required as frequently.

The MCOs indicated that a number of the services are purchased or provided even in the absence of requirements. Most provide trauma-informed treatments (69%) without specific requirements; half provide respite; and more than a third provide intensive care coordination, family peer support, therapeutic mentoring, and flex funds.

Several services emerged as least frequently required and not purchased or provided. Nearly half of the MCOs do not have contractual requirements for and do not provide youth peer support, supported independent living, and therapeutic mentoring.



PARTNERSHIPS WITH FAMILY AND/OR YOUTH ORGANIZATIONS

The MCOs were asked if they contract with family and youth organizations and/or with family and youth leaders for policy participation, to provide services such as peer support, or for other purposes. As shown in **Figure 9**, most of the MCOs reported having contracts with family organizations or family leaders (about 85%), but many fewer reported having contracts with youth organizations or youth leaders (about 39%).

CHALLENGES IN ALIGNING WITH THE SYSTEM OF CARE APPROACH

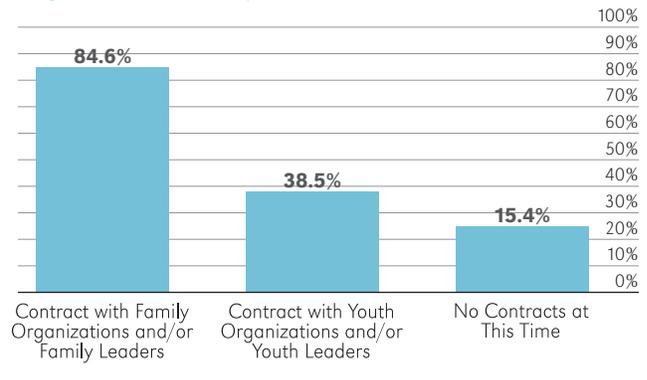
The scan asked the MCOs to note the most significant challenges they face in aligning with the system of care approach. The challenges cited most frequently related to working with various state agencies that may not be aligned with or buy into the approach. Comments suggested that agencies such as child welfare, juvenile justice, and juvenile courts may not be aligned, may see the approach as only a “mental health service,” and may have different priorities. Comments also noted challenges with respect to providers, specifically lack of buy-in or lack of coordination across providers.

Over 80% of the MCOs indicated that they would be interested in a self-assessment tool to assess their alignment with the system of care approach. The current Rating Tool for Implementation of the System of Care Approach (see Stroul, Dodge, Goldman, Rider, & Friedman, 2015) is being modified to create a version that is applicable to MCOs and provider agencies for this purpose.

DISCUSSION

With the low response rate, it is possible that the MCOs responding to the scan are those more familiar with the system of care approach. As a result, the responses may indicate greater congruence with the approach than would be found across a larger group of MCOs. The information gathered through this scan, however, can provide a starting point for a dialogue with MCOs at the national and state levels about the system of care approach and how they can increase their alignment.

Figure 9 Contracts with Family and Youth Organizations and/or Leaders



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