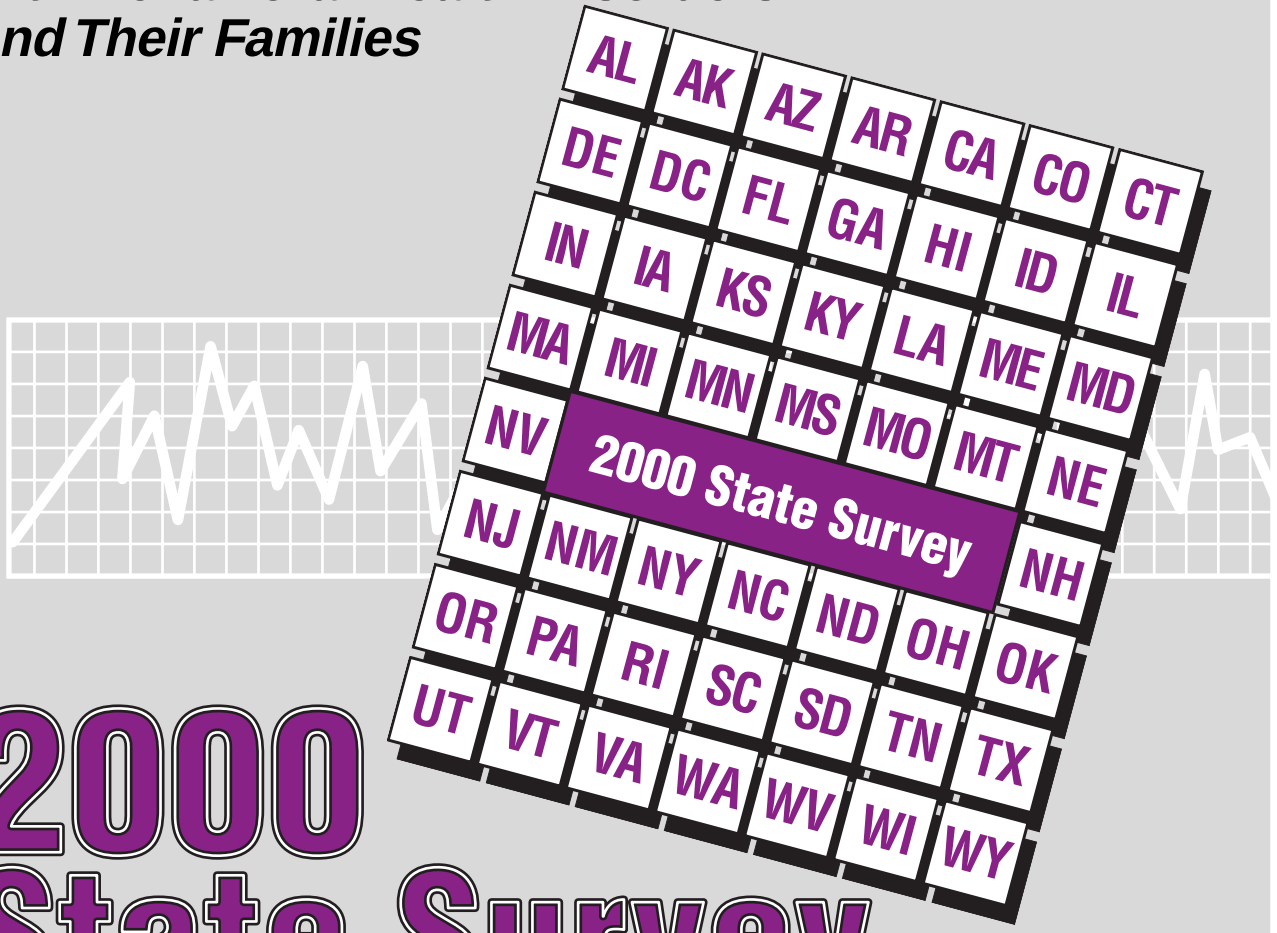
Health Care Reform Tracking Project:

Tracking State Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families



2000 State Survey

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Suggested APA Citation:

Stroul, B. A., Pires, S. A., Armstrong, M. I., (2001). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 2000 State Survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida.

FMHI Publication #198

Series Note: Health Care Reform Tracking Project, 2000 State Survey

First Printing: August 2001

This report was published by the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida with funding from the National Institute on Disability and Rehabilitation Research, US Department of Education and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services grant #H33D40023-97A, and the Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Partial Contents: Executive Summary — Introduction and Methodology — General Information about State Managed Care Initiatives — Populations Covered by Managed Care Reforms — Managed Care Entities — Service Coverage and Capacity — Special Provisions for Youth with Serious and Complex Behavioral Health Needs — Financing and Risk — Clinical Decision Making and Management Mechanisms — Access — Service Coordination — Early Identification and Intervention — Cultural Competence — Family Involvement — Providers — Accountability — State Child Health Insurance Program — Concluding Observations — Child Welfare Special Analysis — Technical Assistance Materials/Information — 2000 State Survey.

Available from:

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Acknowledgments

We would like to express our appreciation to the children's mental health representatives in each state who gave their time and effort to complete the 2000 State Survey. Their commitment to improving mental health services for children and adolescents and their families is evidenced by their prompt and thoughtful responses.

We also acknowledge the staff from the Louis de la Parte Florida Mental Health Institute who so ably assisted with study tasks including mailings, survey tracking, follow-up telephone calls, data entry and checking, data analysis, and report preparation. Special thanks go to Amy Quinlan, Jeana Matos, Mary Ann Kershaw, Kristina Chambers, and Bill Leader.

Throughout the Tracking Project, family members have played a vital role as members of the study team, participating in all aspects of the project, including survey design, data collection, data analysis, and report preparation activities. We would like to acknowledge and express our gratitude to Ginny Wood for coordinating these efforts and for her insights and contributions to the 2000 State Survey and to all other Tracking Project endeavors.

We also appreciate the partnership with the Child Welfare League of America (CWLA) Managed Care Institute to coordinate survey efforts to explore managed care reforms affecting children and families in the child welfare system. Special thanks go to Charlotte McCullough and Barbara Schmitt from CWLA, to Jan McCarthy from the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center, and to the Center for Health Care Strategies, Inc. in Princeton, New Jersey for making this coordination possible.

We wish to recognize and thank our funders for their support and recognition of the importance of this work, and our project officers for their continuing guidance and encouragement. We are grateful to the National Institute on Disability and Rehabilitation Research (NIDRR), U.S. Department of Education and to our NIDRR Project Officer, Rosanne Rafferty. In addition, we express our gratitude to the Child, Adolescent, and Family Branch of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. Particular recognition and thanks go to our CMHS Project Officers, Diane Sondheimer and Judith Katz-Leavy, for their ongoing support and mentoring throughout this project. Finally, we wish to acknowledge and express our appreciation to the Administration on Children, Youth, and Families of the Administration for Children and Families, U.S. Department of Health and Human Services for the additional financial support provided to the Tracking Project that has enabled us to incorporate a special focus on the child welfare population.

Beth A. Stroul
Sheila A. Pires
Mary I. Armstrong

Table of Contents

Page

Table of Contents (continued)

Page

Table of Contents (continued)

Page

Table of Contents (continued)

Page

Index of Tables & Matrices

Page

Index of Tables & Matrices (continued)

Index of Tables & Matrices (continued)

Page

VII. Financing and Risk

Index of Tables & Matrices (continued)

Page

Index of Tables & Matrices (continued)

Page

Index of Tables & Matrices (continued)

Executive Summary

The Health Care Reform Tracking Project was initiated in 1995 for the purpose of tracking and analyzing state and local, publicly financed managed care initiatives as they affect children and adolescents with behavioral health disorders and their families. It is co-funded by two federal agencies — the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services and the National Institute on Disability and Rehabilitation Research in the Department of Education. Supplemental funding has been provided by the Administration for Youth and Families of the Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to support a special focus on children involved with the child welfare system and special analyses of the effects of managed care initiatives on this population. The Tracking Project is being conducted jointly by the Research and Training Center for Children's Mental Health at the Louis de la Parte Florida Mental Health Institute, University of South Florida; the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center; and the Human Service Collaborative of Washington, D.C.

The Tracking Project is being undertaken during a period of rapid change in public sector health and human service systems. States, and, increasingly, local governments are applying managed care technologies to the delivery of mental health and substance abuse services (together referred to as "behavioral health services") for children and adolescents and their families in Medicaid, mental health, substance abuse, child welfare, and State Children's Health Insurance Program (SCHIP) systems. These public sector managed care reforms are the focus of the Health Care Reform Tracking Project. The Tracking Project is the only ongoing national study focusing specifically on the impact of these public sector managed care reforms on children and adolescents with behavioral health disorders and their families.

Since its inception, the Tracking Project has been exploring whether and how different kinds of managed care approaches and characteristics have differing effects on this population of children and adolescents and their families and on the systems of care that serve them. Throughout its activities, the Tracking Project has been comparing the characteristics and effects of managed care systems with two basic types of designs:

- **Carve Out Designs** — defined by the Tracking Project as arrangements whereby behavioral health services are financed and administered separately from physical health services.
- **Integrated Designs** — defined by the Tracking Project as arrangements in which the financing and administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted, in effect, creating a "sub-carve out").

The project's findings are intended to be useful to public officials, families, managed care entities, providers, advocates, and other key stakeholders involved in and affected by public sector managed care.

The methodology of the Tracking Project has involved two major components: 1) conducting periodic surveys of all states, and 2) conducting impact analyses through in-depth site visits to a select sample of states. To date, the Tracking Project has completed three state surveys and two impact analyses. The state surveys were designed *to identify and describe public sector*

managed care activity occurring in all 50 states and the District of Columbia that affects children and adolescents with behavioral health disorders and their families. The 1995 State Survey provided a baseline description of state managed care activity, which the 1997–98 and 2000 State Surveys updated by examining changes over time. In addition, a new focus was incorporated into the 2000 State Survey, *to identify promising strategies, approaches, and features of managed care systems* that can be studied and disseminated in an effort to assist states and communities to better meet the needs of children with behavioral health treatment needs and their families in the context of managed care.

While the state surveys were designed to identify and describe managed care activity, the impact analyses were conducted *to examine the impact of managed care activity* as perceived by multiple key stakeholders interviewed during site visits (to 10 states for the 1997 analysis and eight new states for the 1999 analysis) and as documented quantitatively to the extent that data were available. Another component of the 1999 Impact Analysis involved examining changes that occurred in the first sample of 10 states since the 1997 analysis through a series of telephone interviews with key stakeholders (referred to as the "maturational analysis"). Reports have been issued on the 1995 and 1997–98 State Surveys and on the 1997 and 1999 Impact Analyses; two special reports related to the child welfare systems also have been issued. This report documents the results of the 2000 State Survey, building on the previous work of the Tracking Project.

General Information about State Managed Care Initiatives

Description of Managed Care Initiatives

As in the previous surveys, in 2000 most states (42) reported involvement in publicly financed managed care activity affecting behavioral health services for children and adolescents and their families. Only two states reported no involvement in behavioral health managed care activity (either planned or implemented or previously planned or implemented). A slightly higher number of states (46) in 1997–98 reported involvement in managed care activity than in 2000, and, in addition, there were more reports in 2000 of states' terminating managed care reforms that were either planned or underway. These data do not necessarily suggest that states are beginning to move away from managed care for behavioral health services, but rather suggest the extent of experimentation underway in the states with managed care approaches and the political and technical challenges associated with managed care implementation. In fact, three new reforms were initiated since 1997–98. In response to the 2000 State Survey, respondents submitted *detailed descriptive data* on a total of 35 reforms underway in 34 states. *The analysis that follows pertains to these 35 reforms underway in 34 states.*

Of the 35 reforms described, 15 (42%) were identified by respondents as reforms involving only Medicaid, 16 (46%) were described as reforms involving both Medicaid and public behavioral health systems, 2 (6%) were described as involving only the public behavioral health system, and 2 (6%) were described as "other". Eight of the 35 reforms (23%) were described as reforms with integrated designs; (77%) were described as carve outs. Most of the reforms in the 2000 sample (71%) involve the use of a Medicaid waiver, but there has been a 15% decline in the use of Medicaid waivers since 1997–98. Most reforms in the 2000 sample (71%) are in late stages of implementation (defined as older than three years), representing more than a 50% increase over 1997–98, in which only

19% of reforms were in late stages of implementation. The 2000 data indicate that reforms implemented more recently (those in earlier stages) are more likely to have carve out designs, suggesting that states are continuing to experiment with carve out approaches for behavioral health service delivery for children and their families.

Inclusion of Substance Abuse Services

Reportedly, there has been an 11% decline in the percentage of reforms that include substance abuse in addition to mental health services since the 1997–98 survey. Given the known co-morbidity of mental health and substance abuse disorders, legitimate concern may be raised that over a third of the carve outs and a quarter of the integrated reforms do not include substance abuse services. The exclusion of substance abuse services from managed care systems may indicate a policy decision to create a safety net for those needing substance abuse treatment services and/or recognition that substance abuse treatment providers in a particular state may not have the capacity to operate in a managed care environment. When substance abuse services are not included with mental health services in the managed care system, reportedly, they remain fee-for-service in most cases (73% of the reforms not including substance abuse).

Goals of Managed Care Reforms

Improving quality and increasing access were cited most frequently as goals for managed care reforms (97% and 91% of reforms, respectively), findings similar to 1997–98 results. However, there has been a noticeable decline (14%) in the percentage of reforms in which cost containment is a stated goal. In contrast, improved accountability has increased as a goal (up 14% since 1997–98). Integrated reforms are more likely to focus on cost containment; carve outs are more likely to focus on improving accountability and also are twice as likely as integrated reforms to include as a goal expansion of the service array for children's behavioral health.

Lead Agency Responsibility

The state Medicaid agency is most likely to be the lead agency responsible for managed care reforms, having lead responsibility for 88% of the integrated reforms and 44% of the carve outs — overall 55% of the reforms. While state mental health agencies are playing a significant role in managed care affecting behavioral health service delivery, the 2000 findings, similar to those in 1997–98, indicate that the state Medicaid agency continues to be the predominant player in terms of lead agency responsibility.

Involvement of Key Stakeholders

Since its inception, the Tracking Project has been looking at the issue of key stakeholder involvement in the planning, implementation and refinement of managed care reforms. Both the 1997–98 State Survey and the 1999 Impact Analysis noted a gradual trend toward increased stakeholder involvement in managed care reforms, though both also found that most key stakeholder groups lacked *significant* involvement in most reforms. The 2000 survey found that key stakeholder groups continued to increase their involvement in managed care planning, implementation, and refinement activities since the 1997–98. Families and state agency staff from child mental health, substance abuse, child

welfare, and juvenile justice systems all increased significant involvement in managed care reforms to some extent. However, even with reported gains in involvement, significant involvement for all stakeholder groups, except child mental health staff and providers, occurs in fewer than half of the reforms. State education staff, the least likely stakeholder group to have involvement, reportedly has significant involvement in only 19% of reforms, in spite of the major role schools play in providing and referring for behavioral health services. Juvenile justice staff reportedly has significant involvement in only 23% of reforms, in spite of increased enrollment of the juvenile justice population in managed care. State substance abuse staff is involved significantly in just over a third of reforms, and child welfare staff in 46%. Families also reportedly have significant involvement in less than half (48%) of reforms — all carve outs — in spite of heightened national attention to amplifying the consumer and family voice in managed care systems.

Planning for Special Populations

The 2000 State Survey explored whether states engaged in discrete planning processes for certain special populations in managed care and found that planning for special populations in managed care has increased since 1997–98, with increased planning for children with serious emotional disorders (up 10%), children in child welfare (up 26%), and children in juvenile justice (up 24%). Most reforms reportedly now have a discrete planning process for children with serious emotional disorders (83%) and for children involved with the child welfare system (72%). However, even with increased planning, only about one-third of reforms engaged in discrete planning with respect to adolescents with substance abuse disorders or for culturally diverse children and adolescents.

Education and Training of Key Stakeholders About Managed Care

According to respondents, states are increasing efforts to educate and train key stakeholder groups about the goals and operations of managed care systems. Families, in particular, reportedly are receiving more education and training, with 16% more reforms engaged in such efforts in 2000 than in 1997–98. Large percentages of reforms, regardless of design, were reported to have engaged in educating and training, not only families, but providers, the child welfare system, the juvenile justice system, and other child serving systems, such as education.

Populations Covered by Managed Care Systems

As in 1997–98, about half of the reforms cover the total Medicaid population, and about half cover a portion of the Medicaid population. About half also cover the population eligible for the State Children's Health Insurance Program (SCHIP). Carve outs are far more likely than integrated reforms to cover the total Medicaid population (62% versus 12% of the integrated reforms), and over half of the carve outs (54%) also cover non-Medicaid, non-SCHIP populations (such as uninsured children and children whose families exhaust private coverage due to the severity of their children's disorders), compared to none of the integrated reforms. The 2000 survey data suggest acceleration of the trend noted in 1997–98 of states' covering more Medicaid populations, including those that would be expected to use more and costlier services, such as children with serious disorders, those involved in the child welfare and juvenile justice systems, and those eligible for Supplemental Security Income (SSI). There has

been a 22% increase in reforms covering the child welfare population, a 23% increase in the percentage of reforms covering the SSI population, and a 42% increase in reforms covering the juvenile justice population. These data also are consistent with findings in 2000 that states, increasingly, are including both acute and extended care services within their managed care systems as they include more populations requiring extended treatment.

Managed Care Entities

As in the two previous state surveys, many states reported using multiple types of entities to manage behavioral health service delivery within their managed care systems. The 2000 State Survey results show some decline in the use of for-profit MCOs both in carve outs and in managed care systems with integrated designs (18% decline, down to 29% of the reforms). This shift, however, is accompanied by a 7% increase (up to 41% of the reforms) in the use of for-profit behavioral health organizations (BHOs) perhaps indicating a trend toward the use of specialized behavioral health entities to manage behavioral health services, either through a direct contract with the state agency (which occurs in behavioral health carve outs) or through a subcontract to an MCO (which occurs in integrated physical health/behavioral health systems). The shift from generic MCOs to specialized BHOs is most notable among reforms with integrated designs. Despite these changes, there remains significant use of for-profit entities to manage behavioral health care across states. Another emerging trend noted in 1997–98 was an increase in the use of government entities as MCOs. This trend continues to be reflected in the 2000 survey data, with a 15% increase in the use of government entities from the last survey (now used in 44% of the reforms), occurring almost exclusively in carve outs. Community-based private, nonprofit agencies remain the least likely type of entity to be used by reforms as MCOs, used in only 15% of the reforms.

Both impact analyses found that in most states using commercial MCOs, stakeholders complained that these MCOs lacked familiarity with the Medicaid population in general, with children with emotional disorders in particular, as well as with the child welfare and juvenile justice populations. Training in these areas was cited as a significant need. Consistent with 1997–98 results, most reforms in 2000 (82%) reportedly have engaged in efforts to educate and train MCOs in a variety of areas, with training related to children and adolescents with serious emotional disorders and children and adolescents involved with the child welfare systems being areas of focus for training in the most managed care systems (55% and 52% respectively). Training related to home and community-based service approaches and to system of care values and principles was also reported by about half of the reforms. Training for MCOs on adolescents with substance abuse disorders was the area least likely to be addressed, regardless of managed care design, a finding consistent with the 1997–98 State Survey.

Service Coverage and Capacity

Coverage of Acute and Extended Care

One recommendation from the 1997 and 1999 Impact Analyses was to include both acute and extended care in managed care systems. For purposes of the Tracking Project, acute care is defined as brief short-term treatment with, in some cases, limited intermediate care also provided, and extended care is defined as care extending beyond the acute care stabilization phase, i.e., care required by children with more serious disorders and their families. The 1997–98 State Survey found that states were moving in

the direction of including extended care in managed care systems, and the 2000 State Survey suggests that this trend is continuing. Much of the increase in coverage of both acute and extended care in managed care systems is attributable to increased inclusion of coverage for extended care within integrated managed care systems, with 88% of integrated reforms covering both in 2000, compared with 44% in 1997–98.

Even though most reforms reportedly cover both acute and extended care, other child-serving systems still retain both responsibility and resources for extended care behavioral health services as well. The three systems most likely to have resources and responsibility for extended care services, in addition to the managed care system, are the child welfare system (94% of reforms), the children's mental health system (76%), and the juvenile justice system (76%). All of the integrated reforms indicated that these systems retain resources and responsibility for extended care. This finding suggests that although an increased percentage of integrated managed care systems reported that they include coverage for extended care, the extended care actually provided within these systems may be limited, resulting in reliance on these other child-serving systems for longer-term services.

Service Coverage

The 2000 State Survey showed an 18% increase in the percentage of reforms covering most or all (80 to 100%) of the list of services presented in the survey, up from 39% in the previous survey to 57% of all reforms in 2000. As in 1997–98, carve outs were far more likely to cover most or all of these services — 70% compared with only 13% of the integrated systems. Services most likely to be covered by managed care systems, according to the 2000 State Survey, include: assessment and diagnosis, outpatient psychotherapy, crisis services, medical management, day treatment, and inpatient services. The services least likely to be covered by managed care systems in 2000 include: therapeutic foster care, respite services, therapeutic group care, and residential treatment services. Consistent with previous survey results, coverage in reforms with integrated designs is more likely to be limited to traditional mental health services typically included in commercial insurance plans (such as assessment, outpatient services, medical management, and inpatient services); integrated systems are less likely to cover other services. In contrast, carve outs are more likely to include coverage for additional home and community-based services such as wraparound, home-based services, behavioral aides, crisis residential services, school-based services, respite services, therapeutic foster care, wraparound, and family support/education. When services are not covered under the managed care system, in most cases respondents reported that they are covered by another funding source in the state. In very few cases were services reportedly not covered by any source whatsoever.

The state surveys have explored whether managed care reforms have expanded the array of home and community-based services covered for children and adolescents. Similar to 1997–98 findings, the 2000 survey found that coverage for home and community-based services has been expanded in more than half of the reforms (57%), with carve outs far more likely to do so than integrated systems (63% versus 38%). Similarly, for the majority of reforms (81%), respondents indicated that the managed care reform has indeed made it easier to provide flexible/individualized care, but flexible/individualized service delivery reportedly is facilitated to a much greater extent in carve outs than in integrated systems (88% versus 50%).

Service Capacity

Although managed care reforms may have expanded *coverage* of home and community-based services, the impact analyses revealed that the actual *availability* of these services is a separate and distinct issue. Lack of sufficient service capacity for children's behavioral health services is a systemic issue that pre-dates managed care reforms, and managed care has not necessarily resulted in improvements. Consistent with findings from the impact analyses, significant expansion of the availability of home and community-based services was found in only about one-third of the reforms – all carve outs. Another quarter of reforms reported some expansion of service capacity for home and community-based services. However, 42% of the reforms reported either very little expansion in the availability of services or no service capacity expansion at all. This is in spite of the fact that, as noted, 91% of the reforms focus on expanded access as a managed care goal. Carve outs were far more likely than integrated systems to have expanded service availability (73% versus 12%). However, in only 31% of carve outs and in none of the integrated reforms (24% of all reforms) was behavioral health service capacity for children and adolescents in the state rated as highly developed or close to highly developed. Yet, respondents also reported a 16% decline since 1997–98 in the percentage of reforms that require reinvestment of savings to expand service capacity.

Services to Young Children and Their Families

As in 1997–98, few services reportedly are provided to infants, toddlers, pre-schoolers and their families through managed care systems, with half of the carve outs and three quarters of the integrated reforms reportedly providing "few to no" services to this population.

Special Provisions for Youth with Serious and Complex Behavioral Health Needs

Incorporation of Special Provisions for High Need Populations

An issue emphasized by stakeholders in both of the impact analyses is the need for managed care systems to incorporate special services, arrangements, or provisions for children and adolescents with serious and complex behavioral health needs and their families: children and adolescents with serious emotional disorders, children and adolescents involved with the child welfare system, and children and adolescents involved with the juvenile justice system. The 2000 State Survey results show a dramatic increase (44%) in the incorporation of special provisions for children and adolescents with serious emotional disorders, with a shift from less than half of the reforms having any special provisions to the majority of reforms indicating that they now do (93%). This shift may be the result of recognition of the special needs of this population over time, due to the many problems and challenges encountered in attempting to serve them within the context of managed care systems. The findings continue to reflect the previously established pattern of a greater likelihood of special provisions in managed care systems with carve out designs; however, a substantial proportion of integrated systems also reported having

some special provisions for this group. In 2000, 87% of the managed care reforms also reportedly have special provisions of some type for children and adolescents in the child welfare system and nearly two-thirds (60%) have provisions for children and adolescents in the juvenile justice system.

Of the special provisions for high need youth, most take the form of interagency treatment and service planning, intensive case management, an expanded service array, family support services, or wraparound services. However, few reforms with special provisions include a higher capitation or case rate for these youth, suggesting that although special provisions such as expanded services or intensive case management are included, the resources to provide these additional services to these high need populations may not be sufficient.

Support for Systems of Care

An important focus of the Tracking Project has been to assess the link between efforts to develop community-based systems of care for children and adolescents with serious behavioral health disorders and their families and managed care initiatives in states. The 2000 State Survey examined whether managed care reforms, in general, have facilitated and supported the further development of local systems of care for children and adolescents with serious behavioral health disorders. Most reforms (75%) were thought to facilitate and support local systems of care, but the difference between carve outs and integrated reforms was substantial. Managed care reforms reportedly are supportive of systems of care in the majority of the carve outs (88%) but in only 29% of the integrated reforms. The 2000 State Survey, as in 1997–98, also found striking differences between behavioral health carve outs and integrated systems in the extent to which system of care values and principles are included in their system documents, and thus are incorporated into managed care systems. Behavioral health carve outs have a much higher rate of inclusion of all of these principles, such as a broad array of services, family involvement, and interagency service planning which are incorporated by nearly all (92%) carve outs, although more than half of the integrated systems (57%) reportedly incorporate most principles as well.

Financing and Risk

As in 1997-98, the 2000 State Survey found that Medicaid and mental health agencies are the primary sources of financing for managed care systems, with Medicaid agencies contributing in 91% of the reforms and mental health agencies contributing in 76% of the reforms. All of the integrated reforms reportedly involve Medicaid financing, as well as most of the carve outs (88%). There has been a significant (20%) increase since 1997-98 in reforms with mental health agency financing (up to 76% in 2000), though carve outs are far more likely to involve mental health agency financing than integrated systems (96% versus 13%).

In comparison to the large proportion of reforms involving financial contributions from Medicaid and mental health agencies, the proportion of reforms involving contributions from other agencies is small and may be decreasing; the 2000 survey found declines in the participation of other agencies since 1997-98. Carve outs are far more likely than integrated systems to use dollars from other child serving systems. However, even with the greater use of

resources from other systems in carve outs, overall the child welfare system contributes in only 21% of the reforms, the juvenile justice and substance abuse systems in only 9%, and the education system in none of the reforms.

There is little difference between carve outs and integrated reforms in use of Medicaid, TANF, and SCHIP dollars. However, there are significant differences in the extent to which each uses *other* types of dollars, with carve outs being far more likely to use state general revenue, block grants, and child welfare dollars. Carve outs are far more likely to draw on multiple funding streams from multiple agencies, and integrated systems are more likely to rely almost exclusively on Medicaid and SCHIP dollars contributed by the Medicaid agency.

Further, virtually all reforms (91%) leave Medicaid dollars for behavioral health services for children outside of the managed care system. Reportedly, the education system is most likely to be using Medicaid dollars outside of managed care (in 81% of reforms), but all other child-serving systems (i.e., child welfare, mental retardation/developmental disabilities, juvenile justice, and child mental health) also are using Medicaid dollars outside of managed care (in 72% to 50% of reforms, depending on the system). Thus, even though more managed care reforms include coverage for both acute and extended treatment, other child-serving systems still retain responsibilities and funding for behavioral health service provision outside of managed care systems. This reality may create a safety net for children unable to access needed services through the managed care system, but it also perpetuates opportunities for fragmented care and cost shifting.

Cost Shifting

In only about one-third (32%) of reforms did survey respondents report that cost shifting was *not* occurring. Thus, cost shifting reportedly is occurring in most reforms, and interesting differences between carve outs and integrated reforms with respect to the direction were found. In nearly three-quarters (71%) of the integrated reforms, cost shifting occurs from the managed care system to other child-serving systems, while this reportedly occurs in only 24% of the carve outs. On the other hand, in over half of the carve outs (52%), respondents reported that cost shifting was occurring from other children's systems to the managed care system, while this was reported to be the case in only 14% of integrated reforms. These findings suggest that, in states with carve outs, other child serving systems may be taking advantage of the broader benefit array and flexibility provided by the managed care system. In contrast, in states with integrated reforms, with their more traditional, acute care benefits, other child serving systems may be forced to provide and pay for services as managed care systems identify children but fail to provide the necessary duration or scope of services. Drawing conclusions about cost shifting remains problematic in any event, since the majority of states are not tracking and monitoring cost shifting in any systematic way; only 16% reported tracking cost shifting.

Risk Structuring

Most reforms (88%) use some type of risk-based financing, with 62% of reforms using capitation and 26% using case rates. Only 24% of reforms, including twice as many carve outs as integrated reforms, use neither capitation nor case rates. Consistent with findings in 1997–98, none of the integrated reforms requires that a specified percentage of the overall capitation rate be allocated to behavioral health care. Fewer than a third of reforms (29%) use risk adjusted rates for high need populations of children and adolescents, such

as those in the child welfare and juvenile justice systems and those with serious disorders. Where risk adjusted rates are being used, they are most likely to be in place for children and adolescents with serious behavioral health disorders (70% of reforms with risk adjusted rates); fewer reforms incorporate risk adjusted rates for the child welfare population (40% of the reforms with risk adjusted rates) or the juvenile justice population (20% of the reforms with risk adjusted rates). Also, fewer than one-fifth of reforms, regardless of design, use other risk adjustment mechanisms of any kind. Given the increased enrollment of high need populations in managed care reforms, the low incidence of use of risk adjusted rates and other risk adjustment mechanisms raises a question about the adequacy of safeguards to protect against underservice.

More states seem to be structuring their managed care reforms to incorporate risk sharing arrangements with MCOs than was the case in 1997–98 (20% fewer are pushing full risk to MCOs in 2000), and the 2000 State Survey also found that most reforms (75%) push risk to the behavioral health provider level, a 25% increase over 1997–98. Slightly more than half of reforms (55%) place limits on MCO profits, and about half limit administrative costs. As in 1997–98, carve outs are far more likely than integrated reforms to limit MCO profits. Carve outs also are more likely to tie bonuses or penalties to MCO performance with respect to behavioral health care.

Clinical Decision Making and Management Mechanisms

The 2000 State Survey found that, in fact, the majority of managed care systems (82%) reportedly now have medical necessity criteria that allow consideration of psychosocial and environmental factors in clinical decision making. Problems are more evident, however, with respect to MCO interpretation of medical necessity criteria. In 82% of the carve outs, MCOs reportedly interpret medical necessity criteria broadly to include psychosocial and environmental considerations, but this occurs in only 40% of the managed care systems with integrated designs. Thus, it appears that while most managed care systems have medical necessity criteria that allow consideration of psychosocial and environmental factors, MCOs (primarily those in systems with integrated designs) may still be interpreting and applying these criteria narrowly, without sufficient attention to these issues. Approximately two-thirds of the managed care reforms (67% in 1997–98 and 63% in 2000) reportedly incorporate clinical decision making criteria specific to children and adolescents, again far more likely in carve outs than in integrated systems. Overall, 62% of the reforms with child-specific criteria reportedly have increased consistency in clinical decision making by using these criteria.

As could be predicted, most reforms (two-thirds or more) reported using all the management mechanisms typically associated with managed care systems. The most commonly used management tool in 2000 reportedly is prior authorization, used in 77% of the reforms and also reported as one of the most frequently used management mechanisms in 1997–98. Prior authorization was closely followed by concurrent review, used in 74% of the reforms. About three-quarters of the reforms (76%) — all of the reforms with integrated designs and more than two-thirds of the carve outs — do allow certain services to be provided without prior authorization. According to stakeholders interviewed for the impact analyses, this practice reduces the perceived burden associated with prior authorization and makes the requirements less onerous.

Access

An assessment of the effect of managed care reforms on initial access to behavioral health services in the 2000 State Survey found that, overall, initial access is considered to be improved by managed care reforms in 70% of the total sample. However, survey results also confirmed the observation that initial access is likely to be better in systems with carve out designs and less likely to be found in integrated systems (76% of the carve outs compared with 50% of the integrated systems reported better access). Reports of worse initial access were found in one-third of the integrated systems as compared with only 10% of the carve outs. This finding is particularly significant given that improving access to behavioral health services was a goal reported for most reforms (more than 90% in both 1997–98 and 2000).

Though some improvement in initial access to behavioral health services is evident in the 2000 survey results, access to extended care services remains more problematic. In both impact analyses, there was a widespread perception that it was more difficult to obtain care beyond a certain basic level and that accessing extended care services was more difficult post-managed care reforms. The 2000 State Survey found that access to extended care services reportedly is worse in nearly two-thirds (60%) of the reforms with integrated designs and improved in only 20%. In contrast, access to extended care was characterized as better in 39% of the reforms with carve out designs and was reported to have declined in only 4%.

The 1997 and 1999 Impact Analyses found that stakeholders in most states perceived inpatient services to be more difficult to access as a result of managed care reforms. The 2000 State Survey found that initial access to inpatient care is not considered to be more difficult in most cases as a result of managed care reforms; only 20% of the reforms reported this to be the case. Much more significant, however, is the observation that inpatient lengths of stay are shorter — reported for more than half of the carve outs (56%) and nearly all of the integrated systems (88%). A host of problems associated with changes in access and length of stay in inpatient care were reported, all of which are more significant in reforms with integrated designs than in carve outs. For example, premature discharge before stabilization, children discharged without needed services, and placement in community programs without the clinical capacity to serve them all reportedly occur in about one-quarter of the carve outs and in more than 40% of the integrated systems. Further, inappropriate use of child welfare shelters was reported in 8% of the carve outs and in 43% of the integrated reforms. Similarly, inappropriate use of juvenile justice facilities was reported in 13% of the carve outs and 29% of the integrated systems. The use of residential treatment as a substitute for inpatient services was reported equally among carve outs and integrated systems, occurring in 29% of each. Though more likely in carve outs, both carve outs and integrated systems indicated efforts to develop alternatives to hospitalization – nearly two-thirds (62%) overall have done so. It remains disconcerting, however, that one-third of the carve outs and half of the integrated reforms (38% of the reforms overall) reportedly are not developing alternatives to hospitalization, despite the finding that reduced access and, particularly, reduced length of stay in inpatient settings, and the associated problems, are widespread.

Service Coordination

The 2000 State Survey found improved coordination between physical health and behavioral health services in 60% of the reforms, while in one-third of the reforms, managed care reportedly has had no effect on service coordination. Coordination of physical health and behavioral health services reportedly has worsened in only 7% of the reforms. Despite the

arguments that integrated managed care system designs would improve coordination between physical and behavioral health services, improved coordination was reportedly improved at fairly equal rates among integrated systems (57% reported improved coordination) and carve outs (61% reported improved coordination). These results suggest that states may be devoting increasing attention to the need for improved coordination between physical and behavioral health services and that specific efforts to address this problem, rather than the design of the managed care system, are likely to be associated with improvements. The 2000 survey also shows some improvement in coordination between mental health and substance abuse, with improvements noted in slightly over half (52%) of reforms, again with little difference between carve outs and integrated reforms.

Consistent with previous Tracking Project findings, two-thirds (65%) of the reforms in 2000 reported improved interagency coordination among child serving systems as a result of managed care reforms. Improvement in interagency coordination is more likely in carve outs (71%) than in integrated reforms (43%) and has been attributed by stakeholders to the need to solve problems created by the implementation and ongoing operation of managed care systems.

Cultural Competence

A widespread perception among stakeholders interviewed for the impact analyses was that lack of cultural competence is a problem that pre-existed managed care reforms, and that managed care had little impact in this area. The 2000 State Survey explored the use of a range of strategies that potentially could be used to address and enhance cultural competence within managed care systems, including: special planning for culturally diverse populations, incorporating requirements related to cultural competence in RFPs and contracts, training MCOs and/or providers on cultural competence, outreach to culturally diverse populations, inclusion of specialized services needed by culturally diverse populations, inclusion of culturally diverse providers in provider networks, translation/interpreter services, and tracking utilization and/or outcomes by culturally diverse groups. Of these strategies, two emerged as the most widely utilized among managed care systems, according to respondents. Requirements related to cultural competence reportedly are included in RFPs and contracts in 85% of the reforms, and translation/interpreter services are provided in 82%. Both strategies are utilized at high rates by both carve outs and managed care systems with integrated designs. All other strategies are much more likely to be used in carve outs. For example, nearly half of the carve outs reportedly include special services needed by culturally diverse populations, in addition to translation/interpreter services, compared to none of the integrated reforms, which tend to provide translation/interpretation services only. Nearly half of the carve outs reportedly track utilization and outcomes by culturally diverse groups, compared to none of the integrated reforms.

Comparing the requirements related to cultural competence under the managed care system with the previous system, about two-thirds of the reforms (64%) reported having stronger cultural competence requirements than previously. Very few reported weaker cultural competence requirements under managed care (3%), and in one-third of the reforms (33%) managed care has had no effect on cultural competence requirements. These findings are consistent across carve outs and integrated reforms.

Family Involvement

The 2000 State Survey investigated family involvement by assessing whether or not managed care systems incorporate a range of strategies for involving families at both the system and service delivery levels, including: requirements in RFPs and contracts for family involvement at the system management level, requirements in RFPs, contracts, and service delivery protocols for family involvement in planning and delivering services for their own children, focus in service delivery on families, in addition to the identified child, coverage for and provision of family supports, use of family advocates, and hiring families and/or youth in paid staff roles.

The most frequently reported strategy, noted for nearly two-thirds (64%) of the reforms, was incorporating a focus in service delivery on families, in addition to the identified child. This strategy was followed closely by coverage for and provision of family supports, which reportedly are incorporated in 58% of the reforms. More than half of the reforms also reported including requirements for family involvement at the system management level in managed care systems (55%), as well as requirements for family involvement at the service delivery level in treatment planning and service delivery for their own children (52%). The use of family advocates and hiring family members or youth in paid staff roles were strategies reported with less frequency. Striking differences between carve outs and integrated systems were found with respect to all of these family involvement strategies. Between 62% and 73% of the carve outs reportedly incorporate most of the family involvement strategies, compared with none to a high of 29% of the integrated systems. In fact, 29% of the integrated reforms reported that none of the family involvement strategies are incorporated in their systems.

Requirements for family involvement at both levels are far more likely to be found in carve outs — 69% incorporate system-level involvement requirements compared with none of the integrated systems, and 62% include service-delivery level requirements compared with only 14% of the integrated systems. Family involvement requirements reportedly are stronger in 76% of all managed care systems than they were in previous systems. A substantially higher proportion of the carve outs (85%) were reported to have stronger requirements for family involvement than integrated reforms (42%). Despite this finding that requirements for family involvement are stronger in most managed care systems than they were previously, stakeholders interviewed for the impact analyses cited discrepancies (in this, among other areas) between managed care policy requirements and what actually is occurring in implementation, raising questions as to the degree to which requirements for family involvement are operationalized.

The perception of stakeholders interviewed for the impact analyses was that the focus of services in managed care systems was limited to the identified child, and that family needs typically are neither considered nor addressed. The 2000 State Survey revealed a more encouraging picture. Nearly two-thirds of the managed care systems (64%–73% of carve outs and 29% of integrated reforms) reportedly do include a focus on families in service delivery, in addition to focusing on the identified child. Similarly, 58% of managed care systems (65% of carve outs and 29% of integrated reforms) reportedly include coverage for family support services. In both cases, carve outs are far more likely to incorporate a greater family focus. About half of all reforms reportedly pay for services to family members when only the child is covered.

In the majority of cases (83%), managed care reforms reportedly have not affected, either positively or negatively, the practice of relinquishing custody in order to receive needed but expensive behavioral health services.

Providers

Previous Tracking Project findings suggested that managed care reforms are "opening up" provider networks. At the same time, stakeholders interviewed observed that smaller and nontraditional agencies were struggling to participate in managed care systems, largely due to a lack of administrative infrastructure, fiscal challenges involved in moving from grant funding to a reimbursement rate structure, and the inability to take on financial risk. In addition, credentialing requirements were reportedly impeding the participation of particular types of providers in managed care provider networks, most notably certified addictions counselors.

The 2000 State Survey found that managed care systems, reportedly, most frequently include culturally diverse and indigenous providers in provider networks (82% do so); about two-thirds of all reforms reportedly include certified addictions counselors (68%) and school-based behavioral health providers (62%). For other types of nontraditional providers, carve outs were far more likely to report including them in managed care networks than were integrated reforms. For example, child welfare providers reportedly are included in 65% of the carve outs as compared with only 13% of the integrated systems, and paraprofessionals and student interns are included in 62% of the carve outs compared with 13% of the integrated systems. The use of family members as providers was reported for 42% of the carve outs but for none of the integrated systems. Overall, family members comprised the group least likely to be included in networks as service providers.

Respondents in more than two-thirds of the reforms (68%) indicated that new credentialing requirements associated with managed care reforms were not impeding the inclusion of particular types of providers in managed care systems. However, administrative burden for providers was reported to be higher under managed care than it was previously in nearly two-thirds of reforms (61%). Further, in about one-third of reforms, provider reimbursement rates reportedly are lower under managed care. Provider reimbursements rates are far more likely to be lower in integrated systems — 57% of integrated systems reportedly have lower provider payment rates than under the previous system, compared with only 25% of the carve outs. In almost one-quarter of reforms (23%) provider reimbursement rates reportedly are higher under the managed care system, a finding more likely to be seen in carve outs; reimbursement rates are unchanged in nearly half of the reforms. The finding that rates are either lower or unchanged from previous fee-for-service systems in most managed care systems, combined with the finding that administrative burden is higher as a result of most managed care reforms, suggests that providers are facing financial problems as a result of managed care. Despite reports of financial problems, the 2000 survey found that in most reforms (73%), managed care has reportedly not led to closure of provider agencies.

Accountability

Collection and Use of Data

The 2000 State Survey found that, across all reforms, adequate data for behavioral health care decision making reportedly are available in 59% of the reforms, though adequate data were more likely in carve outs than in reforms with integrated designs. However, a substantial percentage of reforms (41% overall) reportedly do not have adequate data. The significance of this reported lack of adequate data for behavioral health care decision making increases when juxtaposed with the goal of many managed care reforms to enhance data-based decision making and accountability. In reforms

without adequate data to guide behavioral health decision making, the most frequently cited reasons were inadequate MISs (cited by 57% of the reforms with inadequate data), lack of encounter data (cited by 50% of the reforms with inadequate data), and lack of staff capacity to analyze data that are collected (cited by 36% of the reforms with inadequate data).

The three areas reportedly measured most frequently are behavioral health service utilization (measured by all reforms), total cost of behavioral health services (measured by 93% of the reforms — 96% of carve outs and 21% of integrated systems), and access as gauged by child behavioral health penetration rates (measured by 85% of the reforms). The two types of performance information least likely to be tracked by managed care systems reportedly are behavioral health services used by children in the juvenile justice system, tracked by fewer than half of the reforms (46%), and cost shifting among child serving systems, tracked by only 16% of the reforms.

For most types of performance information, even if it is collected, respondents generally reported that the information is used for system planning in only about one-third to one-half of the reforms that collect the information. The gap between information that is tracked and information that is used for system planning that emerged from the 2000 State Survey and previous Tracking Project activities indicates that this continues to be a problem for managed care systems — generating data in a form and in a time period that is relevant and helpful for planning and decision making.

Quality and Outcome Measurement

The majority of reforms responding to the 2000 State Survey also reported including some child-specific measures in their quality measurement systems for behavioral health (71%), although this represents a 17% decrease in reforms with child-specific quality measures since 1997–98. Carve outs reportedly are more likely to have child-specific quality measures. The 2000 survey also revealed a continuing increase in the measurement of clinical and functional outcomes in managed care systems, up from 51% in 1995 to 63% in 1997–98, with a 27% increase to 90% of the reforms in 2000. Despite increased attention to this area, the early stage of development of these outcome measurement systems is still evident, as it was in previous findings. In 44% of the reforms, outcome measurement was described as being in an early stage of development, and an additional 4% reported that the system was developed but not yet implemented. Another 26% described their outcomes measurement systems as implemented, but with no results available as yet. Carve outs reportedly are ahead of integrated systems in the measurement of clinical and functional outcomes for children's behavioral health. Only about one-quarter (26%) of the reforms – all carve outs – have results from the measurement of clinical and functional outcomes, according to the 2000 State Survey.

Just as increases were noted over time in measurement of clinical and functional outcomes, similar increases were reported in the measurement of parent satisfaction– 69% of the reforms reported measuring parent satisfaction in 1995, 80% in 1997–98, and 91% in 2000 (an 11% increase since the last survey). Both carve outs and integrated systems measure parent satisfaction at high rates — 92% of the carve outs and 86% of the integrated systems. Youth satisfaction receives less attention overall; only 56% of the reforms reported assessing youth satisfaction.

Impact Findings

A new area of exploration for the state surveys was implemented in 2000 by incorporating an assessment of the impact of managed care reforms on various indicators: child behavioral health penetration rates, overall child behavioral health utilization, total cost of child behavioral health services, overall clinical and functional outcomes, and overall family satisfaction with services. The most striking finding is that in each of these areas, substantial numbers of respondents reported that the impact of managed care reforms is not known. For example, in 41% to 46% of the reforms, the impact on managed care reforms on penetration rates, service utilization, cost, quality, and family satisfaction remains unknown. In 63% of the reforms, the impact on clinical and functional outcomes is not known. Given the managed care reform goals of increasing access, improving quality, containing costs, and improving accountability, the lack of information on system performance in these areas seems critical.

Where effects were reported, however, most were in a positive direction:

- 41% of the reforms with data reported an increase in child behavioral health penetration rates
- 34% reported an increase in overall child behavioral health service utilization
- 38% reported an increase in the overall quality of services
- 24% reported an increase in overall clinical and functional outcomes
- 31% reported an increase in overall family satisfaction with services.

Negative effects reported in these areas were significantly lower, ranging from 3% to 19% of the reforms. In general, positive effects were more likely to be reported for carve outs, and negative effects were more likely to be reported for integrated managed care systems.

Although an explicit and major goal of managed care reforms is to control costs, reported results in this area were mixed. Increased aggregate costs were reported in some reforms (about 25% of the reforms), decreased aggregate costs were reported in fewer (19%), and costs reportedly remained constant in others (16% of the reforms).

State Child Mental Health Insurance Program (SCHIP)

The 2000 State Survey investigated SCHIP and its relationship to states' Medicaid managed care reforms. Reportedly, 29 states (57%) have implemented SCHIP as a Medicaid expansion, and 28 states (55%) have developed separate programs from Medicaid for their SCHIP implementation. Six states have adopted a combined approach, with some subpopulations falling under a Medicaid expansion and other subpopulations covered through a separate program. Two-thirds of SCHIP programs were characterized as having a broad behavioral health benefit; the remainder were characterized as limited, with the types of day and visit limits more akin to commercial insurance plans. Additional analyses of these data revealed that SCHIP behavioral health benefits are more likely to be broad when SCHIP programs are designed as Medicaid expansions. Limited SCHIP benefits are strongly associated with separate SCHIP programs; 82% of separate SCHIP programs were characterized as having limited behavioral health benefits, as compared with only 18% of the Medicaid expansions.

In 87% of states with a separate SCHIP program, efforts reportedly are being made to coordinate Medicaid and SCHIP programs. A concern, however, is that less than half (43%) of the separate SCHIP programs incorporate strategies for the identification and referral of children with behavioral health needs. More than half of the states (57%) reported that no data are available regarding the impact of SCHIP on the delivery of children's behavioral health services. About one-third of states (35%) indicated that more children and adolescents are receiving behavioral health services as a result of SCHIP.

Child Welfare Special Analysis

A specific focus on child welfare issues has been incorporated into all aspects of the Tracking Project. The 2000 State Survey explored a number of issues related to the impact of behavioral health managed care reforms on children and adolescents involved with the child welfare system and their families. Most states now include children in the child welfare systems in their behavioral health managed care systems; 82% of the reforms analyzed for the 2000 State Survey reportedly include this population, increased from only 45% that included the child welfare population in 1995 and 60% that included the child welfare population in 1997–98. Findings from the 2000 State Survey demonstrate that many concerns of child welfare stakeholders are being addressed. For example:

- Most reforms have special provisions for children in the child welfare systems (87%).
- Most reforms provide training for the child welfare system about managed care (72%).
- More than half of the reforms train MCOs about the unique needs of children and families in the child welfare system (52%).
- Most reforms include medical necessity criteria that allow for consideration of psychosocial and environmental factors in clinical decision making (82%).
- Nearly two-thirds of the reforms have incorporated strategies for clarifying responsibilities for service provision and payment across child-serving systems (64%).
- Most reforms are able to track the use of behavioral health services for children in the child welfare systems (74%).

On the other hand, a number of concerns reportedly have not as yet been addressed:

- In 54% of the reforms, the child welfare system is *not significantly* involved in planning, implementing, and refining the behavioral health managed care system.
- Only 11% of the reforms have an enhanced capitation or case rate for children in the child welfare system.
- Children in the child welfare and juvenile justice systems can lose eligibility for the managed care system based on being in particular types of placement in 73% of the reforms.
- Fundamental services used by children in the child welfare system are not covered in nearly half of the managed care systems (e.g., therapeutic foster care, therapeutic group homes, respite services, and residential treatment).
- Although most reforms track utilization for children in the child welfare system, only 35% actually use this information for system planning.
- Child welfare providers are not included in provider networks in 47% of the reforms.

- Even with broadened medical necessity criteria, in 46% of the reforms, the criteria for making clinical decisions differ with each MCO (which is especially problematic for children who move frequently).
- Half of the managed care systems do not pay for services to family members of the identified child unless the family is covered.

The special child welfare analysis included in this report also compares findings from the 2000 State Survey to findings from a survey conducted by the Child Welfare League of America in order to further understand issues related to children and families involved with the child welfare systems.

Concluding Observations

Through the three state surveys and two impact analyses conducted to date, the Tracking Project has identified areas of progress — mostly at the system design and policy level — that suggest that managed care systems have taken some steps to be more responsive to the needs of children and adolescents with behavioral health treatment needs and their families. For example, a trend toward increased stakeholder involvement in managed care system planning, implementation, and refinement activities has been noted as well as a trend toward covering a broader service array, including increased coverage for home and community-based services, incorporating special provisions for high need children and adolescents, broadening medical necessity criteria to allow consideration of psychosocial and environmental factors, and incorporating a family focus in service delivery. Despite these areas of progress, however, a number of areas of concern remain, leaving questions as to the quality and appropriateness of behavioral health services for children and adolescents and their families within managed care systems. For example, responsibility and resources for children's behavioral health services are still retained by other child-serving systems creating continued opportunities for fragmentation and cost shifting, the availability of home and community-based services has not expanded significantly in most states, higher rates or risk adjustment mechanisms are rarely used to support service provision to high need populations, MCOs continue to interpret medical necessity and other clinical decision making criteria narrowly, access to extended care services reportedly is more difficult in many managed care systems, and requirements for family involvement may not be operationalized at the implementation level.

Publicly financed managed care continues to present opportunities and challenges for children's behavioral health care. States and counties are becoming more sophisticated designers and purchasers, and, particularly in the case of carve outs, often incorporate specifications that would seem to benefit children needing behavioral health care. However, managed care implementation continues to lag behind policy intentions. Broad benefit designs are hampered by lack of service capacity, and broad medical necessity criteria designed by states are rendered meaningless by narrow interpretation at the MCO level. Greater attention is paid to special needs populations in planning and policy as states increasingly enroll these populations in managed care, but training of MCOs about these populations and changes in financing to guard against underservice does not necessarily follow.

The design and implementation of managed care is a developmental process. States are beginning to turn their attention to implementation problems, and most have made mid-course corrections in policy and design. Particularly in states with integrated designs, children with behavioral health disorders typically have not emerged initially as a priority population. Through the efforts of family members, advocates, and researchers, and as a result of their own quality

improvement activities, states are beginning to look more closely at how this population experiences managed care and at approaches that may be more effective. As part of this developmental process, the Health Care Reform Tracking Project, while it will continue to survey managed care developments, also is moving to a new phase of identifying promising approaches and features of managed care reforms. The 2000 State Survey captured (and describes throughout the report) a number of promising approaches that states are undertaking on behalf of children with behavioral health disorders and their families. The Tracking Project will be studying and reporting on promising practices in greater depth in future activities. These efforts will be directed toward providing information to states and communities to demonstrate how managed care systems, or aspects of them, can be refined to improve behavioral health service delivery to children and adolescents and their families. □

I. Introduction and Methodology

Health Care Reform Tracking Project

The Health Care Reform Tracking Project was initiated in 1995 for the purpose of tracking and analyzing state and local, publicly financed managed care initiatives as they affect children and adolescents with behavioral health disorders and their families. It is co-funded by two federal agencies — the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services and the National Institute on Disability and Rehabilitation Research in the Department of Education. Supplemental funding has been provided by the Administration for Youth and Families of the Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to support a special focus on children involved with the child welfare system and special analyses of the effects of managed care initiatives on this population. The Tracking Project is being conducted jointly by the Research and Training Center for Children's Mental Health at the Louis de la Parte Florida Mental Health Institute, University of South Florida; the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center; and the Human Service Collaborative of Washington, D.C.

The Tracking Project is being undertaken during a period of rapid change in public sector health and human service systems. States, and, increasingly, local governments are applying managed care technologies to the delivery of mental health and substance abuse services (together referred to as "behavioral health services" in this study) for children and adolescents and their families in Medicaid, mental health, substance abuse, child welfare, and State Children's Health Insurance Program (SCHIP) systems. These public sector managed care reforms are the focus of the Health Care Reform Tracking Project. The Tracking Project is the only ongoing national study focusing specifically on the impact of these public sector managed care reforms on children and adolescents with behavioral health disorders and their families.

The Tracking Project focuses on children, adolescents, and families who rely on public sector agencies for behavioral health services. These include Medicaid-eligible, SCHIP-eligible, poor, and uninsured children and their families; children and adolescents who have serious behavioral health disorders whose families exhaust their private health coverage; and families who turn to the public sector to access particular types of services that are not available through their private coverage. Often, these youth are involved with multiple state and local systems, including mental health, substance abuse, health, child welfare, juvenile justice, and education systems.

Public sector managed care reforms are occurring against a backdrop of reform efforts in the children's mental health arena to develop community-based systems of care, particularly for children with serious disorders and their families. A significant focus of the Tracking Project is to explore the impact of public sector managed care reforms on the development and operation of these community-based systems of care.

Since its inception, the Tracking Project has been exploring whether and how different kinds of managed care approaches and characteristics have differing effects on this population of children and adolescents and their families and on the systems of care that serve them. It is examining the impact of managed care across a broad range of areas associated with effective

behavioral health service delivery for children, including: access to and availability of services, services for children with serious and complex disorders, family involvement, service coordination, provider capacity, cultural competence, financing approaches, quality, outcomes, and cost. The Tracking Project is intended to be useful to public officials, families, managed care entities, providers, advocates, and other key stakeholders involved in and affected by public sector managed care.

Methodology of the Tracking Project

The methodology of the Tracking Project has involved two major components: 1) conducting periodic surveys of all states, and 2) conducting impact analyses through in-depth site visits to a select sample of states. Throughout these activities, the Tracking Project has been comparing the characteristics and effects of managed care systems with two basic types of designs:

Carve Out Designs — defined by the Tacking Project as arrangements whereby behavioral health services are financed and administered separately from physical health services.

Integrated Designs — defined by the Tracking Project as arrangements in which the financing and administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted, in effect, creating a "sub-carve out").

To date, the Tracking Project has completed three state surveys and two impact analyses:

- The 1995 State Survey
- The 1997–98 State Survey
- The 2000 State Survey
- The 1997 Impact Analysis
- The 1999 Impact Analysis

The 1995, 1997–98, and 2000 State Surveys were designed *to identify and describe public sector managed care activity* occurring in all 50 states and the District of Columbia that affects children and adolescents with behavioral health disorders and their families. The 1995 State Survey provided a baseline description of state managed care activity, which the 1997–98 and 2000 State Surveys updated by examining changes over time. In addition, a new focus was incorporated into the 2000 State Survey, *to identify promising strategies, approaches and features of managed care systems* that can be studied and disseminated in an effort to assist states and communities to better meet the needs of children with behavioral health treatment needs and their families in the context of managed care.

While the state surveys were designed to identify and describe managed care activity, the 1997 and 1999 Impact Analyses were conducted *to examine the impact of managed care activity* as perceived by multiple key stakeholders interviewed during site visits and as documented quantitatively to the extent that data were available. For the 1997 Impact Analysis, site visits were conducted to a sample of 10 states, and for the 1999 Impact Analysis, the Tracking Project conducted site visits to a sample of eight new states. Site visits were conducted by teams comprised of four to five trained interviewers knowledgeable in the areas of children's mental health, child welfare, adolescent substance abuse, and managed care; each site visit team included a family member with expertise in these areas. Another component of the 1999 Impact Analysis involved examining changes that occurred in the first sample of 10 states since the 1997 analysis through a series of telephone interviews with key stakeholders (referred to as the "maturational analysis"). **Table 1** shows the samples of states that were studied for the impact analyses.

Reports have been issued on the 1995 and 1997–98 State Surveys and on the 1997 and

Table 1
Sample of States Studied for Impact Analyses

	Carve Out Design	Integrated Design	Integrated with Partial Carve Out
1997 Sample N=10	Arizona Iowa Massachusetts North Carolina Oregon Utah Washington	Connecticut Rhode Island	Delaware
1999 Sample N=9	Colorado Maryland–Mental Health Nebraska Pennsylvania	Maryland–Physical Health/ Substance Abuse New Mexico Oklahoma Vermont	

1999 Impact Analyses.[1] This report documents the results of the 2000 State Survey, building on the previous work of the Tracking Project. New in this survey report are descriptions of promising strategies and approaches reported by respondents in a variety of areas.

[1] The following reports are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271:

Pires, S.A., Stroul, B.A., Roebuck, L., Friedman, R.M., McDonald, B.B., & Chambers, K.L. (1996). Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1995 State Survey. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998). Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1997 Impact Analysis. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Pires, S.A., Armstrong, M.I., & Stroul, B.A. (1999). Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1997–98 State Survey. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Pires, S.A., Stroul, B.A., Armstrong, M.I. (2000). Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1999 Impact Analysis. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

The following special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University (202) 687-5000:

McCarthy, J. & Valentine, C. (2000). Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with emotional disorders and their families — Child Welfare Impact Analysis — 1999. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Schulzinger, R., McCarthy, J., Meyers, J., de la Cruz Irvine, M., & Vincent, P. (1999). Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with emotional disorders and their families — Special Analysis — Child Welfare Managed Care Reform Initiatives. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Methodology of the 2000 State Survey

The approach to conducting the 2000 State Survey involved three distinct phases: survey development, survey distribution and collection, and data analysis and report development. Each phase is briefly described below.

Survey Development

The 2000 State Survey, included as **Appendix B**, was designed to build on previous activities and findings of the Tracking Project. The primary goals in developing the survey instrument included:

- Retaining key items from the 1995 and 1997–98 State Surveys in order to be able to track continuing development, changes, and trends in managed care reforms affecting children and adolescents with behavioral health needs over time.
- Incorporating additional items to address issues that were identified during the two impact analyses and to clarify findings from the impact analyses by examining key questions across all states.
- Incorporating additional items in order to identify promising strategies and approaches used in managed care systems to address the behavioral health treatment needs of children and adolescents and their families.

With these objectives as a guide, the 1997–98 State Survey instrument was revised and refined to create the 2000 survey instrument. The survey design team included individuals, including family representatives, with expertise in child and adolescent behavioral health, child welfare, managed care, and survey design. The survey captures information in the following domains:

- General information about the extent and nature of managed care activity
- Populations included in managed care systems
- Managed care entities
- Service coverage and capacity
- Special provisions for youth with serious and complex behavioral health needs
- Financing and risk
- Clinical decision making and management mechanisms
- Access
- Service coordination
- Early identification and intervention
- Family involvement
- Cultural competence
- Providers
- Accountability
- State Child Health Insurance Program
- Child welfare issues
- Technical assistance materials that can be shared

Survey Distribution and Follow-Up

The survey was sent by mail to state child mental health directors in all 50 states and the District of Columbia in May 2000. In addition to sending a written copy of the survey form, a computer disc was enclosed in each envelope, providing a digital copy of the survey in two different word processing formats. This afforded respondents a choice in method of response; they could complete the survey on paper, return the disc with the survey completed, or return the completed survey via e-mail. The computer versions of the instrument were included to facilitate completion and return of the survey with reduced burden for respondents. A one-month deadline for responses was provided.

The follow-up process to encourage survey completion was extensive. Two reminder letters were followed by repeated telephone calls and e-mail contacts on a weekly basis by University of South Florida staff to encourage the completion and return of missing surveys over a period of three months. Additional copies were sent or e-mailed to respondents when necessary. In some cases, it was necessary to contact others in the state mental health agency to identify the proper respondent. Further, in several cases in which no other strategy was successful, staff completed the surveys during telephone interviews with respondents. The result of this exhaustive follow-up process was a 100% response rate — responses from all 50 states and the District of Columbia.

Survey Analysis and Report Development

Once surveys were received, they were reviewed for completion. If items were overlooked, the respondent was contacted for verification of nonresponse or for additional information. When the survey was deemed complete, it was reviewed by one of the primary research partners to ensure that responses throughout the completed survey were compatible with the intent of the questions and were internally consistent. This second round of review often resulted in additional calls to respondents for further clarification.

The data analysis process was guided by a data analysis plan developed by the study team. Staff at the University of South Florida entered the data, reviewed all data entry for accuracy, and derived the tables and analyses specified by the plan. Following individual review of findings, study team members met as a group to analyze and discuss findings and to correct any perceived errors.

This report presents the results of the 2000 State Survey. Where possible, findings are compared with survey results obtained in 1995 and 1997–98 to identify changes and trends, and, as appropriate, findings are displayed by carve out versus integrated managed care reforms to capture differences and similarities between these system designs. In addition, findings from the 1997 and 1999 Impact Analyses are cited where relevant and appropriate to elucidate issues or survey results. As noted, a new feature incorporated into this report is the description of promising approaches or strategies reported by respondents in many aspects of managed care system development and operation. Examples of promising strategies are presented in boxes and are interspersed throughout the report in the appropriate sections. □

II. General Information about State Managed Care Initiatives

Extent of Managed Care Activity

All 50 states, plus the District of Columbia, responded to the survey, with most states (42) reporting involvement in 2000 in publicly financed managed care activity affecting behavioral health services for children, adolescents and their families. States reported a total of 43 reforms underway in these 42 states in response to the 2000 survey (**Table 2**). Only two states, Kansas and Wyoming, reported no involvement in behavioral health managed care activity (either planned or implemented or previously planned or implemented); three states (Mississippi, South Dakota, and West Virginia) reported new managed care activity since the previous 1997–98 survey.

Table 2

Number of States Reporting on a Public Sector Managed Care Reform Affecting Behavioral Health Services in 2000 State Survey

	Year 2000
Number of states reporting on a managed care reform	42
Total number of managed care reforms identified	43
Total number of managed care reforms described in detail	35

A slightly higher number of states (46) in 1997–98 reported involvement in managed care activity than in 2000. In addition, there were more reports in 2000 of states' terminating managed care reforms that were either planned or underway. Eight states (Alabama, Alaska, Arkansas, Kentucky, Louisiana, Montana, New York, and North Carolina) reported that they had terminated planned or already implemented managed care reforms in 2000, with only one of those states (New York) continuing to remain involved in managed care affecting behavioral health service delivery for children and their families at the time of the survey. These data do not necessarily suggest that states are beginning to move away from managed care for children's behavioral health services. Reports regarding termination of reforms are as likely to suggest the extent of experimentation underway in the states with managed care approaches and the political and technical challenges associated with managed care implementation. However, the termination of reforms identified through the 2000 State Survey, at the least, surfaced as an issue that will be watched closely by the Tracking Project in the future.

Matrix 1 displays the behavioral health managed care reforms, by state, reported in response to the 2000 State Survey, including specification of those states in which managed care reforms were terminated and those reporting no managed care reforms.

* Total Number of States with Reforms = 42 * Total Number of Reforms = 43		Matrix 1: Focus of Managed Care Reforms by State					
		No Behavioral Health Managed Care Reform	Behavioral Health Managed Care Reform Terminated	Medicaid Behavioral Health Reform	Public Sector Behavioral Health System	Medicaid & Public Sector Behavioral Health Reform	Other Behavioral Health Managed Care
Alabama	AL		●				
Alaska	AK		●				
Arizona	AZ					●	
Arkansas	AR		●				
California	CA			●			
Colorado	CO			●			
Connecticut	CT					●	
Delaware	DE					●	
District of Columbia	DC					●	
Florida	FL			●			●
Georgia	GA						●
Hawaii	HI					●	
Idaho	ID						●
Illinois	IL			●			
Indiana	IN				●		
Iowa	IA			●			
Kansas	KS	●					
Kentucky	KY		●				
Louisiana	LA		●				
Maine	ME						●
Maryland	MD					●	
Massachusetts	MA					●	
Michigan	MI					●	
Minnesota	MN			●			
Mississippi	MS				●		
Missouri	MO			●			
Montana	MT		●				
Nebraska	NE			●			
Nevada	NV			●			
New Hampshire	NH			●			
New Jersey	NJ					●	
New Mexico	NM					●	
New York	NY		●			●	
North Carolina	NC		●				
North Dakota	ND			●			
Ohio	OH			●			
Oklahoma	OK					●	
Oregon	OR					●	
Pennsylvania	PA			●			
Rhode Island	RI			●			
South Carolina	SC			●			
South Dakota	SD			●			
Tennessee	TN			●			
Texas	TX					●	
Utah	UT			●			
Vermont	VT			●			
Virginia	VA			●			
Washington	WA					●	
West Virginia	WV					●	
Wisconsin	WI					●	
Wyoming	WY	●					
Total:		**2**	**8**	**20**	**2**	**17**	**4**

While states reported a total of 43 reforms underway in 42 states in response to the 2000 State Survey (as shown on **Matrix 1**), respondents submitted *detailed descriptive data* on a total of 35 reforms underway in 34 states. *The analysis that follows pertains to these 35 reforms underway in 34 states.* **Table 3** provides a description of the 35 reforms that are analyzed in this report.

Table 3
Description of Managed Care Reforms

State			Type of Design	Type of Waiver	Implementation Date
Arizona	AZ	Arizona has had an 1115 waiver since the beginning of its Medicaid program. The waiver allows for the enrollment of Medicaid eligible persons in a statewide system of health plans that operate similarly to HMOs. OBRA 89 allowed for Medicaid expansions, including mental health services for children. Beginning October 1990, under contract with the state Medicaid agency, the Arizona Department of Health/ Division of Behavioral Health began to phase in Medicaid eligible populations under capitated managed mental health contracts with Regional Behavioral Health Authorities (RBHAs). RBHAs offer a continuum of behavioral heath services in each geographic service area of the state.	Carve Out	1115	1990
California	CA	The State Department of Mental Health (DMH), under an interagency agreement with the state Medicaid agency, administers the Medi-Cal Specialty Mental Health Services Consolidation program. DMH contracts with county mental health departments to function as the single county Mental Health Plan (MHP). Most CA counties act as their own MCOs; two have contracted out this function to commercial BHOs. Plans are responsible for authorizing and paying for all inpatient and outpatient Medicaid specialty mental health services formerly provided through Medicaid fee-for-service, as well as county funded services formerly administered under the Short-Doyle Medi-Cal program.	Carve Out	1915(b)	1995
Colorado	CO	Mental health services to Medicaid clients are provided through a capitated behavioral health carve out. Eight contractors, known as Mental Health Assessment and Services Agencies (MHASAs), operate the program in eight separate geographic regions of the state. Enrollment is mandatory based on aid category and county of Medicaid eligibility.	Carve Out	1915(b)	1995
Connecticut	CT	The HUSKY managed care program enrolls 233,000 TANF and related subgroups into one of four health plans providing physical and behavioral health services. All four plans subcontract behavioral health services to BHOs.	Integrated	1915(b)	1995

Table 3 (continued)
Description of Managed Care Reforms

State		Type of Design	Type of Waiver	Implementation Date
Delaware DE	In January 1996, Delaware implemented its 1115 Medicaid waiver mandating managed care for Medicaid Services. The waiver design included a public-private partnership for children's behavioral healthcare intended to maximize integration of primary and behavioral healthcare for children. The private, contracted MCOs provide the Medicaid basic benefit, while the public agency (Division of Child Mental Health Services–DCMHS) provides extended care services. The basic benefit for children includes 30 hours of mental health and/or substance abuse outpatient services, renewable annually. If a child requires more intensive services (e.g., day treatment, residential treatment, psychiatric hospital), the MCO refers the child to DCMHS for extended services. DCMHS level of care criteria are public and widely available (e.g., on website and in provider manual). MCOs contract with the DCMHS outpatient providers to help ensure seamless service delivery for children. In Delaware, DCMHS serves children with Medicaid or SCHIP and children without insurance. The public MCO role of the state agency includes three unique features: 1) a care assurance model (no benefit limit), 2) clinical services management model for care coordination and management, and 3) an automated electronic MIS system which includes mental health/ substance abuse, child welfare and criminal justice, all of which are included in Delaware's integrated children's services department (Department of Services for Children, Youth and Their Families–DSCYF).	Integrated with Partial Carve Out	1115	1996
District of Columbia DC	The District of Columbia is in the early planning stages of a behavioral health carve out designed to focus on both Medicaid and public behavioral health system reform. The planned implementation year is 2001.	Carve Out	N/A	Planned for 2001
Florida (BHSCN) FL	Legislation was passed to establish a Specialty Network of Behavioral Health Care (BHSCN) to provide services to 303 of Florida's SCHIP-eligible children with severe emotional disturbances. A monthly case rate was established by researching the historical service profile for providing treatment to children who met the diagnostic behavioral profile. Each of Florida's 15 Districts developed its own network of behavioral health providers and executed contracts with those networks.	Integrated with Partial Carve Out	None	1998
Florida (PMHP) FL	The Prepaid Mental Health Plan (PMHP) currently operates in five Florida counties. It is a mental health carve out that covers TANF, foster care, SOBRA, and SSI populations, excluding Medicare. Capitation rates are paid to cover mandated mental health services for eligible recipients. It is currently being expanded to cover substance abuse services and to cover other parts of the state.	Carve Out	1915(b)	1996

Table 3 (continued)
Description of Managed Care Reforms

State			Type of Design	Type of Waiver	Implementation Date
Hawaii	HI	Hawaii QUEST is an integrated physical/behavioral health Medicaid managed care reform that includes a partial carve out for children and adolescents registered with the Child and Adolescent Mental Health Division of the Department of Health who have an Individualized Education Plan (IEP). The service delivery design changed dramatically with the state's commitment to serve all IDEA/504-eligible youth with behavioral health needs. That change increased the number of children who need services from 2000 to over 10,000. Service delivery moved from state worker/occasional fee-for-service approach to a full array of contracted services with an emphasis on community and school-based service delivery. Services are described and monitored through clinical/practice standards, including Medicaid requirements. Providers bill electronically and provide documentation for units of service delivered. Intensive case management is at the core of providing coordinated services through plans that are developed by child and family teams. Youth with less intensive needs receive care coordination through schools. There are seven family guidance centers statewide to serve and provide intensive case management to children with intensive needs.	Integrated with Partial Carve Out	N/A	1994
Indiana	IN	The Hoosier Assurance Plan (HAP) is a risk sharing managed care system for non-Medicaid public behavioral health services, operated by the State Division of Mental Health, which acts as a purchasing agent, contracting with qualified managed care providers offering an array of individualized mental health and substance abuse services. HAP creates a priority for individuals with greatest needs, and incorporates separate case rates for children with serious emotional disorders and for adolescents with substance abuse problems.	Carve Out	None	1995
Iowa	IA	Iowa has a 1915(b) waiver to operate a statewide carve out for behavioral health services for Medicaid recipients.	Carve Out	1915(b)	1995
Maine	ME	Maine's carve out targets publicly funded behavioral health services for Maine residents under age 21. Key features are central registration, assessment and care plans, authorization for all services (some, like hospitalization, are preauthorized, others are authorized after services have begun), improved coordination of scarce resources, better access to information for families, and implementation of quality improvement activities. The reform does not involve financial risk.	Carve Out	None	2000
Maryland	MD	Mental health services are provided through a carve out administered by the state Mental Hygiene Administration in conjunction with local Core Service Agencies and a contracted BHO that provides ASO functions.	Carve Out	1115	1997
Massachusetts	MA	Under an 1115 waiver, MA has created a Primary Care Clinician Program (PCCP) with access to a behavioral health carve out operated by a private BHO under contract with the state on a shared risk basis.	Carve Out	1115	1992

Table 3 (continued)
Description of Managed Care Reforms

State			Type of Design	Type of Waiver	Implementation Date
Michigan	MI	Michigan began implementation of a statewide 1915(b) Medicaid waiver in 1998. Behavioral health is carved out of Medicaid physical health care plans and arrangements (although there is an outpatient benefit of up to 20 visits that remains with the health plans).The local county community mental health services programs function as the Prepaid Health Plan for Medicaid behavioral health care services.	Carve Out	1915(b)	1998
Minnesota	MN	Minnesota has been engaged in integrated physical/ behavioral health Medicaid managed care reform since 1985, which the state has been implementing incrementally. Most of the counties (and Medicaid population) are now covered.	Integrated	1115	1985
Mississippi	MS	Mississippi Connections is a pilot project implemented in two sites. The services in the state's Medicaid plan remain fee for service, but are supplemented with a global case rate that is used for flexible services and supports. A Local Coordinating Care entity made up of interagency representatives and family members oversees the pilot at each site. The target population includes children and youth who have been in psychiatric inpatient care or residential treatment level placements, or who are at imminent risk of either.	Carve Out	N/A	Not Available
Missouri	MO	MC+ Managed Care is a 1915(b) waiver operating since 1995 in three regions in Missouri: Western, which includes the Kansas City metropolitan area and eight surrounding counties; Eastern, which includes St. Louis metropolitan area and four surrounding counties; and Central, which includes the Jefferson City-Columbia metropolitan areas and 16 surrounding counties. In 1998, MO expanded Medicaid coverage to low income, uninsured children under an 1115 waiver.	Integrated	1915(b) and 1115	1995 and 1998
Nebraska	NE	NE is implementing a Medicaid behavioral health carve out covering AFDC, TANF, SOBRA, and SSI populations, including children in child welfare. It is managed by a statewide commercial BHO.	Carve Out	1915(b)	1995
New Jersey	NJ	New Jersey's Department of Human Services (DHS) is undergoing a full-scale reform of children's services. The reform will proceed incrementally over a three to five year period to transition the reform agenda into a new system. The Children's System of Care will address all children with emotional and behavioral disturbances and their families across DHS child-serving systems, including children eligible for child welfare, mental health, and/or Medicaid services, ages 0–18 and youth 18–21 transitioning to the adult system. The reform involves use of care management organizations at regional levels and a statewide ASO-like system administrator.	Carve Out	None	2001

Table 3 (continued)
Description of Managed Care Reforms

State			Type of Design	Type of Waiver	Implementation Date
New Mexico	NM	New Mexico employs an "integrated" model in which the state contracts with three statewide MCOs. The MCOs are required to subcontract with three statewide BHOs for behavioral health services. The three BHOs, in turn, are required to contract with regional provider networks.	Integrated	1915(b)	1997
New York	NY	This reform involves the combining of Medicaid and child welfare funds in Oneida County (population 250,000) to provide a full array of community-based services for children under 18 with serious emotional disturbances, who would have otherwise gone into out-of-home care. The reform uses case rates and an organized provider network.	Carve Out	None	1993
North Dakota	ND	This proposed 1915(b) waiver for a mental health carve out will take cost savings and reinvest in four new services, including respite care, independent living, parent to parent support and psychosocial rehabilitation services. It also requires service coordination for children who are in need of intensive mental health services.	Carve Out	1915(b)	2001
Oklahoma	OK	SoonerCare Plus is the Medicaid managed care reform for the urban areas of the state, including the surrounding counties of Lawton, Oklahoma City, and Tulsa. Behavioral health care was carved out of SoonerCare Plus in the first year; it became part of the HMO system in the second year. The first population to be brought into managed care was AFDC/TANF. The Aged, Blind and Disabled population was added to SoonerCare Plus in July 1998. Children who are in the custody of the Department of Human Services or the Office of Juvenile Affairs are not enrolled in managed care. For the rural areas of the state, a partially capitated program (SoonerCare CHOICE) is provided, using a primary care provider/case manager model for medical needs. Under SoonerCare CHOICE, individuals may self refer for behavioral health care and payment is made through Medicaid fee for service.	Integrated	1115	1995
Oregon	OR	The Oregon Health Plan is a statewide managed care plan utilizing a capitation rate. It provides for mandatory enrollment of all eligibles and enrolls all mental health recipients (Medicaid and non-Medicaid), except those in secure detention. OR implemented a mental health package statewide in 1997, and is the only state with an EPSDT waiver for treatment requirement.	Carve Out	1115	1995
Pennsylvania	PA	In 1997, PA introduced a new coordinated health care delivery system, known as HealthChoices, which includes a behavioral health carve out, to provide medical, psychiatric and substance abuse services to Medical Assistance recipients in a five county area in Southeastern PA. In 1999, the HealthChoices capitated, mandatory managed care program was implemented in ten counties in the Southwestern area of the state. Plans are underway to introduce the program to a 10 county region in the Lehigh/ Capital area starting in October 2001.	Carve Out	1915(b)	1997

Table 3 (continued)
Description of Managed Care Reforms

State			Type of Design	Type of Waiver	Implementation Date
Rhode Island	RI	Rhode Island has been implementing RiteCare, an integrated Medicaid managed care reform, since 1994. RiteCare expanded Medicaid eligibility and increased access to physical health services and to limited behavioral health services. The state currently is focused on enrolling foster care children in RiteCare.	Integrated	1115	1994
Tennessee	TN	TennCare Partners is an 1115 waiver covering over 800,000 Medicaid eligibles and 400,000 uninsured statewide. Tennessee contracts with two BHOs to provide services previously covered by Medicaid. The BHOs are paid a capitated rate on a per member/per month basis.	Carve Out	1115	1996
Texas	TX	NorthSTAR is a fully capitated behavioral health carve out providing behavioral health services for persons residing in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties of Texas. NorthSTAR provides services to both Medicaid and non-Medicaid (medically indigent) individuals using state, local, and federal funds to provide a more integrated and less fragmented system of care for eligible individuals.	Carve Out	1915(b)	1999
Utah	TX	Utah operates a behavioral health carve out for all Medicaid recipients residing in 25 of the 29 counties of the state.	Carve Out	1915(b)	1991
Vermont	VT	Vermont is implementing an integrated Medicaid managed care initiative with two basic goals: to expand eligibility to cover low income uninsured people, and to institute managed care for all Medicaid only (as opposed to dual Medicare-Medicaid) recipients and to individuals already enrolled in another waiver.	Integrated	1115	1996
Virginia	VA	Medallion II is an integrated Medicaid managed care reform utilizing HMOs. The reform covers clinic option services only (e.g., outpatient, inpatient, and emergency) for mental health. State plan option services for mental health remain fee for service.	Integrated	None	1995
Washington	WA	Washington implemented a capitated mental health carve out that began with outpatient services only in 1993 and slowly integrated inpatient by 1996. State hospital services are exempted.	Carve Out	1915(b)	1993
West Virginia	WV	New Directions is a behavioral health carve out that involves several phases. Phase One is the development of a data and tracking system for eligibility and service authorization. Phase Two entails contracting with an ASO to authorize needed behavioral health services.	Carve Out	None	1996

Table 3 (continued) Description of Managed Care Reforms				
State		Type of Design	Type of Waiver	Implementation Date
Wisconsin WV	Wisconsin has a number of managed care reforms. Survey response refers to two county-based behavioral health carve outs: Children Come First in Dane Co. is operated by a network of not-for-profit providers, and Milwaukee Wraparound in Milwaukee Co. is operated by the county mental health agency. Both reforms serve children with serious emotional disorders, including those in the child welfare and juvenile justice systems.	Carve Out	None	1989

Focus and Design of Managed Care Activity

As **Table 4** summarizes, of the 35 reforms described, 15 (42%) were identified by respondents as reforms involving only Medicaid, 16 (46%) were described as reforms involving both Medicaid and public behavioral health systems, 2 (6%) were described as involving only the public behavioral health system, and 2 (6%) were described as "other". This latter category tended to include reforms involving multiple agencies.

Table 4
Focus of Managed Care Reforms

	2000	
	Number of Reforms	Percent of Reforms
Medicaid reform	15	42%
Public sector behavioral health system reform	2	6%
Medicaid and public behavioral health system reform	16	46%
Other	2	6%

Of the 35 reforms, eight (23%) were described as reforms with integrated designs, in which the financing and administration of physical and behavioral health services are integrated; 27 (77%) were described as carve outs, in which behavioral health services are financed and administered separately from physical health services.[2]

[2] The number of carve outs includes Delaware, Hawaii, and Florida, states that use an integrated design with a partial carve out for children with moderate to severe behavioral health disorders.

Table 5 Number and Percent of Reforms by Type of Design				
	1997–98		2000	
	Number of Reforms	Percent of Reforms	Number of Reforms	Percent of Reforms
Integrated	15	35%	8	23%
Carve Out	28	65%	27	77%

As **Table 5** indicates, there were almost twice as many integrated reforms in the 1997–98 sample and roughly the same number of carve outs, as reported in 2000. There is a growing maturity in the development of carve outs, leading some states in 2000 to focus more exclusively on their carve out reforms in their survey responses. For example, Texas reported in 1997–98 that it was planning a behavioral health carve out, but chose to submit detailed information about its integrated reform, which had been underway for some time. In its 2000 response, Texas did just the opposite, providing detailed information on its carve out and little data on the integrated reform. **Table 6** lists the 34 states in the 2000 sample by type of design. (Note that Florida provided detailed information on two reforms.)

Table 6 Type of Design For Managed Care Reform by State	
2000	
Carve Out Design N=27	Integrated Design N=8
Arizona	Connecticut
California	Minnesota
Colorado	Missouri
Delaware	New Mexico
District of Columbia	Oklahoma
Florida (BHSCN)	Rhode Island
Florida (PMHP)	Vermont
Hawaii	Virginia
Iowa	
Maine	
Maryland	
Massachusetts	
Michigan	
Mississippi	
Nebraska	
New Jersey	
New York	
North Dakota	
Oregon	
Pennsylvania	
Tennessee	
Texas	
Utah	
Washington	
West Virginia	
Wisconsin	

Use of Waivers

Most of the 35 reforms in the 2000 sample (71%) involve the use of a Medicaid waiver. However, as **Table 7** indicates, this is 15% fewer than in 1997–98.

Table 7
Percent of Reforms Involving Any Medicaid Waiver

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Any Waiver	84%	86%	67%	88%	71%	-13%	-15%

Table 8 shows that there has been a 20% reduction in the use of 1115 (Research and Demonstration) waivers since 1997–98, and a 12% decline in the use of 1915(b), so called Freedom of Choice, waivers. As in 1997–98, the 2000 survey found that 1915 (b) waivers are the more common waiver type.

Table 8
Percent of Reforms by Type of Medicaid Waiver

Type of Waiver	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
1115	37%	37%	19%	13%	17%	-20%	-20%
1915 (b)	44%	49%	37%	38%	37%	-7%	-12%

Stage of Implementation

As **Table 9** shows, most reforms in the 2000 sample (71%) are in late stages of implementation (defined as older than three years). This represents more than a 50% increase over 1997–98, in which only 19% of reforms were in late stages of implementation. Only 20% of reforms in the 2000 sample reported being in either the planning or early implementation (less than one year) stages, compared to 44% of reforms in 1997–98 and 79% of reforms in 1995 — the first year of the Tracking Project.

Table 9
Implementation Stage of Managed Care Reforms

Stage of Implementation	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Planned, not yet implemented	58%	21%	11%	0%	9%	-12%	-49%
Early implementation (Less than 1 year)	21%	23%	11%	13%	11%	-12%	-109%
Middle implementation (1–3 years)	12%	33%	11%	0%	9%	-24%	-3%
Late implementation (More than 3 years)	9%	19%	67%	88%	71%	+62%	+52%

Table 9 also suggests that states have somewhat greater experience with integrated reforms than with carve outs, since most of the integrated systems (88%) are in late implementation stages as compared with about two-thirds of the carve outs. The 2000 data indicate, however, that reforms implemented more recently are more likely to have carve out designs. Of the reforms in either the planning or early implementation stages, there are almost twice as many carve outs as integrated reforms. Upholding a trend that was noted in the 1997–98 survey report, the 2000 State Survey suggests that states are continuing to experiment with carve out approaches for behavioral health service delivery for children and their families.

Since the early days of the Tracking Project, states have developed considerable experience with managed care. It should also be noted, however, that, this report defines "late implementation" as more than three years — not a very long period of time to plan, implement, and absorb the ramifications of a major systems change, such as managed care. As noted in the 1999 Impact Analysis, states are actively engaged in refining and fine tuning their initiatives as they gain experience with managed care.

Inclusion of Substance Abuse Services

Table 10 shows the percentage of reforms that include substance abuse services, in addition to mental health services. Reportedly, there has been an 11% decline in the percentage of reforms that include substance abuse since the 1997–98 survey. As in 1997–98, integrated reforms were somewhat more likely to include substance abuse services than were carve outs. In 2000, 75% of the integrated reforms included substance abuse, as compared with 65% of the carve outs. Given the known co-morbidity of mental health and substance abuse disorders, legitimate concern may be raised that over a third of the carve outs and a quarter of the integrated reforms do not include substance abuse services. On the other hand, the exclusion of substance abuse services from managed care systems may indicate a policy decision to create a safety net for those needing substance abuse treatment services and/or recognition that substance abuse treatment providers in a particular state may not have the capacity to operate in a managed care environment.

Table 10
Percent of Reforms Including Substance Abuse Services

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Reforms include substance abuse services	75%	79%	65%	75%	68%	-7%	-11%
Reforms do not include substance abuse services	25%	21%	35%	25%	32%	+7%	+11%

When substance abuse services are not included with mental health services in the managed care system, reportedly, they remain fee-for-service in most cases (73% of the reforms not including substance abuse). There were two reports of separate substance abuse carve outs and one report of substance abuse being integrated with physical health care in a state that also has a mental health carve out. However, in most cases, substance abuse treatment remains fee-for-service if it is not part of the managed care system involving mental health.

Parity Between Physical Health and Behavioral Health Services

As **Table 11** shows, of the eight reforms in the sample that include both physical and behavioral health services, 88% reportedly include parity for behavioral health services, that is, behavioral health coverage is reported to be equal to physical health coverage. This represents a 28% increase in parity from 1997–98, a larger increase than might have been predicted. Since the 1997–98 State Survey, there has been heightened attention to the issue of parity, both at the federal level and within states; several states have enacted parity laws since the 1997–98 survey. Despite this reported increase in parity, there is a widespread perception among stakeholders that behavioral health services are still subject to greater restrictions than those placed on physical health care. The 1999 Impact Analysis found that, even in states with parity laws, the duration or types of mental health services provided under managed care systems were often curtailed through the imposition of restrictive medical necessity or level of care criteria. The issue of parity needs to be explored more fully to reach accurate conclusions as to what is actually occurring in states.

Table 11
Percent of Reforms with Parity Between Behavioral Health and Physical Health Services

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Reforms with parity	71%	60%	80%	88%	83%	+12%	+23%
Behavioral health more limited	29%	40%	20%	12%	17%	-12%	-23%

In those integrated reforms in which there was not parity, the types of limitations included day and visit limits on behavioral health services that were not imposed on physical health services, as well as lifetime limits on behavioral health services.

Goals of Managed Care Reforms

Table 12 depicts the types of goals that managed care reforms are attempting to achieve, according to survey respondents. Improving quality and increasing access were cited most frequently as goals (97% and 91% of reforms, respectively), findings similar to 1997–98 results. However, there has been a noticeable decline in the percentage of reforms in which cost containment is a stated goal. In 1997–98, 93% of reforms identified cost containment as a goal, as compared with 79% of reforms in 2000. In contrast, improved accountability has increased as a goal, with 79% of reforms citing it as a goal in 2000, a 14% increase from 1997–98.

Table 12 Percent of Reforms by Types of Stated Goals					
	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Cost containment	93%	72%	100%	79%	-14%
Increase access	93%	96%	75%	91%	-2%
Expand service array	63%	76%	38%	67%	+4%
Improve quality	91%	100%	88%	97%	+6%
Improve accountability	65%	92%	38%	79%	+14%
Other	16%	24%	13%	21%	+5%

There is a noticeable difference among stated goals between integrated and carve out reforms. Integrated reforms are more likely to focus on cost containment (100% of integrated reforms versus 72% of carve outs). Carve outs are more likely to focus on improving accountability (92% of carve outs versus 38% of integrated reforms). Carve outs also are twice as likely as integrated reforms to include as a goal expansion of the service array for children's behavioral health (76% of carve outs versus 38% of integrated reforms).

Carve outs also are nearly twice as likely as integrated reforms to focus on other goals beyond those listed in the survey instrument. Among the "other" goals cited by respondents for the use of managed care were:

- Fund nontraditional services more difficult to fund through Medicaid fee-for-service
- Incorporate wraparound services
- Promote system of care values
- Reduce fragmentation
- Decentralize service delivery by allowing counties to manage services
- Promote better use of appropriate levels of care
- Increase consumer choice

Except for consumer choice, all of the above goals were cited for carve outs only.

Lead Agency Responsibility

As **Table 13** shows, the State Medicaid agency is most likely to be the lead agency responsible for managed care reforms. According to survey respondents, Medicaid has lead responsibility for 88% of the integrated systems and 44% of the carve outs; the state mental health agency has the lead responsibility for about a third of the carve outs. There were a handful of reports as well, primarily with respect to carve outs, of interagency responsibility for managed care systems. While state mental health agencies are playing a significant role in managed care affecting behavioral health service delivery, the 2000 findings, similar to those in 1997–98, indicate that the state Medicaid agency continues to be the predominant player in terms of lead agency responsibility.

Table 13 Percent of Reforms by Lead Agency Responsibility			
	2000		
	Carve Out	Integrated	Total
Governor's office	4%	0%	3%
State health agency	8%	0%	6%
State Medicaid agency	44%	88%	55%
State mental health agency	32%	0%	24%
Other	12%	12%	12%

Involvement of Key Stakeholders

Since its inception, the Tracking Project has been looking at the issue of key stakeholder involvement in the planning, implementation, and refinement of managed care reforms. Key stakeholders as defined by the Tracking Project include: families; providers; and the major state child-serving systems, including children's mental health, substance abuse, child welfare, juvenile justice and education systems. Nationally, both in the federal government and in national foundations, there has been increasing attention paid to the issue of the role of families and consumers in the design and operation of managed care systems. Historically, there has been recognition that, because children with behavioral health problems often are involved with multiple systems, a cross-agency perspective is critical to the design and operation of major policy initiatives affecting this population. Since 1995, the Tracking Project has been analyzing the extent to which these key constituencies are involved in managed care reforms.

Both the 1997–98 State Survey and the 1999 Impact Analysis noted a gradual trend toward increased stakeholder involvement in managed care reforms, though both also found that most key stakeholder groups lacked *significant* involvement in most reforms. As **Table 14** shows, key stakeholder groups continued to increase their involvement in managed care planning, implementation, and refinement activities since the 1997–98 State Survey. Families and state agency staff from child mental health, substance abuse, child welfare, and juvenile justice systems all increased significant involvement in managed care reforms to some extent. State child mental health staff reportedly had the largest increase in involvement (up 20% over 1997–98), followed by substance abuse staff (up 12%), families (up 10%) and child welfare staff (up 9%). State education staff lost a little ground (down 2% from 1997–98). It should be noted, however, that even with reported gains in involvement since 1997–98, significant involvement for all stakeholder groups, except child mental health staff and providers, occurs in fewer than half of the reforms.

Table 14

Percent of Reforms Involving Various Key Stakeholders in Planning, Implementation, and Refinements

	1997–98 Total			2000 Carve Out			2000 Integrated			2000 Total			Percent of Change 1997/98–2000
	Not Involved	Some Involvement	Significant Involvement	Not Involved	Some Involvement	Significant Involvement	Not Involved	Some Involvement	Significant Involvement	Not Involved	Some Involvement	Significant Involvement	Significant Involvement
Families	2%	60%	38%	0%	36%	64%	38%	63%	0%	9%	42%	48%	+10%
State child mental health staff	0%	46%	54%	0%	13%	88%	14%	57%	29%	3%	23%	74%	+20%
State substance abuse staff	18%	60%	23%	11%	48%	41%	29%	57%	14%	15%	50%	35%	+12%
State child welfare staff	7%	56%	37%	7%	44%	48%	25%	38%	38%	11%	43%	46%	+9%
State juvenile justice staff	21%	58%	21%	17%	58%	25%	29%	57%	14%	19%	58%	23%	+2%
State education staff	21%	58%	21%	33%	58%	21%	43%	57%	14%	35%	45%	19%	-2%
Providers	*NA	*NA	*NA	0%	32%	68%	25%	38%	38%	7%	33%	60%	*NA

*NA=Not asked in 1997–98

State education staff is the stakeholder group least likely to be involved, reportedly having significant involvement in only 19% of the reforms. Given that schools are a major provider and referral source for mental health services for children, both through regular and special education, their lack of involvement in managed care reforms is disconcerting. In spite of the increased attention nationally to the importance of the family and consumer role, families of children with behavioral health problems reportedly have significant involvement in only 48% of reforms, all carve outs. In spite of increased enrollment of the juvenile justice population in managed care systems, state juvenile justice staff reportedly are significantly involved in only 23% of reforms. State substance abuse staff have significant involvement in just over a third of reforms.

Key stakeholders are more likely to have significant involvement in carve outs than in integrated reforms. Only in the case of child welfare staff does significant involvement in integrated reforms come close to their involvement in carve outs.

Promising strategies for involving families in planning, implementing, and refining managed care reforms were noted by respondents from many states.

- A number of states reported involving families in the initial design of managed care systems, and in the ongoing development of RFPs and contracts and the selection of contractors. The **Delaware** Medicaid agency included families and advocates in the waiver design process. **Colorado** seeks family input in RFP and contract development and the selection of

(Promising strategies continued on next page)

(Promising strategies continued)

contractors. Input is sought from families serving on the mental health agency's advisory council in such areas as draft policies, guidelines, and rates in **Indiana**. Families were standing members of the planning groups for the managed care system in **Maine**, and representatives of the family organization in **Maryland** reviewed proposals and rated companies vying to be the ASO. **New York** reportedly involved families in all planning and implementation activities, including hiring parent advisors, and **Pennsylvania** involves families in the development of RFPs and the evaluation of proposals. Parents in **North Dakota** serve on state and regional teams for waiver development and on managed care planning task forces; managed care plans have been presented at state Federation of Families conferences in **North Dakota** to invite comment.

- Family representation on various advisory and monitoring structures is another frequently reported strategy. For example, in **Hawaii** families are involved in all performance improvement committees, including the management team. In **Massachusetts**, a behavioral health family advisory council meets monthly and is co-chaired by the director of the state family organization. Families and representatives of the family advocacy organization serve on committees in **Michigan**. In **Oregon**, each MCO is required to develop specific methods for family involvement; they have used membership on advisory committees as well as internal and external governing bodies. Families have served on statewide planning committees, as well as BHO advisory committees which must be comprised of 51% consumers and families, in **Tennessee**. **Pennsylvania** has involved families on committees including planning, advisory, review, grievance and appeals, and others; families serve on a quality improvement council in **West Virginia**.
- In **Arizona**, a parent advocacy organization is contracted to provide information and outreach to parents of children with mental health issues. In addition to representing families through membership on the state's Children's Behavioral Health Council and other interagency structures, the organization is a resource for reaching families to assist in managed care planning and implementation activities.
- Strategies in **Colorado** include an independent ombuds program governed by consumers and family members, a Capitation Program Advisory Committee with family representation, and requirements for MCOs to have family advocates.
- In **Hawaii**, parent partners made available through the state family organization work at each family guidance center to provide support for families and consultation to staff. In both **Utah** and **Pennsylvania**, families serve on teams that are integrally involved in decision making and evaluating managed care system operations. In **Pennsylvania**, families serve on readiness review teams that assess the readiness of counties for managed care and on consumer/family satisfaction teams that evaluate service delivery. In **Utah**, families participate on teams conducting quality of care reviews.

Promising strategies for involving other child-serving systems in managed care planning, implementation, and refinements also were reported.

- Cross-system planning and problem solving was described in a number of states. In **Arizona**, a Children's Interagency Agreement was established; state agency chiefs are required to be members of an executive committee that meets regularly to respond to service issues and to do collaborative planning. An Interagency Children's Work Group meets monthly in **Massachusetts**. An interagency task force has formed in **Michigan** to explore how children in the juvenile justice system can be better served in the managed care system. State-level and local committees including all child-serving systems do joint planning and problem solving in **Oregon**, and, in **Delaware**, the Medicaid agency has quarterly meetings with the Department of Services for Children, Youth, and Families to obtain ongoing input on the managed care system from the perspective of the children's mental health, substance abuse, child welfare, and juvenile justice systems. In **Missouri**, an interagency committee (also including the MCOs, families, and consumers) was established to assess the managed care system and address issues of mutual concern.
- Joint planning with other state agencies and providers resulted in the development of standards, rules, procedures, and utilization review plans for **Maine's** managed care system. All system partners in **New Jersey** are represented on implementation committees and work groups related to the reform. Other systems were key resources in designing the waiver process in **North Dakota**; and in **Pennsylvania**, other agencies are represented on the state-level management committees for the managed care system.
- Involving other systems in developing RFPs and contracts, reviewing proposals, and selecting contractors for the managed care system was reported in **Colorado**, **Nebraska**, **Minnesota**, and **New Mexico**.
- Interagency agreements were reported in **Washington**, **Tennessee**, and **Texas**.
- In **Texas**, the existing system of interagency Community Resource Coordination Groups and Community Management Teams was integrated into the design of the managed care system for interagency coordination at the system and service delivery levels.
- In **Missouri**, an Interdepartmental Initiative for Children with Severe Needs and their Families was implemented to integrate funding to support a comprehensive system of behavioral health care for children through a care management organization (CMO) responsible for developing a locally organized system of services and supports. The CMO coordinates services with the child's MCO in the managed care system.
- Also in **Missouri**, the medical services and mental health agencies jointly developed and implemented two protocols that address the coordination of state funded mental health and substance abuse services with services provided by the MCOs.

Planning for Special Populations

The 2000 State Survey explored whether states engaged in discrete planning processes for certain special populations in managed care, including adolescents with substance abuse disorders, children and adolescents with serious emotional disorders, children and adolescents involved in the child welfare system, and culturally diverse children. As shown on **Table 15**, planning for special populations in managed care has increased since 1997–98. Most reforms, regardless of design, reportedly have included a discrete planning process for children with serious emotional disorders (83% of reforms) and for children involved with the child welfare system (72% of reforms). However, even with increased planning, only about one-third of reforms engaged in discrete planning with respect to adolescents with substance abuse disorders or for culturally diverse children and adolescents. Interestingly, integrated reforms were more likely to include a special planning focus on culturally diverse children than were carve out reforms (43% of integrated reforms versus 27% of carve outs). However, carve outs were slightly more likely to include a planning focus on adolescents with substance abuse disorders (36% of carve outs versus 29% of integrated reforms) and on children with serious emotional disorders than were integrated reforms (86% of carve outs versus 71% of integrated reforms).

In general, the huge disparities in planning for special populations between carve outs and integrated reforms that characterized the 1997–98 survey results, in which carve outs were far more likely to engage in special planning for every population, were not found in the 2000 survey reports. Both carve outs and integrated reforms show movement toward planning for special populations, in particular for children involved in child welfare and for children with serious emotional disorders.

Table 15
Percent of Reforms with Discrete Planning Process for Special Populations

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Adolescents with substance abuse disorders	24%	36%	29%	34%	+10%
Children and adolescents with serious emotional disorders	57%	86%	71%	83%	+26%
Children and adolescents involved with the child welfare system	48%	73%	71%	72%	+24%
Culturally diverse children and adolescents	19%	27%	43%	31%	+12%

The increased planning with respect to children with serious emotional disorders and children involved in the child welfare system may be partially attributable to the increased enrollment of these populations in managed care systems and states' growing experience with managed care. Stakeholders interviewed for the 1999 Impact Analysis reported that problems arising in implementation often led states to create work groups to focus on issues pertaining to various special populations, as did increased advocacy on the part of key stakeholders.

Education and Training in Managed Care for Stakeholders

As **Table 16** indicates, states are increasing efforts to educate and train key stakeholder groups about the goals and operations of managed care systems. Families, in particular, reportedly are receiving more education and training, with 16% more reforms engaged in such efforts in 2000 than in 1997–98. Large percentages of reforms, regardless of design, were reported to have engaged in educating and training, not only families, but providers (88% of reforms), the child welfare system (72% of reforms), the juvenile justice system (63% of reforms) and other child serving systems, such as education (72% of reforms). Only 6% of reforms reported no efforts to educate and train key stakeholders, 9% fewer than in 1997–98. There also were reports in 24% of the reforms of efforts to educate "other" key constituencies, such as judges, advocates, and minority organizations. There also were several reports of states' building requirements for educating and training key stakeholder groups into their contract specifications with managed care organizations.

Table 16

Percent of Reforms Providing Education and Training to Stakeholder Groups about Goals and Operation of Managed Care System

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
No training	15%	4%	13%	6%	-9%
Families	59%	79%	63%	75%	+16%
Providers	79%	96%	63%	88%	+9%
Child welfare system	67%	71%	75%	72%	+5%
Juvenile justice system	*NA	67%	50%	63%	*NA
Other child serving systems	64%	79%	50%	72%	+8%
Other	10%	38%	25%	34%	+24%

*NA=Not asked, included in "other child serving systems" category in 1997–98

Of all of the stakeholder groups, providers were most likely to receive education and training (88% of reforms), followed by families (75% of reforms), the child welfare system (72% of reforms), and other child serving systems (72% of reforms). As in 1997–98, except in the case of child welfare stakeholders, carve outs were more likely to provide education and training than were integrated reforms.

One state respondent submitted comments emphasizing the importance of education and training at all levels of the system but also noting the difficulty of getting buy-in from agency directors to allow front-line staff to participate in trainings. This respondent also emphasized the danger in underestimating the amount of time that people need to absorb the changes associated with managed care reforms.

A number of promising strategies for educating and training key stakeholders about managed care were described.

- In **Arizona**, the state agency requires its contracted MCOs to provide outreach and training to other child-serving agencies; health plans in **Oklahoma** also are required to provide information and education to parents, service recipients, and others.
- In **Colorado**, written materials from the state and MCOs and presentations at conferences and meetings are vehicles used to educate and train key stakeholders; written materials such as booklets, pamphlets, and newsletters are used for education of stakeholders in **Utah** and **Washington**.
- A contract with a health benefits manager is used in **Delaware** to provide broad education to key stakeholders about the managed care system. Similarly, enrollment brokers in **Texas** and **Connecticut** provide education about the managed care system to various groups, including families, enrollees, community-based organizations, and others. Another subcontractor also provides information to families, child welfare workers, providers, and others in **Connecticut**.
- In **New York**, ongoing training for providers about the managed care system has been incorporated.
- **Pennsylvania** uses its Child and Adolescent Services Institute at Penn State University to provide training to child serving systems. In addition, technical assistance sessions sponsored by the state provide training to key stakeholders in areas such as fiscal issues, program development, management information systems, and rate setting.
- In **Missouri**, educational meetings among the various agencies and systems are held to promote a better understanding of managed care as it relates to children and to promote better cross-system communication. Collaborative interagency meetings are also used as a strategy in **Oklahoma** to educate key stakeholders.
- In **Oklahoma**, a formal training module on managed care is included in the orientation for new employees of the Department of Human Services. □

III. Populations Covered by Managed Care Reform

Population Types Covered

Tables 17 and **18** indicate the types of populations covered in states' managed care reforms. As in 1997–98, about half of the reforms cover the total Medicaid population, and about half cover a portion of the Medicaid population. About half also cover the population eligible for the State Children's Health Insurance Program (SCHIP). Carve outs are far more likely than integrated reforms to cover the total Medicaid population; 62% of carve outs cover the total Medicaid population, compared with 12% of integrated reforms. Integrated systems are more likely to cover only a portion of the Medicaid population — 88% of integrated reforms cover only a portion of the Medicaid population, compared with 35% of carve outs. Over half of the carve outs (54%) also cover non-Medicaid, non-SCHIP populations, compared to none of the integrated reforms. The non-Medicaid populations covered in carve outs most often include children with serious emotional disorders who are dependent on the public system, including uninsured children and children whose families exhaust private coverage due to the severity of their children's disorders.

Table 17
Percent of Reforms Covering Population Types

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Total Medicaid population	59%	49%	62%	12%	50%	-9%	+1%
Portion of Medicaid population	Not Asked	47%	35%	88%	47%	Not Asked	0%
SCHIP population	Not Asked	Not Asked	54%	50%	53%	Not Asked	Not Asked
Non-Medicaid, non-SCHIP population	Not Asked	Not Asked	54%	0%	41%	Not Asked	Not Asked

As **Table 18** shows, the 2000 survey data suggest acceleration of the trend noted in 1997–98 of states' covering more Medicaid populations, including those that would be expected to use more and costlier services, such as children with serious disorders and those involved in child welfare and juvenile justice systems. The 2000 data indicate significant increases in the inclusion in managed care systems of children involved with child welfare and juvenile justice systems and of children eligible for Supplementary Security Income (SSI). In 1997–98, most reforms (84% to 96%, depending on population category) covered the Temporary Assistance for Needy Families (TANF) and poverty-related populations, as well as pregnant women and children; this was true for both carve outs and integrated reforms. Fewer reforms in 1997–98 (40 to 60%, depending on population category) covered the SSI, child welfare, and juvenile justice populations, and these were predominantly carve outs. In 2000, larger percentages of both carve outs and integrated reforms cover these higher need populations (79 to 82%, depending on population category).

Table 18
Percent of Reforms Covering Medicaid Subpopulations

	1995	1997–98	2000			Percent of Change	
	Total	Total	Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
TANF population	44%	96%	85%	100%	88%	+44%	-8%
Poverty related population	24%	88%	85%	100%	88%	+64%	0%
SSI population	20%	56%	81%	75%	79%	+59%	+23%
Pregnant women and children	34%	84%	77%	100%	82%	+48%	-2%
Children and adolescents in child welfare system	37%	60%	88%	63%	82%	+45%	+22%
Children in juvenile justice system	Not Asked	40%	88%	63%	82%	Not Asked	+42%
Other	15%	12%	15%	13%	15%	0%	+3%

Table 18 shows that, since 1997–98, there has been a reported 23% increase in the percentage of reforms covering the SSI population, a 22% increase in reforms covering children involved in child welfare, and a 42% increase in the percentage of reforms covering youth involved in the juvenile justice system. These data suggest that states are at the end stage of phasing in coverage of Medicaid populations in managed care and are not reluctant to cover populations that need more intensive and costlier services. These data also are consistent with findings in 2000 that states, increasingly, are including both acute and extended care services within their managed care systems as they include more populations requiring extended treatment. Increasing enrollment of these populations in managed care systems creates both opportunities and challenges in such areas as care coordination, financial streamlining, and outcomes accountability. Inclusion of high need populations requires creative adaptation of the commercial managed care model that, typically, manages acute care services only. Both the 2000 State Survey, as well as the 1999 Impact Analysis, suggest that states and counties, increasingly, recognize the need for such adaptation and are in a period of experimentation with managed care approaches for behavioral health care to high need populations.

Disruption in Eligibility for Child Welfare and Juvenile Justice Populations

Given the increased coverage of children involved in child welfare and juvenile justice systems in managed care reforms, the 2000 survey explored whether there were any types of placements in which children involved in these systems would lose their eligibility for services from the managed care system. This is an important area to examine, because these children use behavioral health services and frequently change placements, so that continuity of care is a significant issue. The 2000 State Survey data indicate that, in 73% of the reforms, children, reportedly, do lose eligibility based on type of placement (**Table 19**). Examples of the types of placements identified by respondents in which children lose eligibility for services from the managed care system include:

- Placement in a residential treatment facility
- Placement in a juvenile detention facility
- Placement in a state inpatient psychiatric hospital

- Group home placements
- Out-of-state placements
- Out-of-county placements if county of placement is not engaged in managed care reform
- Return home, depending on family's income.

Table 19

Percent of Reforms in Which Children Lose Eligibility for the Managed Care System Based on a Specific Type of Placement

	2000		
	Carve Out	Integrated	Total
Percent of reforms in which children lose eligibility based on a type of placement	71%	83%	73%

Loss of eligibility for the managed care system based on type of placement can create both incentives and disincentives to keep a child in certain placements, and it can create disruption in continuity of both providers and treatment. □

IV. Managed Care Entities

Types of Managed Care Organizations Used

The types of managed care organizations (MCOs) that states are using to administer their managed care systems are shown on **Table 20**. As in the two previous state surveys, many states reported using multiple types of entities to manage behavioral health service delivery within their managed care systems.

Table 20
Percent of Reforms by Types of Managed Care Organizations Used

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
For-profit MCO	47%	23%	50%	29%	-18%
Nonprofit MCO	29%	12%	50%	21%	-8%
For-profit BH/MCO	34%	38%	50%	41%	+7%
Nonprofit BH/MCO	24%	27%	50%	24%	0%
Private, nonprofit agencies	13%	15%	13%	15%	+2%
Government entitites	29%	50%	3%	44%	+15%
Other	0%	4%	0%	3%	+3%

The 1997–98 State Survey found growth in states' use of for-profit MCOs. The use of for-profit MCOs increased from one-third of the reforms in 1995 to nearly half of the reforms in 1997–98 (47%), and was the type of managed care entity used most frequently in 1997–98. The 2000 State Survey results show some decline in the use of for-profit MCOs both in carve outs and in managed care systems with integrated designs (an 18% decline, down to 29% of the reforms). This shift, however, is accompanied by a 7% increase in the use of for-profit behavioral health organizations (BHOs), perhaps indicating a trend toward the use of specialized behavioral health entities to manage behavioral health services, either through a direct contract with the state agency (which occurs in behavioral health carve outs) or through a subcontract to an MCO (which occurs in integrated physical health/behavioral health systems). The shift from MCOs to specialized BHOs is most notable among reforms with integrated designs; there was a 21% increase in the use of BHOs among integrated systems since 1997–98. Although for-profit MCOs were used most frequently in 1997–98, their reported use has been surpassed in 2000 by both for-profit BHOs (used in 41% of the reforms) and government entities (used in 44% of the reforms). Despite these differences, there remains significant use of for-profit entities to manage behavioral health care across states, with some apparent shift from generic MCOs to specialized BHOs.

Another emerging trend noted in 1997–98 was an increase in the use of government entities as MCOs, up from 20% of the reforms in 1995 to 29% in 1997–98. This trend continues to be reflected in the 2000 survey data — 44% of the reforms in 2000 reported using government entities, a 15% increase from the last survey. The use of government entities to manage behavioral health services is found almost exclusively in carve outs — half of them reported using government entities. In contrast, integrated managed care systems are more

likely to use for-profit or nonprofit MCOs or BHOs; half reported using each of these types of entities. Community-based private, nonprofit agencies remain the least likely type of entity to be used by reforms as MCOs (13% in 1997–98, 15% in 2000).

Use of Multiple Managed Care Organizations

Both impact analyses found that when states use multiple MCOs (as opposed to a single MCO) either statewide or within a single region, significant challenges are created for providers, families, and for state agencies as well. In systems using multiple MCOs statewide or within regions, stakeholders noted that each MCO developed different procedures for every aspect of system operations — billing and reimbursement, credentialing, utilization management, service authorization, reporting, and others. According to stakeholders, many problems result, including administrative burden for providers who must contract with multiple MCOs, inconsistency in clinical decision making, difficulty for consumers in understanding and navigating the system, and monitoring challenges for states. The use of multiple MCOs statewide or within a region creates particular difficulties for families involved in the child welfare system, such as foster families, who may have children enrolled in different MCOs. Although state officials reported that the use of multiple MCOs was intended to create consumer choice and competition, consumers interviewed for the impact analyses emphasized that choice in providers was more important to them than choice in MCO.

Table 21
Percent of Reforms Using Single Versus Multiple Managed Care Organizations

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
One MCO statewide	27%	25%	25%	25%	-2%
One MCO per region	23%	46%	0%	34%	+11%
Multiple MCOs statewide or within regions	50%	29%	75%	41%	-9%

In 1997–98, half of the reforms reported using multiple MCOs statewide or within regions, the preponderance of these being reforms with integrated designs; 93% of the integrated systems reported the use of multiple MCOs statewide or within regions. As shown on **Table 21**, the 2000 State Survey found a slight (9%) decline in the use of multiple MCOs statewide or within regions and an accompanying increase in the use of one MCO per region. In integrated systems, some increase was found in the use of one MCO statewide, while carve outs reported more extensive use of the approach involving one MCO per region as compared with 1997–98 data. Movement away from the use of multiple MCOs statewide or within regions (though only a 9% drop) may reflect emerging recognition of the many problems and challenges associated with this approach that were reported by stakeholders.

Several promising strategies for addressing the problems associated with the use of multiple MCOs statewide or within regions were cited by survey respondents.

- In **Delaware**, the Medicaid agency directed for-profit MCOs to contract with the same outpatient behavioral health care providers used by the Division of Children's Mental Health Services (which is the public MCO for the carve out serving youngsters with moderate to severe disorders). This practice reportedly helps to ensure a more seamless system for children's behavioral health care.
- In several states, standardization of criteria and processes is the approach taken. In **Connecticut**, standardized treatment authorization forms and processes are used, and in **Oklahoma** a task force is working to standardize some of the forms required for service across MCOs, such as treatment plans.
- Regular meetings are used in several states in an effort to standardize and coordinate implementation of the managed care system across MCOs. Monthly statewide meetings with a subcommittee are held in **Oregon**, and regional quarterly meeting with MCOs are held in **Virginia**.

Training and Education for Managed Care Organizations

Both impact analyses found that in most states using commercial MCOs, stakeholders complained that these MCOs lacked familiarity with the Medicaid population in general and with children with emotional disorders in particular, and training in these areas was cited as a significant need. Stakeholders from the child welfare and juvenile justice systems in most states, regardless of the type of MCO being used, reported that MCOs lacked sufficient knowledge about these systems and the populations they serve and that greater priority on training in these areas is needed. The 1999 Impact Analysis results suggested increased recognition of the need to provide training and education for MCOs.

Consistent with findings from the 1999 Impact Analysis and the 1997–98 State Survey, in 2000 most states reported that they have engaged in efforts to education and train MCOs in a variety of areas — 84% reported providing such training in 1997–98, 82% in 2000 (**Table 22**).

Table 22
Percent of Reforms Providing Training or Education to Managed Care Organizations

	1997–98 Total	2000			Percent of Change 1997/98–2000
		Carve Out	Integrated	Total	
No training	16%	19%	14%	18%	+2%
Training related to children and adolescents with serious emotional disorders	57%	62%	29%	55%	-2%
Training related to adolescents with substance abuse disorders	27%	27%	29%	27%	0%
Training related to children and adolescents involved with child welfare system	49%	50%	57%	52%	+3%
Training related to children and adolescents involved in the juvenile justice system	Not Asked	38%	29%	36%	NA
Training related to Medicaid population in general	68%	38%	43%	39%	-29%
Training related to home and community-based services approaches	Not Asked	54%	29%	48%	Not Asked
Training related to system of care values and principles	Not Asked	58%	29%	52%	Not Asked

There has been little change in the areas receiving the most attention in training across reforms. Both in 1997–98 and in 2000, training related to children and adolescents with serious emotional disorders and children and adolescents involved with the child welfare systems were areas of focus for training in the most managed care systems. Training in both of these areas reportedly is provided by more than half of the reforms — 55% educate MCOs about youth with serious emotional disorders and 52% about youth involved with the child welfare systems. Two areas not assessed in 1997–98 also were cited by many reforms as significant topics for training, training related to home and community-based service approaches (reported by 48% of the reforms) and training related to system of care values and principles (reported by 52% of the reforms). The next most frequently cited areas for training were training related to the Medicaid population in general (reportedly provided by 39% of the reforms) and training related to children and adolescents involved in the juvenile justice system (reportedly provided by 36% of the reforms).

Carve outs were more likely than systems with integrated designs to provide training to MCOs on children and adolescents with serious emotional disorders, home and community-based service approaches, system of care values and principles, and the juvenile justice population. Integrated systems were slightly more likely to provide training related to the child welfare population (57% as compared with 50% of carve outs) and training related to the Medicaid population in general (43% as compared with 38% of carve outs).

Training for MCOs on adolescents with substance abuse disorders was the area least likely to be addressed, regardless of managed care design, a finding consistent with the 1997–98 State Survey. Only about a quarter (27%) of the reforms reported providing any training in this

area, highlighting the need for greater attention to substance abuse services given the high rates of substance abuse problems among children and adolescents served by managed care systems and the co-morbidity between mental health and substance abuse disorders.

Respondents noted a number of promising strategies related to increasing the knowledge base of MCOs through training and education.

- An interagency coordinating committee in **Arizona** has funded training to MCOs and their contracted providers on serving the early childhood population. Experts offer on-site training in each region, and follow-up technical assistance to MCOs is provided by consultants to assist them in implementing services for this population.
- In **Delaware**, the state offers a series of ongoing training workshops on a wide range of topics for MCOs and providers; recent topics have included mental health/substance abuse integration and cultural competence. The cost of the training is low and continuing education units are offered to help participants maintain their licenses.
- **Pennsylvania** includes in its RFP a required list of training topics for MCOs and their provider networks. The provision of this training is monitored in monthly and quarterly monitoring sessions with MCOs as well as in their annual reviews. Additionally, for their readiness reviews, MCOs must submit their training schedule, topics, and speakers for the first year.
- In addition to statewide and regional children's mental health conferences, **Utah** provides on-site psychiatric consultation and quality of care case reviews to its MCOs.
- In **Oklahoma**, training is provided to MCOs on identification, assessment, and service delivery to children and adults with special behavioral health treatment needs. □

V. Service Coverage and Capacity

Coverage of Acute and Extended Care Services

One recommendation from the 1997 and 1999 Impact Analyses was to include both acute and extended care in managed care systems. For purposes of the Tracking Project, acute care is defined as brief short-term treatment with, in some cases, limited intermediate care also provided, and extended care is defined as care extending beyond the acute care stabilization phase, i.e, care required by children with more serious disorders and their families. The impact analyses found that inclusion of both types of services creates the potential to integrate care for the total eligible population and reduces the potential for cost shifting and fragmentation at the service delivery level. Although early findings of the Tracking Project found many managed care systems limiting coverage to acute care, both the 1999 Impact Analysis and the 1997–98 State Survey found that states were moving in the direction of including extended care in managed care systems. This movement paralleled movement by states to include higher need populations in managed care systems, such as the SSI and child welfare populations.

Table 23
Percent of Reforms Including Acute and Extended Care Services

Services Covered	1997–98 Total	2000			Percent of Change 1997/98–2000
		Carve Out	Integrated	Total	
Acute care only	26%	8%	12%	9%	-17%
Acute care and extended care	74%	88%	88%	88%	+14%
Extended care only	0%	4%	0%	3%	+3%

As shown on **Table 23**, the 2000 State Survey suggests that this trend is continuing; 88% of reforms in 2000 reportedly include both acute and extended care, a 14% increase since 1997–98. Only 9% of the reforms reported covering only acute care in 2000, a 17% decrease from 1997–98.

A notable increase in coverage of extended care services among reforms with integrated designs was observed in the 2000 data; half of the integrated reforms covered only acute care in 1997–98 compared with only 12% limiting coverage to acute care services in 2000. Thus, much of the increase in coverage of both acute and extended care in managed care systems is attributable to increased inclusion of coverage for extended care within integrated managed care systems, with 88% of integrated reforms covering both in 2000, compared with 44% in 1997–98.

Regardless of how extended care is covered, ensuring smooth transitions between acute and extended care services has proven to be challenging to many managed care systems. Several states reported promising strategies to improve the transitions between acute and extended care service levels.

- **Delaware** has created a multifaceted approach to ensure smooth transitions from the basic behavioral health outpatient benefit of 30 hours of treatment managed by the MCOs to the intermediate and extended care services provided by the carve out managed by the state children's mental health division (DCMHS). The Medicaid agency requires that MCOs providing the basic benefit contract with the same providers as DCMHS to ensure smooth transitions. The Medicaid agency also funded DCMHS to develop a screen for use by MCOs to identify behavioral health problems, which triggers a more complete assessment and referral to appropriate levels of care. Clear and widely disseminated eligibility and level of care criteria, developed by DCMHS, are used to ensure appropriate referrals for extended care services. A clinical services management model is used whereby each child and family is assigned to a clinical services management team and a special coordinator who works with them throughout their participation in the system and ensures smooth transitions across services and levels of care. Also, the Delaware Care Assurance Model has no benefit limits and requires that services at appropriate levels of care are provided to all children (both Medicaid and uninsured populations) as long as clinical necessity is certified by a clinical services management team within DCMHS.
- In **Oregon**, Intensive Treatment Services pilot projects are being implemented to integrate intensive services (such as psychiatric residential treatment and day treatment) with the inpatient and outpatient services provided through the managed care system in order to create more comprehensive, coordinated systems of care.
- In **Oklahoma**, a case manager from the MCO and a designated professional from the acute care setting together determine the most appropriate level of care for a youngster upon discharge, and follow-up appointments are made with the step-down provider prior to discharge. Similarly, MCOs in **Missouri** are required to participate in planning for discharge from acute care facilities and to ensure follow up for members leaving acute care settings.

Other Systems with Resources and Responsibility for Extended Care

While states increasingly are designing or refining managed care systems to include extended care services (and populations typically needing extended care), stakeholders interviewed in the impact analyses noted that the actual provision of extended care services often is hampered by factors such as strict interpretation of medical necessity criteria to limit duration of care, MCOs creating arbitrary limits on certain types of services, and lack of capacity to provide extended care services. A significant challenge also noted by stakeholders was that large amounts of extended care funding streams remain outside of managed care systems for a variety of reasons.

Table 24

Percent of Reforms in Which Other Systems Have Responsibility and Resources for Behavioral Health Extended Care Services

	2000		
	Carve Out	Integrated	Total
Child mental health system	68%	100%	76%
Child welfare system	92%	100%	94%
Juvenile justice system	68%	100%	76%
Education system	60%	63%	61%
Substance abuse system	44%	50%	45%
Other	16%	38%	21%

Table 24 shows that, even though most reforms reportedly cover both acute and extended care, other child-serving systems still retain both responsibility and resources for extended care behavioral health services as well. The three systems most likely to have resources and responsibility for extended care services, in addition to the managed care system, are the child welfare system (reported in 94% of the reforms), the children's mental health system (reported in 76% of the reforms), and the juvenile justice system (also reported in 76% of the reforms). The education system was cited as having resources and responsibility for extended care behavioral health services in 61% of the reforms.

All of the integrated reforms (100%) indicated that the child welfare, mental health, and juvenile justice systems retain resources and responsibility for extended care. This finding suggests that although an increased percentage of integrated managed care systems reported that they include coverage for extended care, the extended care actually provided within these systems may be limited, resulting in reliance on these other child-serving systems for longer-term services.

The continued fragmentation of resources and responsibility for extended care across managed care systems and other child-serving systems raises the potential for boundary issues, creation of parallel systems, duplication of services across systems, and resource disputes across systems. In addition, this may contribute to incentives for managed care systems to underserve extended care populations, especially when responsibility can be shifted to another child-serving system that has resources for these services.

Coverage of Behavioral Health Services in Managed Care Systems

Both the 1997–98 and 2000 State Surveys presented respondents with a list of services and asked respondents to identify which mental health services were covered under their managed care reforms. In 1997–98, 39% of the reforms covered most or all of the services (most or all was defined as covering 80 to 100% of the services on the list presented in the survey). Carve outs were much more likely to cover most of all of the services (58% did as compared with only 7% of the integrated reforms).

Matrix 2 shows, state by state, the mental health services that respondents to the 2000 State Survey reported are currently covered by their managed care systems. The 2000 State

Survey showed a 18% increase in the percentage of reforms covering most or all (again, 80 to 100%) of the same list of services that was used in 1997–98, up from 39% in the previous survey to 57% of all reforms in 2000 (**Table 25**). As in 1997–98, carve outs were far more likely to cover most or all of these services — 70% compared with only 13% of the integrated systems.

● = Covered under reform
○ = Covered by another funding source
☒ = Not covered by the State through any source

N=35

		Matrix 2: Mental Health Services Covered by Reforms																			
		Assessment and Diagnosis	Outpatient Psychotherapy	Medical Management	Home-Based Services	Day Tx/Partial Hospitalization	Crisis Services	Behavioral Aide Services	Therapeutic Foster Care	Therapeutic Group Homes	Residential Treatment Centers	Crisis Residential Services	Inpatient Hospital Services	Case Management Services	School-Based Services	Respite Services	Wraparound Services	Family Support/Education	Transportation	Mental Health Consultation	Other
Arizona	AZ	●	●	●	●	●	●	●	○	●	●	●	●	●	●	●	○	○	●	●	
California	CA	●○	●○	○	●	●	●○	●	●	○	○	○	●	●	●○	○	○	●○	○	○	
Connecticut	CT	●	●	●	●	●○	●○		●	●	●	○	●	●○	●○	○	○	○	●○	●○	
Colorado	CO	●	●	○	●	●	●	●	●○	●○	●○	●	●	●	●	●	●	●	●○	●	
Delaware	DE	●	●	●	●	●	●	●	●	●	●	●					●	●			
District of Columbia	DC	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Florida (BHSCN)	FL	●	●	●	●	●	●	●	○	○	○	●	●	●	●	●	●	●	●	●	
Florida (PMHP)	FL	●	●	●	●	●	●	●	○	○	○	●	●	●	●	●	●	●	●	●	
Hawaii	HI	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	●
Indiana	IN	●	●	●	●	●	●		●	○	○	○	●	●		○	●	●	○	☒	
Iowa	IA	●	●	●	●	●	●					●	●	○	●	○	●	○	○	○	○
Maine	ME	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Maryland	MD	●	●	●	●	●	●	●	●○	●	●	●	●	●	●	●	●	●	●	●	●
Massachusetts	MA	●	●	●	●	●	●	○	○	○	○	●	●○	○	○	○	○	●○	●○	●○	
Michigan	MI	●	●	●	●	●	●	●	○	○	○	●	●	●	●	●	●	●	●	●	●
Minnesota	MN	●	●	●	●	●	○	○	○	○	○	○	●	○	○	○	○	●	●	☒	
Mississippi	MS																●				
Missouri	MO	●	●	●	●	●	●	○	○	○	☒	●	●	●○	●○	●	○	○	●	●	
Nebraska	NE	●○	●○	●○	○	●○	●○	●○	●○	●○	●○	●○	●○	○	●○	○	●○	○	●○	○	
New Jersey	NJ	●	●	●	●	●	●	●	●○	●	●	●	●	●	○	●	●	●	●○	●	●
New Mexico	NM	●	●	●	●	●	●	●	●	●	●	●	●	●	○	○	●	○	●	●	
New York	NY	●	●	●	●	●	●	●	○	○	○	●	●	●	●	●	●	●	●	●	
North Dakota	ND	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	●	●		●	●○
Oregon	OR	●	●	●	●	●	●	●	○	○	○	○	●	●	●	●	●	●	●	●	
Oklahoma	OK	●	●	●	●	●	●	☒	●	○	●	○	●	●	○	○	☒	☒	●	☒	
Pennsylvania	PA	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	
Rhode Island	RI	●○	●○	●○	○	●○	●○	○	○	○	●○	○	●○	●○	●○	○	●	●○	●○	○	
Tennessee	TN	●	●	●	●	●	●	●	○	○	●	●	●	●	○	●	○	○	●	●	
Texas	TX	●	●	●	●	●	●	☒	●	☒	●	●	●	●	●	●	●	●	●○	●	●
Utah	UT	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Vermont	VT	●	●○	●○	○		●○	○	○	○	○	○	●	○	○		○	○	○	○	
Virginia	VA	●	●	●	○	○	○	●	○	●	○	●	○	○	○	○	○	○	○	○	
Washington	WA	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●		●	
West Virginia	WV	●	●	●	●	●	●	●	●	●	○	●	○	●	○	○	○	○	○	☒	
Wisconsin	WI	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	

For the 2000 State Survey, three additional services were added to the list presented in 1997–98, family support/education, transportation, and mental health consultation. When considering the expanded list of services, comparable results were obtained. Overall, 54% of the reforms reportedly cover most or all (80 to 100%) of the expanded service list — 70% of the carve outs and none of the integrated reforms (**Table 25**).

Table 25

Percent of Reforms Covering Most or All (80–100%) of the Service Array Shown on Matrix 2

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Reforms cover 13 or more of the first 16 services listed, up to and including wraparound	39%	70%	13%	57%	+18%
Reforms cover 15 or more of the expanded list of 19 services in the array shown on Matrix 2	Not Asked	70%	0%	54%	Not Asked

The services most and least likely to be covered also can be derived from the matrix. The services most likely to be covered by managed care systems, according to the 2000 State Survey, include:

- Assessment and diagnosis
- Outpatient psychotherapy
- Crisis services
- Medical management
- Day treatment
- Inpatient services

A change from 1997–98 is that case management was among the services most likely to be covered by managed care systems at that time, but is no longer included in this group in 2000.

The services least likely to be covered by managed care systems in 2000 include:

- Therapeutic foster care
- Respite services
- Therapeutic group care
- Residential treatment services

In the 1997–98 State Survey, crisis residential services also were among the least likely to be covered, but are not included in this category in 2000, perhaps suggesting increased attention to alternatives to hospitalization.

Consistent with previous survey results, coverage in reforms with integrated designs is more likely to be limited to traditional mental health services typically included in commercial insurance plans (such as assessment, outpatient services, medical management, and inpatient services); integrated systems are less likely to cover other services. In contrast, carve outs are

more likely to include coverage for additional home and community-based services, such as home-based services, behavioral aides, crisis residential services, school-based services, respite services, therapeutic foster care, wraparound, and family support/education.

When services are not covered under the managed care system, in most cases respondents reported that they are covered by another funding source in the state. In very few cases were services reportedly not covered by any source whatsoever. The service reported to be without coverage most frequently was mental health consultation, which involves mental health specialists providing clinical consultation to other providers, such as schools or day care centers. Lack of coverage by any source for mental health consultation was reported by four states, and lack of coverage for behavioral aide services was reported by two states. In all other cases, the absence of any coverage for any particular service was reported by only one state.

Matrix 2 also shows the services that are covered by another source, *either instead of or in addition to* coverage under the managed care system. The services most likely to be covered by another source include therapeutic foster care, therapeutic group care, residential treatment, school-based services, transportation, family support/education, wraparound services, and respite services. Although it is encouraging to note that most children's behavioral health services and supports apparently are covered to some extent by some funding source in states, the multiple funding sources and systems used to provide these services may perpetuate the historic fragmentation in behavioral health service delivery for children and adolescents and their families, resulting in discontinuity, potential duplication, cost shifting, and confusion for providers and families.

Home and Community-Based Services and Flexible/Individualized Care

The state surveys have explored whether managed care reforms have expanded the array of home and community-based services covered for children and adolescents. The 2000 findings were similar to those in 1997–98 — 57% of the reforms reported that coverage of home and community-based services has been expanded (**Table 26**). However, consistent with the results reported above, a sharp contrast was found between the expansion of coverage of home and community-based services in carve outs and in integrated systems. Nearly two-thirds of the carve outs (63%) expanded coverage of home and community-based services through their managed care reforms, compared with only about one-third (38%) of the integrated systems. Both impact analyses also found that managed care reforms were credited with expanding the range of mental health services covered in systems with carve out designs but much less so in integrated systems.

Table 26

Percent of Reforms that Expanded Coverage of Home and Community-Based Services

Expanded Coverage	1997–98 Total	2000			Percent of Change 1997/98–2000
		Carve Out	Integrated	Total	
Yes	56%	63%	38%	57%	+1%
No	44%	37%	62%	43%	-1%

Where it occurred, expansion in the coverage of home and community-based services was attributed primarily to filling in the mid-range between outpatient and inpatient hospital services by adding an array of home and community-based service modalities, such as home-based services, case management, crisis services, respite care, day treatment, intensive outpatient services, family support and education, wraparound, and others.

A similar contrast was found with respect to whether or not the managed care reform has facilitated the provision of flexible/individualized services. As shown on **Table 27**, in 2000, for the majority of reforms (81%), respondents indicated that the managed care reform has indeed made it easier to provide flexible/individualized care. However, as with expansion of coverage, it is reportedly easier to provide individualized care in the majority of the carve outs (88%) but only half (50%) of the integrated systems. In both impact analyses, stakeholders also reported that flexible/individualized service delivery was facilitated to a much greater extent in carve outs than in integrated systems.

Table 27

Percent of Reforms Facilitating Flexible/Individualized Service Provision

	2000		
	Carve Out	Integrated	Total
Easier to provide flexible/individualized services	88%	50%	81%
Not easier to provide flexible/individualized services	12%	50%	19%

Survey respondents cited a number of factors to explain the greater flexibility and ability to individualize care provided by some managed care systems:

- Lifting many of the restrictions inherent in a fee-for-service system by using capitation financing which allows MCOs to use premiums creatively
- Incorporating a wider range of covered services in the managed care systems, such as mental health rehabilitation services
- Incorporating “wraparound” as a covered service in managed care systems
- Requiring individualized service planning
- Creating flexible funds within the managed care system to allow greater individualization in service provision
- Allowing MCOs to provide flexible, home and community-based services with funds previously spent on high cost out-of-home placements

Where managed care has not supported flexible/individualized service delivery, stakeholders pointed to the following factors:

- Billing procedures and service codes that impede flexibility
- Reporting methods used to track encounter data that are disincentives to flexible service delivery
- Rigid authorization processes
- The tendency of MCOs to focus on single episodes of discrete services
- Lack of MCO and provider understanding of how to use flexible approaches

Home and Community-Based Service Capacity

Although managed care reforms may have expanded *coverage* of home and community-based services, the impact analyses revealed that the actual *availability* of these services is a separate and distinct issue. Across states in both the 1997 and 1999 Impact Analysis samples, respondents agreed that, although managed care reforms have broadened the array of covered services (in most carve outs and in some integrated systems), and some service capacity expansion has occurred, there remain significant gaps in behavioral health service availability for children and adolescents, regardless of managed care design. Lack of sufficient service capacity for children's behavioral health services is a systemic issue that pre-dates managed care reforms. However, stakeholders interviewed for the impact analyses noted that managed care reforms have not necessarily resulted in improvements, and that lack of sufficient capacity, particularly for home and community-based services, remains a daunting problem. Lack of start-up resources often was cited as a problem in expanding capacity, as well as provider reluctance to develop and offer new types of services if they perceive the managed care system's payment rates for these services to be insufficient or if they perceive overly restrictive authorization practices among MCOs.

A new area of exploration was incorporated into the 2000 State Survey to assess more fully the issue of service capacity for home and community-based mental health services for children and their families. Consistent with findings from the impact analyses, significant expansion of the availability of home and community-based services was found in only about one-third of the reforms (32%) — all carve outs (**Table 28**). Another 26% of reforms reported some expansion of service capacity for home and community-based services. However, 42% of the reforms reported either very little expansion in the availability of services or no service capacity expansion at all. This is in spite of the fact that, as noted, 91% of the reforms focus on expanded access as a managed care goal.

Table 28

Percent of Reforms Expanding Availability of Home and Community-Based Services

	2000		
	Carve Out	Integrated	Total
Not at all	12%	50%	21%
Very little	15%	38%	21%
Somewhat	31%	12%	26%
Significant	42%	0%	32%

Again, the differences between carve outs and integrated systems are evident. Most integrated systems (88%) reportedly have had none or very little expansion in the availability of home and community-based services. In contrast, most carve outs (73%) have had some or significant expansion of home and community-based service capacity.

In addition to reporting on the expansion of home and community-based service capacity, the 2000 State Survey also asked respondents to rate on a scale of 1 to 5 the *general level* of development of home and community-based service capacity in the state, with 5 being highly developed and 1 being poorly developed. The mean ratings shown on **Table 29** suggest that the

level of development of home and community-based services for children is judged to be higher in states with carve outs (3.15) as compared with states with integrated systems (2.63).

Table 29
Mean Ratings of Home and Community-Based Service Capacity in the State

	Mean Rating
Carve Out	3.15
Integrated	2.63
Total	3.03

However, in neither carve outs nor integrated systems was service capacity in the state characterized as highly developed or even approaching this level. Only one-quarter of the reforms (24%) — all carve outs — rated their capacity as highly developed or close to highly developed by assigning a rating of 4 or 5 (**Table 30**). Integrated reforms were more likely to characterize service capacity in the state as poorly developed by assigning a rating of 1 or 2; 38% did so as compared with only 15% of the carve outs.

Table 30
Percent of Reforms Rating Home and Community-Based Service Capacity as Highly and Poorly Developed

	2000		
	Carve Out	Integrated	Total
Highly developed (1 and 2 on 5 point scale)	31%	0%	24%
Poorly developed (4 and 5 on 5 point scale)	15%	38%	21%

Given the finding that service capacity remains underdeveloped in most states, investment in the development of children's behavioral health services is an important issue. In the two impact analyses, stakeholders in nearly all states reported insufficient investment in service capacity development for children's behavioral health services. They noted that although inpatient and residential services reportedly are more difficult to access as a result of managed care reforms, there has been little development of service capacity on the home and community-based end of the service spectrum.

To assess the extent of efforts to invest in service capacity development, the 2000 State Survey explored two areas — the reinvestment of savings from the managed care reform back into the system to expand service capacity and state investment in service capacity with resources separate and apart from the managed care system.

As shown on **Table 31**, most reforms (68%) do not require reinvestment of savings from managed care reforms back into the system to expand service capacity for behavioral health services to children and their families. In fact, there has been a 16% decline since the 1997–98

State Survey in reforms that do require reinvestment (32%, down from 48% in 1997–98). Carve outs are more likely to require reinvestment (38% do as compared with only 12% of the integrated systems), yet the majority of carve outs do not have such requirements.

Table 31

Percent of Reforms Requiring Reinvestment of Savings in Service Capacity Development

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Reforms requiring reinvestment	48%	38%	12%	32%	-16%
Reforms not requiring reinvestment	52%	62%	88%	68%	+16%

Some states reported promising strategies related to reinvestment of savings.

- In **Colorado**, MCOs are required to reinvest savings in the public mental health system, though not specifically for children and adolescents. Savings are reportedly used to provide services to non-Medicaid children, develop new service options, and increase salaries to attract and retain more qualified staff.
- Savings in **North Dakota** were invested in the development of four new services — respite care, independent living, parent to parent support, and psychosocial rehabilitation.
- **Pennsylvania** requires that a reinvestment plan be submitted by MCOs and approved by the state. Capitated dollars not expended in a contract year may be used for purchasing cost-effective alternative services, seed money to develop increased service capacity, or purchasing additional in-plan or supplemental services.
- In **Texas**, each BHO must develop a reinvestment plan in collaboration with the local behavioral health authority and obtain state approval.

Both the 1997 and 1999 Impact Analyses found a broad consensus among stakeholders that they consider state investment in service capacity development for children's behavioral health services, beyond reinvestment of savings generated by the implementation of managed care, to be inadequate. The maturational analysis of the 1997 sample suggested that, over time, states may be devoting increased attention to the need for investing in service capacity development. The 2000 State Survey confirmed this observation, finding an 11% increase in reforms reporting state investment in service capacity development, from 68% in 1997–98 to 79% in 2000 (**Table 32**). Again, states with carve outs are more likely to invest resources in service capacity development (84% of the carve outs reported state investment), but nearly two-thirds (62%) of the integrated reforms also reported state investment in services. Despite the large number of states reporting investments, the impact analysis results suggest that stakeholders still consider such investments to be insufficient in relation to the need.

Table 32
Percent of Reforms with State Investment in Service Capacity Development

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
State investment in service capacity development	68%	84%	62%	79%	+11%
No state investment in service capacity development	32%	16%	38%	21%	-11%

Promising state strategies for investing in service capacity development were reported by a number of respondents.

- In **California**, the state provides an advanced distribution of state funds to the MCOs at about 75% of estimated costs to provide funding for capacity building.
- In **Arizona**, a Single Purchase of Care process has created a single statewide contracting process with service providers that can be used by all child-serving agencies. This has enabled rural areas to attract new providers and has encouraged expansion of services among current providers.
- **Maryland** provides grants to help new providers start particular services in order to build capacity in the state, for example, respite services, behavioral health services to the juvenile justice population, and services to transition age youth. State grants in **Minnesota** are used for similar purposes, including developing capacity to serve youth who have emotional disorders and are violent and developing services for youth in the juvenile justice system.
- State initiated system improvement grants to counties were funded in **Wisconsin** to create community-based wraparound services. Additionally, new Medicaid billing codes were created to support community-based care.
- **North Dakota** allocated increased resources to expand the wraparound process throughout all eight regions of the state.
- **New Jersey** is funding and implementing a new children's mental health system of care development plan statewide.
- State funding allocations to develop specific services were reported by several states. For example, in **Delaware**, states funds were allocated to develop therapeutic group homes, in **Washington** to develop telemedicine, family networks, and services for youth in the juvenile justice system, and in **Maine** to develop targeted case management and in-home services.

Services to Young Children and Their Families

Both the 1997 and 1999 Impact Analyses found that few, if any, services were being provided to infants, toddlers, and preschoolers and their families through managed care systems in most states. A number of barriers to serving the early childhood population were identified by stakeholders, including:

- Widespread lack of knowledge among providers about behavioral health problems and appropriate interventions for the early childhood population and lack of expertise in working with this group.
- Typical focus of Medicaid services on an "identified patient," precluding, in some states, working with parents in the absence of the child, which often is required and appropriate when addressing the needs of very young children. (It may be a particular problem in some states to work with parents if they are not Medicaid eligible, that is, if only the child is a Medicaid recipient.)
- Strict medical necessity criteria, the requirement for a diagnosis (considered by some to be inappropriate for young children) and the need for a high level of dysfunction in order for behavioral health services to be authorized also serve as barriers to serving this population in managed care systems.

Given the issues raised by the impact analyses, the 2000 State Survey explored the extent to which services are being provided to young children and their families. Findings shown on **Table 33** indicate that half of the carve outs and 75% of the integrated systems (56% of all the reforms) provide "few" or no services to the early childhood population. Only 44% of all reforms reportedly provide "many" services to this population (50% of the carve outs and 25% of the integrated systems).

Table 33
Percent of Reforms Providing Services to Young Children and Their Families

	2000		
	Carve Out	Integrated	Total
None are provided	12%	12%	12%
Few are provided	38%	63%	44%
Many are provided	50%	25%	44%

Promising strategies for providing behavioral health services to young children and their families were cited by a few states.

- **Arizona's** Early Intervention Program has funded training to MCOs and their contracted providers on serving the 0 to 3 population. On-site training in each region is followed by consultation provided to each MCO in implementing these services.
- Integrating services into day care centers and Head Start programs is a strategy noted by several states. In **Oregon**, mental health providers are integrated into Head Start classrooms in many areas, and in **Washington** behavioral health services are provided in day care centers and preschools, and training and consultation are provided to staff in these settings as well. □

VI. Special Provisions for Youth with Serious and Complex Behavioral Health Needs

Incorporation of Special Provisions for High Need Populations

An issue emphasized by stakeholders in both of the impact analyses is the need for managed care systems to incorporate special services, arrangements, or provisions for children and adolescents with serious and complex behavioral health needs and their families: children and adolescents with serious emotional disorders, children and adolescents involved with the child welfare system, and children and adolescents involved with the juvenile justice system. Many barriers to serving these high need populations were cited, including:

- Medical necessity and other clinical decision making criteria are rigid or applied too stringently making it difficult for children with serious and complex needs to obtain authorization for services.
- MCOs often do not participate in local interagency service planning processes for children with serious and complex needs.
- Managed care systems may include unintended financial incentives to underserve consumers with the most serious (and potentially most expensive) service needs.
- There has been a tendency within managed care systems to emphasize short-term treatment, which is not appropriate or sufficient for high utilizer populations with serious disorders.
- There has been a lack of understanding of the special legal, logistical, coordination, and treatment needs of children involved in other child-serving systems.

Both previous state surveys explored whether special provisions were incorporated for the population of children and adolescents with serious emotional disorders. Forty-four percent of the reforms in 1995 and 49% of the reforms in 1997–98 reported doing so, indicating a slight increase and perhaps a beginning trend to consider the special needs of this population in managed care system planning and operation. In 1997–98, reforms with carve out designs were twice as likely to have some type of differential coverage or special provisions for children with serious emotional disorders than those with integrated designs.

The 2000 State Survey results show a dramatic increase in the incorporation of special provisions for children and adolescents with serious emotional disorders (**Table 34**), with a shift from less than half of the reforms having any special provisions to the majority of reforms indicating that they now do. Overall, 93% of the reforms reportedly include one or more special provisions for this population– all of the carve outs and 71% of the integrated systems– reflecting a 44% increase from 1997–98. This shift may be the result of recognition of the special needs of this population over time, due to the many problems and challenges encountered in attempting to serve them within the context of managed care systems. The findings continue to reflect the previously established pattern of a greater likelihood of special provisions in managed care systems with carve out designs; however, a substantial proportion of integrated systems also reported having some special provisions for this group.

Table 34

Percent of Reforms with Special Provisions for Children and Adolescents with Serious and Complex Behavioral Health Needs

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Children and adolescents with serious behavioral health disorders	44%	49%	100%	71%	93%	+49%	+44%
Children and adolescents in the child welfare system	Not Asked	Not Asked	91%	71%	87%	Not Asked	Not Asked
Children and adolescents in the juvenile justice system	Not Asked	Not Asked	61%	57%	60%	Not Asked	Not Asked

Though not assessed in previous state surveys, in 2000, 87% of the managed care reforms also reportedly have special provisions of some type for children and adolescents in the child welfare system, and nearly two-thirds (60%) have provisions for children and adolescents in the juvenile justice system.

Types of Special Provisions

Of the special provisions for children and adolescents with serious emotional disorders, as shown on **Table 35**, most take the form of interagency treatment and service planning, intensive case management (each found in 86% of the reforms with special provisions), an expanded service array, or family support services (each found in 79% of the reforms with special provisions). More than half of the reforms (57%) reported using wraparound services as a special provision for children with serious emotional disorders. However, only 29% of the reforms with special provisions include a higher capitation or case rate for these youth, a finding consistent with the 1997–98 data and representing a small (9%) decline in the use of financial incentives for this group. This suggests that although special provisions such as expanded services or intensive case management are included, the resources to provide these additional services to this high need population may not be sufficient.

Table 35

Types of Special Provisions for Children and Adolescents with Serious Behavioral Health Disorders in Reforms with Special Provisions

Special Provisions	1997–98 Total	2000			Percent of Change 1997/98–2000
		Carve Out	Integrated	Total	
Expanded service array	90%	78%	80%	79%	-11%
Intensive case management	86%	87%	80%	86%	0%
Interagency treatment and service planning	57%	91%	60%	86%	+29%
Wraparound services	71%	57%	60%	57%	-14%
Family support services	67%	83%	60%	79%	+12%
Higher capitation or case rates	38%	30%	20%	29%	-9%
Other	0%	26%	0%	21%	+21%

Of particular note is the reported increase in the use of interagency treatment and service planning, reportedly used in 86% of the reforms with special provisions, up from 57% in 1997–98. This 20% increase is accounted for by increased use of interagency treatment planning in carve outs; the use of interagency treatment planning among reforms with integrated designs remains at the 1997–98 level of 60%. Of some concern are declines in the incorporation of an expanded service array and wraparound services for youth with serious emotional disorders — down 11% and 14% respectively of the reforms with special provisions from 1997–98 to 2000.

The special provisions incorporated for youth in the child welfare and juvenile justice systems are similar to those for the population of youngsters with serious emotional disorders (**Table 36**). For children involved with the child welfare system, special provisions are most frequently in the form of interagency treatment and service planning (77% of the reforms with special provisions for this group) and an expanded service array (73% of the reforms with special provisions for this group). Similarly, for the juvenile justice population, the special provisions incorporated most frequently are an expanded service array (found in 94% of the reforms with special provisions for this group), interagency treatment and services planning (83%) and intensive case management (78%).

Table 36

Types of Special Provisions Included by Reforms with Special Provisions for Children and Adolescents in Child Welfare and Juvenile Justice Systems

Special Provisions	2000					
	For Children Involved in the Child Welfare System			For Children Involved in the Juvenile Justice System		
	Carve Out	Integrated	Total	Carve Out	Integrated	Total
Expanded service array	67%	100%	73%	93%	100%	94%
Intensive case management	62%	60%	62%	86%	50%	78%
Interagency treatment and service planning	76%	80%	77%	93%	50%	83%
Wraparound services	67%	60%	65%	71%	50%	67%
Family support services	52%	40%	50%	71%	25%	61%
Higher capitation or case rates	14%	20%	15%	14%	25%	17%
Other	10%	0%	8%	14%	0%	11%

A notable difference in the types of special provisions incorporated for these three populations is that intensive case management is a less common strategy for children in child welfare than the other two groups, perhaps because child welfare staff fulfill the case management function. In addition, family support services are much more likely to be included for children and adolescents with serious emotional disorders than for the child welfare or juvenile justice populations. Wraparound services, reportedly provided by about two-thirds of the reforms with special provisions for the child welfare and juvenile justice populations, are slightly less likely to be included as a special provision for youth with serious emotional disorders.

Promising strategies described by respondents to incorporate special provisions for high need populations include the following:

- In **Missouri**, a consortium of state agencies (Interdepartmental Initiative for Children with Severe Needs and their Families) has integrated funding to support comprehensive systems of care for behavioral health services for children and adolescents. Care management organizations are responsible for organizing and delivering locally organized systems of services and supports.
- **Oklahoma** offers an expanded service array, beyond the basic behavioral health services included in the benefit, to children with special behavioral health needs including home-based services, rehabilitative case management, and therapeutic foster care.
- The Clinical Services Management Model used in **Delaware** provides a clinical services management team and service coordinator to plan, deliver, monitor, and coordinate services to children with serious behavioral health needs. Additionally, the Care Assurance Model has no predetermined benefit limits.

(Promising strategies continued on next page)

(Promising strategies continued)

- In **Texas**, a specialty provider network within the larger North Star Program ensures that individuals with serious needs have providers with experience and knowledge about more complex behavioral health problems as well as a history of providing specialized services to these populations.
- In Marion County, **Indiana**, the Dawn Project provides an organized system of care using a managed care approach to serve youth with serious and complex behavioral health needs. Similarly, the Children's Intensive Services Project in **Oregon** creates integrated systems of care for this population.

Two states described promising strategies for incorporating special provisions to meet the needs of the child welfare population.

- In **Maryland**, all children entering the child welfare system are to be screened for mental health problems and appropriate referrals made to the managed care system.
- The child welfare agency in **Oregon** hired regional coordinators to assist case workers in working through access barriers for medical and behavioral health care in the managed care system and to solve problems. The regional coordinators have frequent contact with local MCOs and with the state mental health agency.

Case Management/Care Coordination for Children with Serious and Complex Behavioral Health Needs

The 1997 Impact Analysis found that case management services were expanded to some degree in nearly two-thirds of the states included in the sample. However, very different results were found in the subsequent 1999 Impact Analysis. In the 1999 sample, only one state reported expansion of case management services related to the managed care reform (a state that had added targeted case management services that were not previously covered). Further, two states in the 1999 sample reported that case management services were actually constricted as a result of the managed care reform, due to such factors as the need for authorization, greater emphasis on utilization management as opposed to accessing and coordinating care, and a perception that case management services are neither approved nor reimbursed as readily as under previous fee-for-service systems.

Given these conflicting results, the 2000 State Survey was used to clarify this area and to further assess the effects of managed care reforms on case management/care coordination services. The survey specifically investigated the effects of managed care on case management for children with serious and complex behavioral health needs. As shown on Table **37**, in most reforms (71%), case management/care coordination services for this population reportedly have increased as a result of the managed care reform. However, there are notable differences between reforms with carve out and integrated designs with respect to case management. Nearly 80% of the carve outs, but only 42% of the integrated systems reported increased case management attributed to the managed care reform. Additionally, no carve outs reported

decreased case management, compared with 29% of the integrated systems in which case management/care coordination services reportedly have been compromised as a result of the managed care reform.

Table 37

Effects of Managed Care Reforms on Case Management/Care Coordination Services for Children and Adolescents with Serious Behavioral Health Disorders

	2000 Percent of Reforms		
	Carve Out	Integrated	Total
Increased case management/ care coordination	79%	42%	71%
Decreased case management/ care coordination	0%	29%	6%
No effect	21%	29%	23%

Promising strategies related to case management services for children with serious and complex behavioral health need were cited by several states.

- **Delaware's** Clinical Services Management Model provides a clinical services management team and a service coordinator to youth with serious and complex needs.
- In **Texas**, children with complex needs are assigned to specialty network providers who have expertise in the provision of case management and wraparound services.
- In **Missouri**, MCOs are contractually required to provide case management services for all special needs children.
- MCOs in **Arizona** provide intensive case management to youth during out-of-home placements and transition care coordination to the outpatient provider network when the child returns to the home or community.

Support and Facilitation of Systems of Care

An important focus of the Tracking Project has been to assess the link between efforts to develop community-based systems of care for children and adolescents with serious behavioral health disorders and their families and managed care initiatives in states.

The 1997–98 State Survey explored whether managed care reforms "built on" previous efforts to develop community-based systems of care. The survey found that 85% of reforms were characterized by respondents as having been built on previous or ongoing efforts to develop systems of care, with striking differences between carve outs and integrated systems in response to this item. All carve outs reportedly were building on previous system of care initiatives, compared with only about half (54%) of the integrated reforms.

The 2000 State Survey took a slightly different perspective and examined whether managed care reforms, in general, have facilitated and supported the further development of local systems of care for children and adolescents with serious behavioral health disorders. In response to this question, 75% of the reforms were thought to facilitate and support local systems of care (**Table 38**).

Table 38

Percent of Reforms that Facilitate and Support the Development of Local Systems of Care for Children and Adolescents with Serious Behavioral Health Disorders

	2000		
	Carve Out	Integrated	Total
Reforms facilitate and support local system of care development	88%	29%	75%
Reforms do not facilitate and support local system of care development	12%	71%	25%

Similar to the earlier survey results, the difference between carve outs and integrated reforms was substantial. Managed care reforms are reportedly supportive of systems of care in the majority of the carve outs (88%) but in only 29% of the integrated reforms.

The impact analyses support these findings. In the 1999 Impact Analysis, for example, stakeholders in all but one reform with carve out designs felt that managed care reforms have generally supported and facilitated the development of local systems of care in communities, primarily by allowing for coverage and payment for services that are linked to the system of care philosophy and by creating incentives for the development and use of these services. However, this was not the case for integrated systems. In both impact analyses, stakeholders in most states with integrated physical health-behavioral health designs felt that managed care reforms impeded system of care development, based on their assessment that the design and features of the managed care system were discrepant with the system of care philosophy and approach. This is seen in the 2000 State Survey results, as only 12% of the carve outs, but 71% of the integrated reforms reportedly do not support the development of local systems of care, according to respondents.

Despite the consistent finding across Tracking Project activities that managed care reforms generally support systems of care (at least in carve outs), the impact analyses found that most states did not use managed care reforms as a *strategic opportunity* to advance system of care development. In both impact analyses, stakeholders in only about a third of the states in each sample reported that managed care reforms were used deliberately and planfully to advance the goal of developing community-based systems of care in communities across the state.

The all-state surveys also have examined the extent to which system of care values and principles have been incorporated into the reform's RFPs, contracts, service delivery protocols, and other key system documents — principles including a broad array of services, family involvement, individualized/flexible care, interagency treatment and service planning, case management/care coordination, and cultural competence.

The 1997–98 State Survey found striking differences between behavioral health carve outs and integrated systems in the extent to which system of care values and principles are included in their system documents, and thus incorporated into managed care systems. The 2000 State Survey found the same differences. **Table 39** shows that behavioral health carve outs have a much higher rate of inclusion of all of these principles. Nearly all (92%) include a broad array of services, family involvement, and interagency service planning; the other principles are included by more than 80% of the carve outs. None of the values and principles reach these high levels of inclusion in the integrated reforms. Most principles reportedly are included in about half (57%) of the reforms with integrated designs, with reports of greater inclusion of the values of family involvement and individualized care.

Table 39
Percent of Reforms Incorporating System of Care Values and Principles

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Broad array of community-based services	72%	92%	57%	85%	+13%
Family involvement	79%	92%	71%	88%	+9%
Individualized, flexible care	79%	81%	71%	79%	0%
Interagency treatment and service planning	77%	92%	57%	85%	+8%
Case management	86%	85%	57%	79%	-7%
Cultural competence	81%	85%	57%	79%	-2%

The impact analyses also found that carve outs were more likely to include system of care principles, but some inclusion of system of care principles was observed in integrated systems as well. Of note is the observation that the incorporation of three of the principles as requirements reportedly has increased since 1997–98 — a broad array of community-based services, family involvement, and interagency treatment and service planning. These increases appear largely due to increased incorporation of these principles in integrated systems. □

VII. Financing and Risk

Financing Sources for Managed Care Systems

The 2000 State Survey explored the sources of financing and types of dollars being used by managed care systems. **Table 40** shows that, as in 1997-98, Medicaid and mental health agencies are the primary sources of financing for managed care systems, with Medicaid agencies contributing in 91% of the reforms and mental health agencies contributing in 76% of the reforms. There has been a slight (9%) decline in Medicaid participation since 1997-98 when all of the reforms (100%) reportedly used Medicaid financing. All of the integrated reforms reportedly involve Medicaid financing, as well as most of the carve outs (88%). There has also been a significant increase since the 1997-98 survey in reforms with mental health agency financing, up 20% from 56% in 1997-98 to 76% in 2000. As might be predicted, behavioral health carve outs are far more likely to have mental health agency financing — 96% do as compared with only13% of the integrated systems.

In comparison to the large proportion of reforms involving financial contributions from Medicaid and mental health agencies, the proportion of reforms involving contributions from other agencies is small. Further, the percent of reforms in which each of the other child serving systems contribute declined since 1997-98. For example, the child welfare system is the next most likely agency to contribute to financing the managed care systems, but contributes resources in only 21% of the reforms, representing an 11% decrease from 1997-98. Substance abuse and juvenile justice agencies each contribute resources in only 9% of the reforms; this represents a 6% decline in financial participation by juvenile justice agencies and an 18% decline in participation by substance abuse agencies. Education agencies reportedly do not contribute resources in any of the reforms in 2000, though education contributed in 12% of the reforms in 1997-98. Thus, other systems besides Medicaid and mental health contribute rarely to financing managed care systems, and their participation appears to be decreasing over time.

Table 40

Percent of Reforms by Agencies Contributing to Financing the Managed Care System

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Medicaid agency	100%	88%	100%	91%	-9%
Mental health agency	56%	96%	13%	76%	+20%
Child welfare agency	32%	24%	13%	21%	-11%
Juvenile justice agency	15%	12%	0%	9%	-6%
Education agency	12%	0%	0%	0%	-12%
Substance abuse agency	27%	12%	0%	9%	-18%
Health agency	17%	8%	0%	6%	-11%
MR/DD agency	NA	4%	0%	3%	NA
Other	5%	4%	0%	3%	-2%

Consistent with these results, **Table 41** shows that there has been an increase (15%) since 1997-98 in the percentage of reforms in which both the Medicaid and the behavioral health agencies contribute to financing the managed care system and a corresponding decrease (13%) in reforms in which only the Medicaid agency contributes financing. One or more other agencies (such as child welfare, juvenile justice, or substance abuse) contribute in addition to Medicaid and behavioral health agencies in 39% of the reforms, representing a slight decline since 1997-98. Other agencies are far more likely to contribute to the managed care pool in carve outs than in integrated reforms, which tend to rely predominantly on the Medicaid agency (48% of the carve outs involve financing from one or more other agencies compared with 13% of the integrated systems).

Table 41

Percent of Reforms with Single or Multiple Agencies Contributing to Financing the Managed Care System

	1995	1997–98	2000			Percent of Change	
	Total	Total	Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Medicaid agency only contributing	40%	39%	9%	75%	26%	-14%	-13%
Medicaid and behavioral health both contributing	20%	20%	43%	13%	35%	+15%	+15%
Other agencies (e.g. CW, JJ) contibuting *in addition* to Medicaid and behavioral health agencies	40%	41%	48%	13%	39%	-1%	-2%

Table 42 shows the types of revenue being used to finance managed care systems. Medicaid dollars are being used in most reforms (97%), with little difference between use of Medicaid in carve outs and integrated systems. There also is little difference between carve outs and integrated systems in use of TANF dollars, reportedly used in 12% of reforms. Both carve outs and integrated systems also are using SCHIP dollars, with integrated systems only slightly more likely to use SCHIP dollars (50% of integrated reforms versus 44% of carve outs). However, with respect to other revenue streams, differences between carve outs and integrated reforms emerge, some significant. For example, 80% of carve outs utilize state general revenue funds, compared to only 25% of integrated reforms. Sixty percent of carve outs use block grant dollars, whereas none of the integrated systems do so, and 24% of carve outs use child welfare dollars, compared to 13% of integrated systems. These findings are consistent with the finding discussed earlier that carve outs are more likely to cover non-Medicaid populations.

Table 42

Percent of Reforms by Type of Revenue Financing the Managed Care System

Type of Revenue	2000		
	Carve Out	Integrated	Total
Medicaid	96%	100%	97%
State general revenue	80%	25%	67%
Block grant	60%	0%	45%
Child welfare	24%	13%	21%
TANF	12%	13%	12%
SCHIP	44%	50%	45%
Other	12%	0%	9%

Table 43 provides a more extensive breakdown of the agencies and types of revenue financing managed care reforms. When these data are stratified by carve outs versus integrated systems (**Tables 44A** and **44 B**), a distinct picture emerges of the extent to which carve outs are using multiple funding streams and integrated systems are using predominantly Medicaid funds and SCHIP dollars contributed by the Medicaid agency. However, even with carve outs' more extensive use of multiple funding streams, as noted and shown on **Table 40** (page 55), fewer than a quarter (21%) of all reforms use child welfare dollars and less than 10% use dollars from other systems.

Table 43

Percent of Reforms by Type of Agency and Revenue Source Financing the Managed Care System

Agency Source	Type of Revenue						
	Medicaid	General Revenue	Block Grant	CW (e.g. Title IV-E, IV-B)	TANF	SCHIP	Other
Medicaid agency	82%	21%	3%	0%	3%	39%	3%
Mental health agency	42%	52%	42%	0%	0%	6%	3%
Child welfare agency	6%	6%	3%	21%	6%	3%	0%
Juvenile justice agency	3%	3%	0%	3%	3%	0%	0%
Education agency	0%	0%	0%	0%	0%	0%	0%
Substance abuse agency	9%	9%	3%	0%	0%	0%	0%
Health agency	9%	3%	0%	0%	0%	0%	0%
MR/DD agency	0%	3%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	3%	0%

Table 44A

Percent of Reforms by Type of Agency and Revenue Source Financing the Managed Care System—Carve Out Reforms

Agency Source	Type of Revenue						
	Medicaid	General Revenue	Block Grant	CW (e.g. Title IV-E, IV-B)	TNAF	SCHIP	Other
Medicaid agency	76%	20%	4%	0%	0%	36%	4%
Mental health agency	56%	68%	56%	0%	0%	8%	4%
Child welfare agency	8%	8%	4%	24%	8%	4%	0%
Juvenile justice agency	4%	4%	0%	4%	4%	0%	0%
Education agency	0%	0%	0%	0%	0%	0%	0%
Substance abuse agency	12%	12%	4%	0%	0%	0%	0%
Health agency	12%	4%	0%	0%	0%	0%	0%
MR/DD agency	4%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	4%	0%

Table 44B

Percent of Reforms by Type of Agency and Revenue Source Financing the Managed Care System—Integrated Reforms

Agency Source	Type of Revenue						
	Medicaid	General Revenue	Block Grant	CW (e.g. Title IV-E, IV-B)	TNAF	SCHIP	Other
Medicaid agency	100%	25%	0%	0%	13%	50%	0%
Mental health agency	0%	0%	0%	0%	0%	0%	0%
Child welfare agency	0%	0%	0%	13%	0%	0%	0%
Juvenile justice agency	0%	0%	0%	0%	0%	0%	0%
Education agency	0%	0%	0%	0%	0%	0%	0%
Substance abuse agency	0%	0%	0%	0%	0%	0%	0%
Health agency	0%	0%	0%	0%	0%	0%	0%
MR/DD agency	0%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	0%	0%

The significance of the types of revenue and agencies financing managed care reforms has to do with the fact that many of the populations of children enrolled in publicly financed managed care rely on multiple funding streams and agencies for behavioral health service delivery. This is true, for example, of children involved with the child welfare and juvenile justice systems, children receiving SSI, and those with serious disorders even if they do not qualify for SSI. Historically, there has been fragmentation across these funding streams and agencies, creating cost inefficiencies and confusion for families and providers. Managed care as a technology creates opportunity to blend dollars and "rationalize" the delivery system. The 2000 State Survey results suggest that states implementing carve out approaches are beginning to experiment with the use of multiple funding streams, engaging multiple agencies in this effort. This does not seem to be the case in states with integrated reforms.

Use of Medicaid Outside of Managed Care Systems

In a further effort to gauge the potential for fragmentation and cost shifting between managed care systems and other systems providing behavioral health services for children, the 2000 State Survey explored whether there are Medicaid dollars left outside of managed care systems that are being used by other child-serving systems for behavioral health services. As shown on **Table 45**, virtually all reforms (91%) leave Medicaid dollars for behavioral health services for children outside of the managed care system. This is the case for all integrated reforms and for most of the carve outs (89%).

Table 45

Percent of Reforms in which Other Systems Use Medicaid Dollars for Behavioral Health Services Outside of the Managed Care System

	2000		
	Carve Out	Integrated	Total
Reforms in which other systems use Medicaid dollars outside of managed care system	89%	100%	91%

Table 46 shows the types of systems that are using Medicaid dollars for behavioral health services for children outside of the managed care system. The education system is most often using Medicaid dollars outside of the managed care system, reported in 81% of reforms. This seems consistent with the earlier finding that the education system is not contributing dollars to managed care systems, but is maintaining its own Medicaid funding stream. The child welfare and mental retardation/developmental disabilities systems are the next most frequently reported agencies to use Medicaid dollars outside of the managed care systems (72% of reforms in both cases). The juvenile justice system, reportedly, is using Medicaid dollars outside of the managed care system in 59% of reforms. In half of the reforms, the mental health and substance abuse agencies are using Medicaid dollars outside of the managed care system, though this is more likely to occur in states with integrated reforms than in states with carve outs.

Table 46

Percent of Reforms by Type of Other System Using Medicaid Dollars for Behavioral Health Services Outside of the Managed Care System

	2000		
	Carve Out	Integrated	Total
Mental health agency	42%	75%	50%
Child welfare agency	67%	88%	72%
Juvenile justice agency	58%	63%	59%
Education agency	79%	88%	81%
Substance abuse agency	38%	88%	50%
Health agency	33%	63%	41%
MR/DD agency	67%	88%	72%
Other	8%	25%	13%

These findings are consistent with 1997–98 survey findings and those from the 1999 Impact Analysis which suggest that the major child-serving systems, in most states, continue to have access to Medicaid dollars for behavioral health services for children outside of managed care

systems. This may create a safety net for children should the managed care system fail to provide all necessary services. On the other hand, it perpetuates opportunities for cost shifting and fragmented service delivery.

Cost Shifting

As **Table 47** indicates, in only about one-third (32%) of reforms did survey respondents report that cost shifting was *not* occurring either from the managed care reform to other systems or from other systems to the managed care system. Thus, cost shifting is occurring in most reforms. In slightly more than a third (36%) of reforms, respondents reported that cost shifting was occurring from managed care systems to other child serving agencies, and in 43% of reforms, respondents reported that cost shifting was occurring from other child serving systems to the managed care reform. **Table 47** also shows interesting differences between carve outs and integrated reforms with respect to the direction in which cost shifting, reportedly, is occurring. In nearly three-quarters (71%) of the integrated reforms, cost shifting occurs from the managed care system to other child-serving systems, while this reportedly occurs in only 24% of the carve outs. On the other hand, in over half of the carve outs (52%), respondents reported that cost shifting was occurring from other children's systems to the managed care system, while this was reported to be the case in only 14% of integrated reforms.

Table 47
Percent of Reforms with Reports of Cost Shifting

	2000		
	Carve Out	Integrated	Total
Cost shifting is not occurring	33%	29%	32%
Cost shifting is occurring from managed care system to other child serving system(s)	24%	71%	36%
Cost shifting is occurring from other child serving system(s) into the managed care system	52%	14%	43%

These findings suggest that, in states with carve outs, other child serving systems may be taking advantage of the broader benefit array and flexibility provided by the managed care system. In contrast, in states with integrated reforms, with their more traditional, acute care benefits, other child serving systems may be getting "dumped on" as managed care systems identify children but fail to provide the necessary duration or scope of services.

Drawing conclusions about cost shifting remains problematic in any event since the majority of states are not tracking and monitoring cost shifting in any systematic way. As **Table 48** indicates, only 16% of reforms are tracking and monitoring cost shifting. These findings are consistent with findings from the 1997–98 Survey and the impact analyses.

Table 48 Percent of Reforms Tracking and Monitoring Cost Shifting			
	2000		
	Carve Out	Integrated	Total
Reforms tracking cost shifting	13%	25%	16%

Respondents described several promising strategies to prevent cost shifting.

- In **Arizona**, broadening of the definition of "medical necessity" has increased the ability of the MCO's to retain children in treatment settings covered by Medicaid, thus reducing the need to shift payment responsibility to other agencies.
- Unbundling rates for out-of-home placements is a strategy used in **Maryland** to prevent cost shifting.
- In **Massachusetts**, discussions between the MCOs and other child-serving agencies are required prior to any utilization management decision by the MCO to reduce acute hospital stays and discharge children at high levels of acuity to other services for which the MCO is not financially responsible.
- In **Missouri**, two protocols have been developed and implemented collaboratively between the medical services and mental health agencies to specify how state funded mental health and substance abuse services are to be coordinated with services provided by the MCOs.

A strategy for tracking and monitoring cost shifting was reported by respondents for only two states.

- In **Colorado**, a state-level committee was formed to monitor potential cost shifting.
- In **Massachusetts**, average length of hospital stays pre and post managed care are tracked, as well as costs associated with residential treatment services provided to children who would previously have had longer hospital stays. In addition, additional costs to families (e.g., taking sick leave to provide aftercare for a child who previously would have remained in an inpatient setting) are tracked.

Clarification of Responsibility Across Child-Serving Systems

The 2000 State Survey also investigated whether, in connection with managed care reforms, strategies were in place to clarify responsibility for providing and paying for behavioral health services across child-serving systems. As **Table 49** shows, 64% of reforms, reportedly, do include strategies to clarify responsibility across systems. However, these are predominantly carve outs (72% of carve outs versus 38% of integrated systems). This finding also seems to be consistent with the earlier finding that carve outs have more multi-agency involvement than do

integrated reforms, and, therefore, may be more cognizant of the importance of clarifying responsibility across systems. Given the earlier finding that integrated systems are perceived to cost shift to other child-serving systems, this finding that they also are unlikely to clarify responsibility across systems is not surprising, though disturbing.

Table 49

Percent of Reforms that Include Strategies to Clarify Responsibility for Providing and Paying for Services Across Child-Serving Systems

	2000		
	Carve Out	Integrated	Total
Reforms clarify responsibility	72%	38%	64%
Reforms do not clarify responsibility	28%	62%	36%

Additional analyses revealed that cost shifting is less likely to occur in reforms that incorporate strategies to clarify responsibility for providing and paying for services across child-serving systems. Cost shifting was reported in 63% of the reforms with strategies for clarifying responsibility, as compared with 83% of the reforms without any such strategies.

Promising strategies for clarifying responsibilities across systems were reported in three states.

- In **Delaware**, an MIS system that includes data on mental health and substance abuse as well as child welfare and juvenile justice service utilization provides data on who pays for what services to individual children, providing information to assist in the process of clarifying service and payment responsibility.
- In **Pennsylvania**, the executive management committees are involved in clarifying responsibilities on an ongoing basis. Memoranda of understanding among child-serving systems include specific language clarifying responsibility, as well as a mechanism for resolution of exceptions. Interagency agreements are also used as a vehicle for clarifying financial responsibility for services in **Vermont**.

Use of Risk Based Financing

Most reforms (88%) use some type of risk based financing, with 62% of reforms using capitation and 26% using case rates (**Table 50**). Only 24% of reforms, including twice as many carve outs as integrated reforms, use neither capitation nor case rates. In these instances, there tends to be some type of fee-for-service financing, with an administrative services organization (ASO) contracted to handle administrative aspects of the system, including utilization management.

Table 50
Percent of Reforms Using Capitation and/or Case Rates

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Capitation	88%	92%	54%	88%	62%	-26%	-30%
Case rates	Not Asked	16%	31%	13%	26%	Not Asked	+10%
Neither	12%	11%	27%	13%	24%	+12%	+13%

As shown on **Table 50**, integrated systems are more likely to use capitation than carve outs (88% of integrated reforms versus 54% of carve outs). Carve outs are more likely to use case rates (31% of carve outs versus 13% of integrated reforms). This finding also is consistent with 2000 survey findings that carve outs are more likely to include populations that can be expected to be high service utilizers, such as children with serious disorders and those in child welfare, for whom a case rate, inherently, may make greater sense than a capitation rate.[3] **Table 51** provides examples of capitation and case rate approaches by state.

[3] Capitation financing pays MCOs or providers a fixed rate per *eligible* user of service, while case rates pay a fixed rate per *actual* user of services, based typically on the service recipient's meeting a certain service or diagnostic profile. In a capitated system, a potential incentive is to prevent eligible users from becoming actual users. In a case rated system, there is no such incentive, although case rates do result in an incentive, like capitation, to control the type and amount of service provided.

Table 51
Examples of Capitation or Case Rate Approaches by State

State	Type of Reform (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate	Amount of Case Rate (Per Month or Per Year)	Basis for Rate (Per Month or Per Year)
Arizona AZ	Carve Out	Children and adolescents behavioral health only Adults–behavioral health only Adults with serious and persistent mental illnesses	$23.89 pmpm $13.35 pmpm $51.76 pmpm		Historical cost and utilization data
Florida (BHSCN) FL	Integrated with Partial Carve Out	Children and adolescents with serious emotional disorders		$1,440/Month	Historical service profiles
Florida (PMHP) FL	Carve Out	Children and adolescents–behavioral health only Adults–behavioral health only Children and adolescents with serious emotional disorders Children and adolescents in the child welfare system	$.36–$15.54 pmpm $2.82–$4.28 pmpm $1.85–$74.06 pmpm $.53–$128.90 pmpm (*Range due to age and eligibility category.)		Based on 1997–98 utilization data; rates are 92% of upper payment limit
Indiana IN	Carve Out	Children and adolescents with serious emotional disorders		$1,670/Year	Information based partially on 1999 survey of all providers, of services to SED population, on their average annual costs for services

BH=Behavioral Health, **MH**=Mental Health, **SA**=Substance Abuse, **PH**=Physical Health, **pmpm**=per member per month

Table 51 (continued)
Examples of Capitation or Case Rate Approaches by State

State	Type of Reform (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate	Amount of Case Rate (Per Month or Per Year)	Basis for Rate (Per Month or Per Year)
Michigan MI	Carve Out	Children and adolescents–behavioral health only Adults–behavioral health only Children and adolescents with serious emotional disorders Adults with serious and persistent mental illnesses	$6.81 pmpm $13.41 pmpm $38.53 pmpm (Disabled) $79.29 pmpm (Disabled)		Prior utilization
Mississippi MS	Carve Out	Children and adolescents with serious emotional disorders		$1,500 1st and 2nd year, and $999 for 3rd year per month	Prior utilization and clinical profile data
Missouri MO	Integrated	Category of Aid 1 – TANF Adult, TANF Children, Medicaid for Children, Refugee, Medicaid for Pregnant Women Category of Aid 4 – TANF Foster Care, Child Welfare Services, Division of Youth Services and Foster Care Category of Aid 5 – MC For Kids (SCHIP) and Uninsured Parents	Average monthly capitation rate of $125.98 (includes maternity supplemental payment) Average monthly capitation rate of $100.26 Average monthly capitation rate of $112.86 (includes supplemental maternity payment		Historical fee-for service information
New York NY	Carve Out	Children and adolescents with serious emotional disorders	$3,739 pmpm		Analysis of actuarial data and historic claims data

BH=Behavioral Health, **MH**=Mental Health, **SA**=Substance Abuse, **PH**=Physical Health, **pmpm**=per member per month

Table 51 (continued)
Examples of Capitation or Case Rate Approaches by State

State	Type of Reform (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate	Amount of Case Rate (Per Month or Per Year)	Basis for Rate (Per Month or Per Year)
Oklahoma OK	Integrated	Capitation payments for those designated as Special Behavioral Health Needs	Under age 21: $844.91 pmpm Over age 21: $377.15 pmpm		Information not available
		Supplemental Payments for Childbirth Deliveries	$2,700		
		Rate Categories for TANF by geographic region:			
		Central Oklahoma (Includes Oklahoma City and surrounding urban counties)	>1 = $307 pmpm 1–5 = $60.27 pmpm 6–14 = $82.91 pmpm 15–20 (Female) = $112.72 pmpm (Male) = $108.58 pmpm 21–44 (Female) = $110.47 pmpm (Male) = $85.44 pmpm 45+ = $143.37		
		Northeast Oklahoma (Includes Tulsa and surrounding urban counties)	>1 = $326.39 pmpm 1–5 = $65.70 pmpm 6–14 = $79.32 pmpm 15–20 (Female) = $122.13 pmpm (Male) = $92.53 pmpm 21–44 (Female) = $122.55 pmpm (Male) = $92.67 pmpm 45+ = $136.18 pmpm		Information not available

BH=Behavioral Health, **MH**=Mental Health, **SA**=Substance Abuse, **PH**=Physical Health, **pmpm**=per member per month

Table 51 (continued)
Examples of Capitation or Case Rate Approaches by State

State	Type of Reform (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate	Amount of Case Rate (Per Month or Per Year)	Basis for Rate (Per Month or Per Year)
Oklahoma OK Continued from Previous Page	Integrated	**Southwest Oklahoma** (Includes Lawton and surrounding urban counties)	>1 = $325.81 pmpm 1–5 = $70.02 pmpm 6–14 = $82.65 pmpm 15–20 (Female) = $118.54 pmpm (Male) = $100.26 pmpm 21–44 (Female) = $119.78 pmpm (Male) = $90.64 pmpm 45+ = $149.56 pmpm		Information Not Available
Pennsylvania PA	Carve Out	Adults and children and adolescents–behavioral health only	$56 pmpm		Prior authorization
Texas TX	Carve Out	SSI Aged SSI Adult SSI Child TANF Adult TANF Child	$5.26 pmpm $48.95 pmpm $12.25 pmpm $23.99 pmpm $9.25 pmpm		Prior authorization
Washington WA	Carve Out	Adults–behavioral health only Children and adolescents with serious emotional disorders Adults with serious and persistent mental illnesses Children and adolescents in the child welfare system	$13.68 pmpm $80.03 pmpm $129.32 pmpm $16.27 pmpm		Actuarially determined
Wisconsin WI	Carve Out	Children and adolescents with serious emotional disorders (In Milwaukee)	$3,300 pmpm		Information not available

BH=Behavioral Health, **MH**=Mental Health, **SA**=Substance Abuse, **PH**=Physical Health, **pmpm**=per member per month

Rate Changes and Sufficiency Assessment

As **Tables 52** and **53** show, most reforms (83%) reportedly changed rates since the 1997–98 survey, with most (80%) of those changes being rate increases. Various reasons were reported for rate increases, including:

- Inflation
- Higher costs for services and higher utilization than expected
- Inadequate data informing initial rate setting, with rates proving too low in implementation
- Changes in mix of eligibles, utilization, and costs
- Need for incentives to stop plans from withdrawing
- Automatic increases built into contracts

Respondents also provided several reasons for rate decreases, including:

- Lower costs than expected based on provider survey of average annual costs
- Start up delays
- Unacceptable profits made by MCOs

Table 52
Percent of Reforms Reporting Changes in Capitation or Case Rates

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Rate changes reported	53%	83%	83%	83%	+30%
No rate changes reported	47%	17%	17%	17%	-30%

Table 53
Direction of Rate Changes in Reforms Reporting Changes in Rates

	2000		
	Carve Out	Integrated	Total
Rates have increased	80%	80%	80%
Rates have decreased	20%	20%	20%

The 2000 State Survey investigated whether the managed care system assesses the sufficiency of rates for behavioral health services for children, including high need populations, such as those with serious disorders. As **Table 54** shows, while three-quarters of the carve outs assess sufficiency of rates in this area, only 14% of the integrated reforms do so. This finding is consistent with findings from the impact analyses that the focus in integrated reforms is, predominantly, on physical health concerns.

Table 54

Percent of Reforms that Assess the Sufficiency of Rates for Children's Behavioral Health Services

	2000		
	Carve Out	Integrated	Total
Reforms assess the sufficiency of rates	75%	14%	61%
Reforms do not assess rate sufficiency	25%	86%	39%

While carve outs are far more likely to assess the sufficiency of rates for children with behavioral health disorders than are integrated reforms, integrated reforms are more likely to adjust rates based on assessments. As **Table 55** indicates, only half of the carve outs that assess sufficiency of rates made rate adjustments based on their assessments, as compared with 100% of integrated reforms. A number of explanations for this were suggested by respondents. In some cases, survey respondents indicated that assessments showed no need for an adjustment in that rates were found to be adequate. In some cases in which counties act as MCOs, there were reports that state agencies might not act on county assessments of the need to adjust rates. Similarly, in some carve outs in which the state Medicaid and mental health agencies are both involved, one agency might not act on the assessment made by the other. In some cases, it is not possible to adjust rates, either because of fiscal or political factors.

Table 55

Percent of Reforms that have Made Rate Adjustments Based on Assessments of Rate Sufficiency

	2000 Total
Reforms have made rate adjustments based on assessments of sufficiency	53%
Reforms have not made rate adjustments based on assessments of sufficiency	47%

A number of promising strategies to assess the sufficiency of rates were described by respondents.

- In **Arizona**, providers can contract with all state child-serving agencies through a single contracting process. During contract negotiations, providers are given the opportunity to justify rate differentials according to populations served and services provided. The negotiation process is also used as an opportunity to assess the sufficiency of rates with MCOs in **Pennsylvania**.

(Promising strategies continued on next page)

(Promising strategies continued)

- In **Delaware**, the Medicaid and mental health agencies annually review rates versus the actual costs of services. The Medicaid agency made a commitment to adjust rates as necessary to cover the costs of services.
- In **Florida**, independent audits of services provided in the managed care system are compared with services provided on a fee-for-service basis. Reviews of cost reports and utilization levels, as well as a comparison of costs at different program sites, are undertaken in New York.

The 2000 survey examined whether, in integrated reforms, states require that a certain percentage of the overall capitation rate be allocated to behavioral health. As **Table 56** shows, consistent with findings in 1997–98, none of the integrated reforms requires that a certain percentage of the rate be allocated to behavioral health care. The impact analyses found, in addition, that, in most cases, states also cannot determine how much of the rate is going toward behavioral health care.

Table 56

Percent of Integrated Reforms Requiring a Specified Percentage of the Capitation Rate to be Allocated to Behavioral Health

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Reforms require specified percentage of rate to be allocated to behavioral health	0%	*N/A	0%	0%	0%
Reforms do not require specified percentage of rate to be allocated to behavioral health	100%	*N/A	100%	100%	0%

*N/A=Not applicable

Use of Risk Adjusted Rates

Table 57 shows that fewer than a third of reforms (29%) use risk adjusted rates for high need populations of children and adolescents, such as those in the child welfare and juvenile justice systems and those with serious disorders. **Table 58** shows that, where risk adjusted rates are being used, they are most likely to be in place for children and adolescents with serious behavioral health disorders (70% of reforms with risk adjusted rates). Fewer reforms incorporate risk adjusted rates for the child welfare population (40% of the reforms with risk adjusted rates) or the juvenile justice population (20% of the reforms with risk adjusted rates).

Table 57

Percent of Reforms Using Risk Adjusted Rates for High Need Populations of Children and Adolescents

	2000		
	Carve Out	Integrated	Total
Reforms using risk adjusted rates for high need populations	26%	38%	29%

Table 58

Percent of Reforms Using Risk Adjusted Rates by Risk Adjusted Population

	2000 Total
Risk adjusted rates for children in child welfare system	40%
Risk adjusted rates for children in the juvenile justice system	20%
Risk adjusted rates for children with serious behavioral health disorders	70%

Table 59 shows the use of risk adjusted rates by population across *all* reforms in the sample (i.e., not just those using risk adjusted rates). Analyzed in this way, the data show that fewer than a quarter of reforms overall (20%) incorporate risk adjusted rates for children with serious behavioral health disorders, and these are more likely to be found in carve outs. Only 11% use risk adjusted rates for children involved in the child welfare system, and only 6% use risk adjusted rates for youth involved in juvenile justice — both more likely to be included in integrated systems.

Table 59

Percent of All Reforms that Incorporate Risk Adjusted Rates for Various Populations of High Need Children and Adolescents

	2000		
	Carve Out	Integrated	Total
Risk adjusted rates for children in child welfare system	7%	25%	11%
Risk adjusted rates for children in the juvenile justice system	0%	25%	6%
Risk adjusted rates for children with serious behavioral health disorders	22%	13%	20%

Other Risk Adjustment Mechanisms

In addition to the use of risk adjusted rates, the 2000 State Survey also explored the incorporation of other types of risk adjustment mechanisms. **Table 60** shows the percentage of reforms using various types of risk adjustment mechanisms. The most frequently used risk adjustment mechanism in integrated reforms is reinsurance (38% of integrated reforms), and the most frequently used risk adjustment mechanism in carve outs is risk pools (22%). Overall, however, fewer than one fifth of reforms, regardless of design, use risk adjustment mechanisms of any kind.

Table 60

Percent of Reforms that Incorporate Various Risk Adjustment Mechanisms

	2000		
	Carve Out	Integrated	Total
Stop loss	11%	13%	11%
Risk corridors	19%	0%	14%
Reinsurance	11%	38%	17%
Risk pools	22%	0%	17%
Other	11%	25%	14%

Given the increased enrollment of high need populations in managed care reforms, the low incidence of use of risk adjusted rates and other risk adjustment mechanisms raises a question about the adequacy of safeguards to protect against underservice. This is a particular concern in the case of integrated reforms, which, as noted earlier, tend not to assess the sufficiency of rates for behavioral health services. In some cases, however, as discussed below, states may not be using risk adjustment mechanisms because they have structured the managed care system to share risk with MCOs.

Risk Sharing

More states seem to be structuring their managed care systems to incorporate risk sharing arrangements with MCOs than was the case in 1997–98. As **Table 61** shows, slightly over half (52%)[4] of reforms push full risk to MCOs, 20% fewer than in 1997–98. In about one-third of reforms (31%), states and MCOs share both risks and benefits, a 9% increase in this type of arrangement since 1997–98. In 14% of the carve outs (and none of the integrated reforms), states have assumed full risk and benefits; these tend to be the noncapitated ASO arrangements noted earlier.

[4] The 52% is comprised of the 45% of reforms in which MCOs have all of the benefits and all of the risk, and the 7% of reforms in which MCOs and the state share benefits only, with MCOs having full risk.

Table 61
Percent of Reforms by Type of Risk Sharing Arrangement

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
MCOs have all the benefits and all the risks	31%	59%	43%	50%	45%	+14%	-14%
State has all the benefits and all the risks	6%	0%	14%	0%	10%	+4%	+10%
MCOs and state share risks and benefits	47%	22%	33%	25%	31%	-16%	+9%
MCOs and state share risk only	9%	6%	0%	25%	7%	-2%	+1%
MCO and state share benefits only	0%	13%	10%	0%	7%	+7%	-6%

The 2000 State Survey also found that most reforms (75%) push risk to the behavioral health provider level, a 25% increase over 1997–98. As shown on **Table 62**, carve outs are more likely than integrated reforms to push risk to the provider level, although the risk sharing arrangements that carve outs are using tend to be either case rates or bonuses and/or penalties tied to performance, rather than subcapitation (**Table 63**).

Table 62
Percent of Reforms that Push Risk to Provider Level

	1997–98 Total	2000			Percent of Change 1997/98–2000
		Carve Out	Integrated	Total	
Reforms push risk to provider level	50%	82%	57%	75%	+25%
Reforms do not push risk to provider level (Provider has no risk)	50%	18%	43%	25%	-25%

Table 63
Percent of Reforms that Share Risk with Providers by Type of Risk Sharing Arrangement

	2000		
	Carve Out	Integrated	Total
Subcapitation	29%	80%	41%
Case rates	41%	40%	41%
Bonuses/penalities tied to performance	53%	0%	41%

The movement of risk to the provider level seems to be developmental. As states and providers acquire more experience with managed care, there is increasing interest on the part of states and MCOs to push risk to the provider level, and greater willingness and capacity on the part of providers to assume risk. As **Table 63** shows, states and MCOs are experimenting with multiple forms of risk sharing at the provider level, including subcapitation (in 41% of reforms in which there is risk sharing with providers), case rates (41%) and bonuses and/or penalties tied to performance (41%). Integrated reforms are more likely to use subcapitation arrangements with providers (80% of integrated reforms versus 29% of carve outs), while carve outs are more likely to use bonuses or penalties tied to performance (53% of carve outs versus none of the integrated reforms). About 40% of both integrated reforms and carve outs that push risk to providers are using case rates with providers.

Limits on MCO Profits and Administrative Costs

As **Table 64** shows, over half of reforms (55%), reportedly, place limits on MCO profits, and half limit MCO administrative costs. This represents a slight increase (7%) in states' limiting profits since 1997–98, and a slight decrease (8%) in states' limiting administrative costs. As they were in 1997–98, carve outs are significantly more likely to limit MCO profits than integrated reforms (64% of carve outs versus 29% of integrated systems). However, compared to 1997–98 findings, integrated reforms are coming closer to carve outs in the percentage that place limits on MCO administrative costs (43% of integrated systems versus 56% of carve outs).

Table 64

Percent of Reforms that Place Limits on Managed Care Organization Profits and Administrative Costs

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Reforms that limit MCO profits	48%	64%	29%	55%	+7%
Reforms that limit MCO administrative costs	58%	56%	43%	50%	-8%

MCO Performance Incentives

As **Table 65** shows, slightly more than a quarter of reforms (27%) tie bonuses or penalties to MCO performance. Carve outs are more likely to do so than integrated reforms (30% of carve outs versus 14% of integrated systems). This finding is consistent with the earlier finding that carve outs are more likely than integrated reforms to structure risk at the provider level through performance-based contracting arrangements, rather than through subcapitation.

Table 65

Percent of Reforms with Bonuses or Penalties for Managed Care Organization Based on Performance

	2000		
	Carve Out	Integrated	Total
Reforms with bonuses or penalties based on MCO performance	30%	14%	27%
Reforms with no bonuses or penalties based on MCO performance	70%	86%	73%

Promising strategies for incorporating performance-based incentives in managed care systems were noted by several respondents.

- One MCO in **Arizona** pays its network a monthly case rate payment for enrolled members, based on the prior three months' average enrollment. If enrollment drops, the payment decreases. Since members may choose to enroll with another network at any time, this creates an incentive to provide high quality services and achieve high satisfaction rates among service recipients.
- In **Mississippi**, incentive rewards are earned at the end of 12 months for achieving certain goals.
- In **Connecticut**, MCOs incur penalties for noncompliance with the requirements of their contracts. □

VIII. Clinical Decision Making and Management Mechanisms

Medical Necessity Criteria

The 1997–98 State Survey revealed that nearly all states (86% in 1997–98) use medical necessity criteria in their managed care systems. Given the widespread use of medical necessity criteria, it is important to consider the feedback from stakeholders interviewed during the impact analyses. Stakeholders from a number of states included in the 1997 Impact Analysis noted that medical necessity criteria were the source of problems and complaints, many resulting from narrow definitions of medical necessity. In the 1999 Impact Analysis, stakeholders in most states also felt that medical necessity criteria used in the initial implementation of managed care reforms were problematic. Most problems centered around the perception that they were too narrowly defined and based solely on a medical model, failing to take into account the need to link treatment with the social and environmental supports so critical for supporting children and adolescents with behavioral health needs.

In response to these concerns, a number of states in both the 1997 and 1999 Impact Analysis samples have created broad definitions of medical necessity or have broadened their definitions to allow for the inclusion of psychosocial and environmental considerations in clinical decision making. More than half of the reforms included in the 1999 sample broadened their criteria at some point after initial implementation of their managed care reforms, suggesting a trend toward broadening medical necessity definitions. The trend toward broadening medical necessity criteria also was evident in the 1997–98 State Survey, which indicated that nearly 40% of the reforms had reportedly revised their criteria, primarily with a view towards placing greater emphasis on psychosocial issues.

Even with broader criteria, however, stakeholders interviewed for the impact analyses noted problems related to the *application* of medical necessity criteria. Most notably, they cited inconsistent interpretation and application of medical necessity criteria across MCOs and overly rigid interpretation and application of medical necessity criteria by some MCOs, creating a major barrier to service delivery by limiting both the types and duration of services for children and their families.

The 2000 State Survey built on these earlier findings that suggested a trend toward broadening medical necessity criteria, but also suggested continuing problems in their interpretation and application. Items were included in the 2000 survey to: 1) determine the extent to which medical necessity criteria currently allow for consideration of psychosocial and environmental factors, and 2) assess how MCO interpretation and application of medical necessity criteria may affect clinical decision making and service delivery.

The 2000 State Survey found that, in fact, the majority of managed care systems (82%) reportedly now have medical necessity criteria that allow consideration of psychosocial and environmental factors in clinical decision making. **Table 66** shows that carve outs are more likely to have these types of medical necessity criteria (85% do), but most integrated reforms (71%) also reportedly have broad medical necessity criteria that allow psychosocial and environmental considerations.

Table 66

Percent of Reforms in which Medical Necessity Criteria Allow Consideration of Psychosocial and Environmental Factors

	2000		
	Carve Out	Integrated	Total
Medical necessity criteria allow for psychosocial and environmental factors	85%	71%	82%
Medical necessity criteria do not allow for psychosocial and environmental factors	15%	29%	18%

Problems are more evident, however, with respect to MCO interpretation of medical necessity criteria (**Table 67**). In 82% of the carve outs, MCOs reportedly interpret medical necessity criteria broadly to include psychosocial and environmental considerations, but this occurs in only 40% of the managed care systems with integrated designs. Thus, it appears that while most managed care systems now have medical necessity criteria that allow consideration of psychosocial and environmental factors, MCOs (primarily those in systems with integrated designs) may still be interpreting and applying these criteria narrowly, without sufficient attention to these issues.

Table 67

Managed Care Organization Interpretation of Medical Necessity Criteria in Reforms that Allow Consideration of Psychosocial and Environmental Factors

	2000		
	Carve Out	Integrated	Total
Medical necessity criteria are interpreted narrowly by MCOs	18%	60%	26%
Medical necessity criteria are interpreted broadly to include psychosocial and environmental factors	82%	40%	74%

Level of Care and Patient Placement Criteria

The 1997–98 and 2000 State Surveys investigated the use of clinical decision making criteria, such as level of care and patient placement criteria, that are specific to children and adolescents. Approximately two-thirds of the managed care reforms (67% in 1997–98 and 63% in 2000) reportedly incorporate clinical decision making criteria specific to children and adolescents (**Table 68**). As in 1997–98, the 2000 State Survey showed that reforms with carve out designs are far more likely to have child-specific clinical decision making criteria — 70% of carve outs as compared with 38% of reforms with integrated designs.

Table 68

Percent of Reforms that Incorporate Level of Care and/or Patient Placement Criteria Specific to Children and Adolescents

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Reforms incorporate child-specific level of care and/or patient placement criteria	67%	70%	38%	63%	-4%
Reforms do not incorporate child-specific level of care and/or patient placement criteria	33%	30%	62%	37%	+4%

In the 2000 State Survey, of the 22 reforms that incorporate child-specific criteria, all of them (100%) have level of care criteria for children's mental health services, but only 41% have patient placement criteria specific to adolescent substance abuse treatment (**Table 69**).

Table 69

Types of Criteria in Reforms that Include Child-Specific Criteria

	2000 Total
Level of care criteria for children's mental health	100%
Patient placement criteria for adolescent substance abuse	41%

These results confirm the 1997 Impact Analysis finding that managed care systems are more likely to have level of care criteria for children's mental health than patient placement criteria for adolescent substance abuse services. Although in the 1999 Impact Analysis, about half of the reforms in the sample had each of these types of criteria, the 2000 State Survey substantiated earlier findings that level of care criteria for children's mental health are more common than are decision making criteria for adolescent substance abuse treatment. When considering the entire 2000 survey sample, nearly two-thirds (63%) of all the reforms have child-specific level of care criteria in the children's mental health area, while only 37% of the reforms that include substance abuse services reported having patient placement criteria specific to adolescents.

Several states offered information about their clinical decision making criteria.

- **Arizona's** level of care criteria for children's mental health were developed by the medical directors of the MCOs led by the medical director of the Division of Behavioral Health. They are available on their website (www.hs.state.az.us).
- **Delaware's** clinical criteria also are available on their website (www.state.de.us/kids/cmhhome.htm)

- **Maine** and **Hawaii** indicated that CALOCUS (Child and Adolescent Level of Care Utilization System), an instrument jointly developed by the American Association of Community Psychiatrists and the American Academy of Child and Adolescent Psychiatry, is being used as a clinical decision making instrument.
- In **Pennsylvania**, ASAM (American Society of Addiction Medicine) criteria are used for adolescent substance abuse treatment.

The impact analyses raised some questions as to the extent to which the use of clinical decision making criteria actually improve consistency in clinical decision making. In the 1997 Impact Analysis, stakeholders in most states felt that the use of level of care or patient placement criteria was improving the consistency of clinical decision making, but stakeholders interviewed for the 1999 Impact Analysis did not necessarily feel that consistency was improved by using these clinical decision making guidelines. They raised a number of problem areas:

- Where there are multiple MCOs, each has developed its own criteria, resulting in significant variation within a state with respect to the type, level, and duration of services that children and adolescents may receive.
- Even where standard criteria are prescribed by the state, differing interpretations by MCOs and providers compromise consistency.
- In some states or MCOs, criteria are applied too rigidly, forcing children to change service levels or modalities too often or impeding the ability to provide flexible, individualized care.

The 2000 State Survey explored this issue and found that overall, 62% of the reforms with child-specific criteria reportedly have increased consistency in clinical decision making by using these criteria, and 38% have not seen improved consistency resulting from the use of criteria (**Table 70**). Improvement in consistency was much more likely to occur in managed care systems with carve out designs. About two-thirds (67%) of the carve outs reported improved consistency related to the use of child-specific criteria, compared with only one-third (33%) of the integrated systems. Two-thirds (67%) of the integrated systems reportedly have not experienced increased consistency in clinical decision making — even though they reported having child-specific decision making criteria.

Table 70

Percent of Reforms Reporting Improved Consistency in Clinical Decision Making Resulting from Use of Child-Specific Clinical Decision Making Criteria

	2000		
	Carve Out	Integrated	Total
Consistency in clinical decision making improved	67%	33%	62%
Consistency in clinical decision making not improved	33%	67%	38%

One potential explanation for the greater likelihood of improved consistency in carve outs is that managed care systems with carve out designs are much more likely to have standardized clinical decision making criteria across the state. As shown on **Table 71**, the majority of carve outs (71%) reported having standardized clinical decision making criteria for the state (whether or not they are child-specific). In contrast, no integrated systems reported having standardized criteria across the state; all integrated systems indicated that their clinical decision making criteria differ with each MCO.

Table 71

Percent of Reforms in Which Clinical Decision Making Criteria are Standardized Across the State

	2000		
	Carve Out	Integrated	Total
Criteria are standardized across the state	71%	0%	54%
Criteria differ with each MCO	29%	100%	46%

With different MCOs using different criteria, the result is significant variation within a state with respect to the type, level, and duration of services that children and adolescents receive. According to stakeholders interviewed for the impact analyses, use of different sets of criteria and lack of uniformity are confusing for both providers and consumers. Although standardization of criteria statewide may be linked to reports of greater consistency in clinical decision making, it should be noted that, even with standardization, some stakeholders complained about differing interpretations of criteria by different MCOs and providers within a state.

Management Mechanisms

As could be predicted, most reforms (two-thirds or more) reported using all the management mechanisms typically associated with managed care systems. **Table 72** shows that, based on the 2000 State Survey, the most commonly used management tool reportedly is prior authorization, used in 77% of the reforms and also reported as one of the most frequently used management mechanisms in 1997–98. Though it remains the most frequently used management mechanism, a slight decline (11%) in the use of prior authorization was found from 1997–98 to 2000. Prior authorization was closely followed by concurrent review, used in 74% of the reforms.

Table 72
Percent of Reforms in Using Various Management Mechanisms

	1995 Total	1997–98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Prior authoriation	Not Asked	88%	74%	88%	77%	Not Asked	-11%
Concurrent review	Not Asked	Not Asked	74%	75%	74%	Not Asked	Not Asked
Retrospective review	Not Asked	Not Asked	70%	63%	69%	Not Asked	Not Asked
Case management	89%	76%	70%	50%	66%	-23%	-10%
Other	Not Asked	Not Asked	7%	0%	6%	Not Asked	Not Asked

Interestingly, the use of case management as a management mechanism declined by 13% from 1995 to 1997–98 and another 10% from 1997–98 to 2000. It appears that although case management services *for children with serious and complex disorders* has increased as a result of managed care reforms in most cases (see **Table 37** on page 52), the use of case management in general, as a management tool for the entire population in services, has decreased.

Though the 2000 State Survey has confirmed the extensive use of prior authorization as a management mechanism, stakeholders in most states in both impact analyses complained about prior authorization processes, describing them as cumbersome, time consuming, confusing, and creating barriers to access. In both the 1997 and 1999 Impact Analyses, complaints about prior authorization were fewer in systems which routinely allowed a certain level of services without prior authorization, and reserved authorization requirements for more intensive and expensive levels of care.

The 2000 State Survey explored the extent to which managed care systems allow certain services without prior authorization. As shown on **Table 73**, about three-quarters of the reforms (76%) — all of the reforms with integrated designs and more than two-thirds of the carve outs — do allow certain services to be provided without prior authorization. According to stakeholders interviewed for the impact analyses, this practice reduces the perceived burden associated with prior authorization and makes the requirements less onerous.

Table 73
Percent of Reforms that Allow Provision of Certain Services up to Specified Amount Without Prior Authorization

	2000		
	Carve Out	Integrated	Total
Reforms allow certain services without prior authorization	69%	100%	76%
Reforms do not allow certain services without prior authorization	31%	0%	24%

Examples of allowing certain levels of service delivery without prior authorization were provided by several states.

- In **Arizona**, several MCOs allow up to 10 outpatient visits without prior authorization; 12 non-preauthorized outpatient visits per year are allowed in **Maryland**. In **Missouri**, four behavioral health outpatient visits are allowed without prior authorization in one region, and in **Pennsylvania**, most MCOs allow a predetermined number of behavioral health services without prior authorization.
- In **Iowa**, no prior authorization is required for outpatient services.
- In **Massachusetts**, providers request the outpatient services deemed necessary based on diagnosis and presenting problem; the MCO accepts this and monitors for outliers.

The majority of reforms (80%) also reported having strategies to manage the utilization of intensive services, such as inpatient and residential treatment services (**Table 74**). Carve outs were somewhat more likely to control the use of intensive service options; 83% reported doing so as compared with 67% of the integrated systems.

Table 74

Percent of Reforms with Strategies to Manage Utilization of Intensive Services

	2000		
	Carve Out	Integrated	Total
Strategies to manage intensive services	83%	67%	80%
No strategies to manage intensive services	17%	33%	20%

Several promising strategies for managing the use of intensive services were cited.

- In **Maryland**, local coordinating councils review referrals for residential treatment and must authorize this level of care.
- In **Oregon**, a professional review organization reviews the records of children in residential treatment centers to ensure that they continue to meet state criteria and receive active treatment.
- **Pennsylvania's** clinical decision making criteria have been developed and used to manage the authorization and use of intensive services, and the philosophy of treatment in the least restrictive setting is the basis for service delivery.
- Functional and behavioral criteria are used in **Michigan** to authorize intensive services. □

IX. Access

Initial Access to Behavioral Health Services and Access to Extended Care

In the 1997 Impact Analysis, stakeholders in nearly all states studied felt that initial access to behavioral health services was easier as a result of managed care reforms, regardless of design. In the 1999 Impact Analysis, initial access to services was generally judged to be easier in the reforms with carve out designs, but was judged to be compromised in the reforms with integrated designs.

An assessment of the effect of managed care reforms on initial access to behavioral health services in the 2000 State Survey found that, overall, initial access is considered to be improved by managed care reforms in 70% of the total sample (**Table 75**). However, survey results also confirmed the observation that initial access is likely to be better in systems with carve out designs. This was reported for 76% of the carve outs; initial access reportedly is worse in only 10% of the carve outs. Improvement in initial access in integrated managed care systems is less likely, according to 2000 survey data. Improved access was cited for only half of the integrated managed care systems and has reportedly worsened in one-third of the integrated systems. This finding is particularly significant given that improving access to behavioral health services was a goal reported for most reforms (more than 90% in both 1997–98 and 2000).

Table 75

Impact of Managed Care Reforms on Initial Access to Behavioral Health Services

	2000		
	Carve Out	Integrated	Total
Initial access to behavioral health services is better	76%	50%	70%
Initial access to behavioral health services is worse	10%	33%	15%
No change	14%	17%	15%

Several states described promising strategies to improve initial access to behavioral health services.

- In **Delaware**, the Medicaid agency stipulated that no primary care referral is necessary for mental health and substance abuse services in the basic MCO benefit, which has increased access to care. Access also has been increased by requiring MCOs to contract with public providers of outpatient services.

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- In **Pennsylvania**, access standards are specifically defined in the RFP and contracts. For example, MCOs must have 24-hour capacity for service authorization and 24-hour access to a physician for psychiatric and substance abuse clinical consultation and review; face-to-face intervention must be provided within one hour for emergencies, 24 hours for urgent situations, and seven days for routine appointments and specialty referrals.

Though some improvement in initial access to behavioral health services is evident in the 2000 survey results, access to extended care services remains more problematic. In both impact analyses, there was a widespread perception that it was more difficult to obtain care beyond a certain basic level and that accessing extended care services was more difficult post-managed care reforms. These reported difficulties stem from factors including authorization processes and tighter controls on admission and length of stay in hospitals, residential treatment centers, and other services. In addition, the typical emphasis in managed care systems on short-term treatment was identified by many stakeholders as a major problem; some asserted that managed care systems often do not sufficiently consider or serve children needing more than brief treatment.

As shown on **Table 76**, the 2000 State Survey found that access to extended care services reportedly is worse in nearly two-thirds (60%) of the reforms with integrated designs. In contrast, access to extended care was reported to have declined in only 4% of the reforms with carve out designs and was characterized as better in 39%. Improved access to extended care was reported in only 20% of the integrated reforms. In a substantial proportion of the reforms (50% overall and more than half of the carve outs), the managed care reform has had no impact on access to extended care services, according to respondents.

Table 76

Impact of Managed Care Reforms on Access to Extended Care Behavioral Health Services

	2000		
	Carve Out	Integrated	Total
Access to extended behavioral health services is better	39%	20%	36%
Access to extended behavioral health services is worse	4%	60%	14%
No change	57%	20%	50%

Consistent with findings suggesting improved initial access in most carve outs and half of the integrated reforms, the 2000 State Survey found shorter wait lists for children's behavioral health services in about half of the carve outs (53%) and one-third of the reforms with integrated designs — nearly half of the total sample of reforms (**Table 77**). Only 20% of the reforms across the entire sample reported longer wait lists for services. Longer wait lists were more likely to be reported for integrated systems, 33% as compared with only 15% of the carve outs.

Table 77 Impact of Managed Care Reforms on Waiting Lists for Children's Behavioral Health Services			
	2000		
	Carve Out	Integrated	Total
Waiting lists are shorter	53%	33%	48%
Waiting lists are longer	15%	33%	20%
No change	32%	34%	32%

An explanation for longer wait lists provided by several states is that, with children discharged from hospitals sooner and in more acute conditions, the demand for home and community-based programs that can provide intensive levels of services has increased. Since service capacity has not increased in proportion to the need, longer wait lists for intensive home and community-based services have resulted.

Access to Inpatient Services

The 1997 and 1999 Impact Analyses found that stakeholders in most states perceived inpatient services to be more difficult to access as a result of managed care reforms. More stringent admission and continuing stay authorization processes were seen as severely curtailing access and length of stay in inpatient settings. Concerns were pervasive among stakeholders about discharging youngsters prematurely from inpatient settings in an effort to reduce lengths of stay and cost. Some respondents regarded the decreased use of hospitals (both admissions and length of stay) to be a positive change from previous service systems which, in their opinions, used inpatient services too routinely and where lengths of stay were regarded as excessive. However, many stakeholders felt that the shift away from inpatient care has become too dramatic, that inpatient services have become far too difficult to access, and that stays have become dangerously brief.

The 2000 State Survey explored this area, which was not examined in the previous all-state surveys. The survey found that initial access to inpatient care is not considered to be more difficult in most cases as a result of managed care reforms; only 20% of the reforms reported this to be the case (**Table 78**). Much more significant, however, is the observation that inpatient lengths of stay are shorter — reported for more than half of the carve outs (56%) and nearly all of the integrated systems (88%).

Table 78 Impact of Managed Care Reforms on Access to Behavioral Health Inpatient Services			
	2000		
	Carve Out	Integrated	Total
Initial access to inpatient is more difficult	19%	25%	20%
Average lengths of stay are shorter	56%	88%	63%

Both impact analyses found a host of problems associated with reduced length of stays in inpatient settings, such as discharging children prior to stabilization and returning them to the community in highly vulnerable conditions, discharging children without linking them with needed community services and supports, placement of children in community services that are ill-equipped to serve youth at that level of acuity, and inappropriate use of residential treatment centers and child welfare and juvenile justice facilities.

The 2000 State Survey was used as an opportunity to explore these areas more fully and to obtain a better sense of the extent to which these problems are occurring. Most notable on **Table 79** is that nearly all of the problems associated with changes in access and length of stay in inpatient care are more significant in reforms with integrated designs than in carve outs. For example, premature discharge before stabilization, children discharged without needed services, and placement in community programs without the clinical capacity to serve them all reportedly occur in about one-quarter of the carve outs but in more than 40% of the integrated systems.

Table 79

Problems Associated with Changes in Access to Behavioral Health Inpatient Services

	2000		
	Carve Out	Integrated	Total
Premature discharge before stabilization from inpatient settings	24%	43%	29%
Children discharged without needed services	29%	43%	33%
Placement in community-based services lacking appropriate clinical capacity to serve them	24%	43%	29%
Increased use of residential treatment services as a substitute for inpatient	29%	29%	29%
Inappropriate use of child welfare emergency shelters	8%	43%	21%
Inappropriate use of juvenile justice facilities	13%	29%	21%
Discharge without a safe placement for children in child welfare	4%	14%	8%

Dramatic differences between carve outs and integrated systems emerge when the effects on other systems are considered. Specifically, inappropriate use of child welfare shelters was reported in 8% of the carve outs as compared with 43% of the integrated reforms. Similarly, inappropriate use of juvenile justice facilities was reported in 13% of the carve outs but 29% of the integrated systems. Only the use of residential treatment as a substitute for inpatient services was reported equally among carve outs and integrated systems – this practice reportedly occurs in 29% of each of these types of managed care systems.

A major concern with respect to reduced access to inpatient services is the lack of sufficient capacity to provide home and community-based services as alternatives. Although the availability of home and community-based services reportedly is increasing, in a number of states, stakeholders interviewed for the impact analyses observed that alternatives to inpatient care were not sufficiently developed prior to reducing admissions and/or length of stay.

The 2000 State Survey was used as a vehicle to explore the extent to which alternatives to hospitalization are being developed. Again, carve outs are more likely to do so, 68% as compared with 43% of the integrated reforms (**Table 80**). However, both carve outs and integrated systems indicated efforts to develop alternatives to hospitalization — nearly two-thirds (62%) overall have done so. It remains disconcerting, however, that one-third of the carve outs and half of the integrated reforms (38% of the reforms overall) reportedly are not developing alternatives to hospitalization, despite the finding that reduced access and, particularly, reduced length of stay in inpatient settings, and the associated problems, are widespread. □

Table 80

Percent of Reforms Developing Alternatives to Inpatient Hospitalization

	2000		
	Carve Out	Integrated	Total
Alternatives to hospitalization have been developed	68%	43%	62%
Alternatives to hospitalization have not been developed	32%	57%	38%

X. Service Coordination

The 1997 and 1999 Impact Analyses yielded mixed results with respect to the impact of managed care reforms on the coordination of services to children and adolescents with behavioral health disorders and their families. In both samples, stakeholders in about half of the states felt that managed care reforms had improved service coordination, while stakeholders in the other half reported that managed care impeded service coordination. In the 1999 Impact Analysis, system design appeared to be strongly related to the effects of managed care on service coordination, with reports of improved coordination found in all but one carve out, and reports of impediments to coordination in all of the integrated reforms. Items were added to the 2000 State Survey to clarify the impact of managed care on service coordination, specifically addressing coordination between physical and behavioral health services, coordination between mental health and substance abuse services, and interagency coordination among child serving systems.

Coordination of Physical Health and Behavioral Health Services

The 1997 and 1999 Impact Analyses found near universal reports of inadequate identification and referral by primary care practitioners of children and adolescents with behavioral health problems, regardless of the design of the managed care system. In addition, respondents across sites consistently provided examples of poor communication between physical health and behavioral health providers, poor coordination of physical and behavioral health treatment, and disagreements between physical and behavioral health care providers regarding responsibility for various special needs populations and particular types of services. Stakeholders noted that the lack of coordination between physical and behavioral health services is a problem that pre-existed managed care reforms. An explicit expectation for managed care reforms with integrated designs is that improved coordination between physical and behavioral health care will result. However, the impact analyses revealed little evidence of improvements in this area, and the consensus among stakeholders was that, regardless of design, coordination of physical health and behavioral health services remains a daunting challenge.

In an effort to clarify and note changes in the coordination of physical and behavioral health care, the 2000 State Survey explored the effects of managed care reforms on the coordination between physical health and behavioral health services. As **Table 81** indicates, improved physical health-behavioral health coordination was reported for 60% of the reforms, while in one-third of the reforms, managed care reportedly has had no effect on service coordination. Coordination of physical health and behavioral health services reportedly has worsened in only 7% of the reforms.

Table 81

Impact of Managed Care Reforms on Coordination Between Physical Health and Behavioral Health Services

	2000		
	Carve Out	Integrated	Total
Coordination between physical and behavioral health is improved	61%	57%	60%
Coordination between physical and behavioral health is worse	9%	0%	7%
No effect	30%	43%	33%

Despite the arguments that integrated managed care system designs will improve coordination between physical and behavioral health services, improved coordination was reportedly improved at fairly equal rates among integrated systems (57% reported improved coordination) and carve outs (61% reported improved coordination). These results suggest that states may be devoting increasing attention to the need for improved coordination between physical and behavioral health services. It appears that specific efforts to address this problem, rather than the design of the managed care system, are likely to be associated with improvements.

Respondents described several promising strategies designed to improve coordination between physical health and behavioral health services.

- **California**, **Oregon**, **Missouri** and **Pennsylvania** require memoranda of understanding and communication protocols that address service coordination, referrals and dispute resolution between mental health plans and physical health managed care plans.
- When a child is admitted to the behavioral health plan in **Delaware**, a letter is sent (with consent) to the child's physician to indicate that the child has entered care. The letter provides the name of the child's clinical team leader to allow the physician to make contact. Another letter is sent to the physician when the child is discharged from care.
- In **Florida** joint assessments are conducted by primary and behavioral health care providers.
- In **Maryland** and **Connecticut** each physical health MCO has special needs coordinators on staff who are responsible for coordinating with behavioral health care providers.

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(Promising strategies continued)

- Several states make behavioral health MCOs and providers responsible for aspects of coordinating with physical health care providers. In **New York**, behavioral health case coordinators have health-related checklists and monitor well-child care as well as care for chronic health conditions. In **Pennsylvania**, the behavioral health MCO checks whether EPSDT screens have been completed; if not, a referral is made to the child's primary care practitioner. In **Wisconsin**, physical health is a required domain to be addressed on the child's behavioral health care plan.
- Work is underway at the University of **Missouri** to develop a model for the education of community-based physicians on coordinating services for children with special health care needs.

Coordination of Mental Health and Substance Abuse Services

Stakeholders in most states in both the 1997 and 1999 Impact Analyses described the coordination of mental health and substance abuse services, or lack thereof, as a pre-existing problem that remained largely unaffected by managed care reforms. They indicated that the lack of coordination remains a particularly troublesome obstacle to effectively serving youngsters with the dual diagnosis of substance abuse and mental health disorders.

The 2000 State Survey further examined the effect of managed care reforms on the coordination of mental health and substance abuse services across all reforms. **Table 82** indicates that in about half of the reforms (52%) coordination reportedly has improved, a significant departure from the impact analysis findings that indicated little, if any, improvement in this area as a result of managed care reforms. In most other reforms (45%), managed care reforms were considered to have had no effect on coordination between mental health and substance abuse services. Again, improved coordination in this area may be developmental. Managed care reforms tend to throw a spotlight on pre-existing problem areas, focusing attention to the issues and creating an opportunity to address them.

Table 82

Impact of Managed Care Reforms on Coordination Between Mental Health and Substance Abuse Services

	2000		
	Carve Out	Integrated	Total
Coordination between mental health and substance abuse has improved	52%	50%	52%
Coordination between mental health and substance abuse is worse	0%	17%	3%
No effect	48%	33%	45%

States identified a number of promising strategies used to improve coordination between mental health and substance abuse services.

- In **Colorado** and **Florida**, there are requirements for memoranda of understanding and network agreements for the provision of mental health and substance abuse services.
- **Delaware** provides integrated mental health and substance abuse services for children and adolescents within its managed care system.
- In **Indiana**, **New Mexico**, and **Pennsylvania**, statewide task forces have been created to address this issue. Areas under consideration in these states include conceptual framework, staff credentials, education and training, assessment, services standards and protocols, and services to adolescents and individuals in the criminal justice system.

Interagency Coordination Among Child Serving Systems

Findings from the 1997 and 1999 Impact Analyses indicated that, in most states, problems resulting from the implementation of managed care reforms have forced agencies to increase cross-system collaboration. Stakeholders noted that in the early stages of implementation of managed care systems, insufficient attention was paid to cross-systems issues. Typically by mid-implementation stages, cross-systems issues created so many challenges that both state and local attention was demanded. **Table 83** shows a consistent finding for the 2000 State Survey; in two-thirds (65%) of the reforms, managed care reforms reportedly have resulted in improved interagency coordination among child serving systems. Improvement in interagency coordination is more likely in carve outs (71%) than in integrated reforms (43%). In very few reforms (only 6%) did respondents report that interagency collaboration was worse as a result of managed care.

Table 83

Impact of Managed Care Reforms on Interagency Coordination Among Child Serving Systems

	2000		
	Carve Out	Integrated	Total
Interagency coordination is improved	71%	43%	65%
Interagency coordination is worse	4%	14%	6%
No effect	25%	43%	29%

Respondents identified a number of promising strategies used to improve interagency coordination among child-serving systems at the system level in the context of managed care.

- In **Arizona**, the Department of Health Services was established in statute as the lead agency in creating a coordinated system of behavioral health services along with other child serving agencies. A Children's Interagency Agreement was instituted, naming state agency chiefs as required members of an Executive Committee. The Executive Committee meets regularly to direct a number of shared interagency projects and to respond collaboratively to client, provider, and service issues.
- In **Massachusetts**, two state agencies and the statewide MCO meet weekly for case specific reviews and system planning. □

XI. Early Identification and Intervention

The 1997–98 State Survey found that 93% of reforms included the Early Periodic Screening Diagnostic and Treatment Program (EPSDT) in some way in their managed care systems. However, 1999 Impact Analysis findings indicated that managed care reforms were not resulting in improved early identification and intervention for behavioral health problems, even if EPSDT was incorporated into the managed care system. Stakeholders identified a number of factors that may contribute to the negligible improvement in early identification and intervention:

- Capitation financing may create a disincentive for MCOs and providers to find new cases, with the resulting obligation to provide services.
- Primary care practitioners may resist conducting EPSDT screens because of the time and cost that screening involves.
- PCPs may be penalized by MCOs for spending "too much time" with individual patients or for too many referrals to specialty providers.

Since earlier findings indicated that nearly all managed care systems include EPSDT in some way, but that problems with the early identification process persist, the 2000 State Survey went beyond the issue of whether or not EPSDT is "included" and explored the EPSDT *screening* process more specifically in order to assess how screens are incorporated into managed care system operation and whether or not screening includes a focus on identifying behavioral health problems.

This closer look at the screening revealed that less than half (44%) of the reforms in the 2000 State Survey reported that EPSDT screens are conducted within the managed care system (**Table 84**). The majority of the integrated reforms (88%), but only about one-third of the carve outs (31%) indicated that EPSDT screens are conducted within the managed care system. This large discrepancy may be partially explained by the fact that EPSDT screens are conducted by health care practitioners, and thus may be more likely to be found in integrated systems. In addition, in some of the carve outs, screens conducted on the physical health side of the system may not have been characterized as being "within the managed care system." Despite these qualifications, it appears that, although EPSDT may be "included" in reforms, EPSDT screens for the early identification of problems are incorporated in managed care systems much less frequently.

Table 84
Percent of Reforms Conducting EPSDT Screens

	2000		
	Carve Out	Integrated	Total
EPSDT screens are conducted within the managed care system	31%	88%	44%
EPSDT screens are not conducted within the managed care system	69%	12%	56%

Even if EPSDT screens are being conducted, the question remains as to the extent to which screening for early detection of behavioral health problems is a part of the process. Both the 1997 and 1999 Impact Analyses reported that contractual language regarding EPSDT screens often does not specify that a behavioral health assessment be conducted. However, as shown on **Table 85**, for the 15 reforms that include EPSDT screenings, 80% of the EPSDT screens reportedly do have a behavioral health component.

Table 85

Percent of Reforms with Behavioral Health Component to EPSDT Screens

	2000		
	Carve Out	Integrated	Total
EPSDT screens have behavioral health component	75%	86%	80%
EPSDT screens do not have behavioral health component	25%	14%	20%

Although it is encouraging to find that most EPSDT screens do include a behavioral health component of some type, stakeholders interviewed for the impact analyses noted that the behavioral health focus in screens often is minimal, with the major focus of the screening remaining on physical health issues.

Promising strategies to encourage primary care practitioners to conduct behavioral health screens and to make appropriate referrals were described by a number of states.

- A number of states (**Delaware**, **Iowa**, **Maryland**, and **Vermont**) have developed educational materials for pediatricians and other primary care practitioners. In **Delaware** the Quality Improvement Initiatives Workgroup has disseminated information to PCPs about how to screen for mental health and substance abuse problems in children using the SAMHSA Tips series. **Vermont** has developed and distributed "periodicity" charts and schedules to pediatricians.
- In **Mississippi**, **New Mexico**, and **Minnesota**, behavioral health screening tools for PCPs are being developed. Several states (**Missouri**, **New Mexico**, and **Oklahoma**) are working with MCOs on compliance with HCFA's requirement that 80% of Medicaid beneficiaries under the age of 21 receive EPSDT screens in accordance with the periodicity schedule. Methods to improve compliance include fiscal sanctions and/or fiscal bonuses for MCOs who meet productivity standards.
- In **Washington**, the Medicaid office has included requirements for EPSDT screens in contracts with managed care system providers. □

XII. Cultural Competence

The 1997–98 and 2000 State Surveys investigated whether managed care systems incorporated specific system of care values and principles in their RFPs, contracts, and other key documents. Findings in both 1997–98 and 2000 indicated that about 80% of the reforms reportedly incorporate the principle of cultural competence in some way. However, impact analysis results indicated that, despite including cultural competence requirements, managed care reforms have had little, if any, effect on the overall level of cultural competence of managed care systems. A widespread perception among stakeholders interviewed for the impact analyses was that lack of cultural competence is a problem that pre-existed managed care reforms, and that managed care had little impact in this area.

The 2000 State Survey included new items exploring cultural competence in greater depth. Respondents were asked to indicate the strategies related to cultural competence that are included in their managed care systems, and to characterize the cultural competence requirements in their managed care systems in comparison with their previous system as either stronger, weaker, or unchanged. In addition, respondents were asked to describe promising strategies to enhance cultural competence in managed care reforms.

A range of strategies that potentially could be used to address and enhance cultural competence within managed care systems were presented to respondents, including:

- Special planning for culturally diverse populations
- Incorporating requirements related to cultural competence in RFPs and contracts
- Training MCOs and/or providers on cultural competence
- Outreach to culturally diverse populations
- Inclusion of specialized services needed by culturally diverse populations
- Inclusion of culturally diverse providers in provider networks
- Providing translation/interpreter services
- Tracking utilization and/or outcomes by culturally diverse groups

Of these strategies, two emerged as the most widely utilized among managed care systems, according to respondents to the 2000 survey (**Table 86**). Requirements related to cultural competence reportedly are included in RFPs and contracts in 85% of the reforms, and translation/interpreter services are provided in 82%. Both strategies are utilized at high rates by both carve outs and managed care systems with integrated designs. The next most frequently reported strategies were including culturally diverse providers in provider networks (reported by nearly two-thirds of the reforms), and outreach to culturally diverse populations (reported by 58% of the reforms). All of the other strategies were reported by fewer than half of the reforms, ranging from a low of 33% for specific planning for culturally diverse populations to 42% for training MCOs and providers on cultural competence.

Table 86

Percent of Reforms Incorporating Various Types of Strategies Related to Cultural Competence in Managed Care Systems

	2000		
	Carve Out	Integrated	Total
Specific planning for culturally diverse populations	40%	13%	33%
Requirments in RFPs and contracts related to cultural competence	88%	75%	85%
Training of MCOs and/or providers on cultural competence	48%	25%	42%
Outreach to culturally diverse populations	60%	50%	58%
Inclusion of specialized services needed by culturally diverse populations	48%	0%	36%
Inclusion of culturally diverse providers in provider networks	68%	50%	64%
Translation/interpreter services	80%	88%	82%
Tracking utilization and/or outcomes by culturally diverse groups	48%	0%	36%
None	0%	0%	0%
Other	8%	0%	6%

With only one exception, all of the strategies for enhancing cultural competence were reported with greater frequency by carve outs than by integrated managed care systems. For some strategies, the differences were dramatic. For example, nearly half of the carve outs include special services needed by culturally diverse groups in their managed care systems, while none of the integrated reforms do so. Similarly, nearly half of the carve outs reportedly track utilization and outcomes by culturally diverse groups, but none of the integrated reforms indicated that this is done. Integrated systems surpassed carve outs somewhat only in the provision of translation/interpreter services — 88% provide these services as compared with 80% of the carve outs. Use of some of the strategies is discussed in more detail below.

Specific Planning and Data Analysis for Culturally Diverse Populations

The impact analyses found that, in most states, managed care planning does not include a specific focus on culturally diverse groups or a specific analysis of the needs of culturally diverse children and families. Both in 1997 and 1999, stakeholders identified few attempts by managed care systems to analyze the needs of culturally diverse populations and to address these needs in planning and implementing managed care systems.

The results of the 2000 State Survey uphold these findings. As indicated on **Table 86**, only one-third of reforms (40% of the carve outs and 13% of the integrated reforms) carry out specific planning activities to address the needs of culturally diverse populations. Similarly, few managed care systems track service utilization patterns and/or outcomes by cultural groups, according to 2000 survey results. Only about a third of the reforms (36%, including 48% of the carve outs and none of the integrated reforms) track utilization and/or outcomes by culturally diverse populations.

Outreach and Special Services for Culturally Diverse Populations

In both the 1997 and 1999 Impact Analyses, stakeholders in few states reported outreach efforts to culturally diverse children and families; only about 20% of each sample reported outreach efforts. Findings from the 2000 State Survey are more encouraging. As indicated on **Table 86**, 58% of reforms reportedly incorporate outreach strategies to culturally diverse populations, 60% of the carve outs and half of the integrated systems.

Although outreach to culturally diverse populations may be increasing, the inclusion of specialized services in managed care systems for culturally diverse groups is not as widespread. According to the 2000 survey results, only 36% of all reforms (48% of the carve outs and none of the integrated reforms) reportedly include specialized services for various cultural groups. A notable exception is translation and interpreter services, which are provided by the vast majority of managed care systems. As shown on Table 86, 82% of reforms include translation and interpreter services (80% of the carve outs and 88% of the integrated systems).

Requirements for Cultural Competence

The 1997 and 1999 Impact Analyses found that most states included requirements related to cultural competence in their managed care systems. Consistent with these results, the 2000 State Survey found that the majority of reforms (85%) include requirements related to cultural competence in their RFPs, contracts, and other key system documents (**Table 86**).

Comparing the requirements related to cultural competence under the managed care system with the previous system, about two-thirds of the reforms (64%) reported having stronger cultural competence requirements than previously (**Table 87**). Very few reported weaker cultural competence requirements under managed care (3%), and in one-third of the reforms (33%) managed care has had no effect on the cultural competence requirements. These findings are consistent across carve outs and integrated reforms.

The impact analyses suggested that, even where cultural competence requirements are incorporated, in many cases these are limited to requirements for linguistically appropriate services. Further exploration is required to determine if the requirements included in managed care systems deal primarily with linguistically appropriate services or address cultural competence more comprehensively.

Table 87

Comparison of Cultural Competence Requirements in Managed Care Systems Versus Previous Systems

	2000		
	Carve Out	Integrated	Total
Cultural competence requirements are stronger in the managed care system	64%	62%	64%
Cultural competence requirements are weaker in the managed care system	4%	0%	3%
No change	32%	38%	33%

Training for MCOs and Providers on Cultural Competence

Both the 1997 and 1999 Impact Analyses found few reforms that provided training for MCOs and providers regarding cultural competence (only about 30% of the sample in 1997 and 20% in 1999.) **Table 86** (page 96) indicates that 42% of reforms in the 2000 State Survey include training on cultural competence, suggesting a slight improvement in the proportion of reforms offering training for MCOs and providers related to cultural competence.

Inclusion of Culturally Diverse Providers

Previous findings of the Tracking Project regarding the inclusion of culturally diverse providers in managed care systems have been contradictory. In the 1997 Impact Analysis, stakeholders reported that managed care reforms had impeded the inclusion of culturally diverse providers in nearly half of the sample. Stakeholders interviewed for the 1999 Impact Analysis in all but one state did not feel that managed care reforms had impeded the inclusion of culturally diverse providers.

Given these contradictory results, the state surveys explored whether managed care reforms have specifically focused on including culturally diverse providers in managed care provider networks. The 1997–98 State Survey indicated that 80% of reforms had provisions addressing the inclusion of culturally diverse providers in provider networks. However, as shown on **Table 86** (page 96), 2000 survey results indicated a somewhat reduced emphasis on this strategy. Less than two-thirds (64%) of reforms reported incorporating specific strategies for including culturally diverse agencies and practitioners in provider networks.

A number of states identified promising strategies or practices to enhance cultural competence within managed care systems.

- In **Indiana**, the state sponsors an annual cultural competency conference for behavioral health. In addition, the state contracts with the Fairbanks Research and Training Institute to provide cultural competence training for managed care providers. **New York** also conducts ongoing training of MCOs and other providers on cultural competence.
- Both **Arizona** and **Utah** require MCOs to develop a plan for cultural competence. In **Missouri**, MCOs are contractually required to have culturally competent clinicians available for their members. Quality monitoring of the MCOs includes an emphasis on cultural diversity and culturally competent service delivery approaches. Several MCOs and mental health organizations have conducted focus groups and provider education through key community organizations to address cultural competency issues.
- In **Pennsylvania** a state-level cultural competence committee reviews RFPs and other managed care materials. Credentialing standards, as well as provider contracts and handbooks have cultural competence requirements. □

XIII. Family Involvement

Previous Tracking Project findings revealed a mixed picture with respect to the impact of managed care reforms on family involvement at both the system level in planning and oversight activities and at the service delivery level in planning and delivering services for their own children. For example, while respondents in the 1997–98 State Survey noted that 98% of the reforms involved families in system level planning and oversight activities, they reported this involvement as significant in only 38% of the reforms. In addition, the impact analyses found that, even in states where managed care reforms include requirements for family involvement in planning services for their own children, implementation of this requirement was variable. The 2000 State Survey further investigated family involvement at both the system level and the service delivery level with a number of new items.

Respondents were asked to indicate whether or not their managed care systems incorporate a range of strategies for involving families at both the system and service delivery levels, including:

- Requirements in RFPs and contracts for family involvement at the system management level
- Requirements in RFPs, contracts, and service delivery protocols for family involvement in planning and delivering services for their own children
- Focus in service delivery on families, in addition to the identified child
- Coverage for and provision of family supports
- Use of family advocates
- Hiring families and/or youth in paid staff roles

The most frequently reported strategy, noted for nearly two-thirds (64%) of the reforms, was incorporating a focus in service delivery on families, in addition to the identified child. This strategy was followed closely by coverage for and provision of family supports, which reportedly are incorporated in 58% of the reforms. More than half of the reforms also reported including requirements for family involvement at the system management level in the managed care systems (55%), as well as requirements for family involvement at the service delivery level in treatment planning and service delivery for their own children (52%). The use of family advocates and hiring family members or youth in paid staff roles were strategies reported with less frequency.

Table 88

Percent of Reforms Incorporating Various Types of Family Involvement Strategies within Managed Care Systems

	2000		
	Carve Out	Integrated	Total
Requirements in RFPs and contracts for family involvement at the system level	69%	0%	55%
Requirements in RFPs, contracts, and service delivery protocols for family involvement in planning and delivering services for their own children	62%	14%	52%
Focus in service delivery on families in addition to the identified child	73%	29%	64%
Coverage for and provision of family supports	65%	29%	58%
Use of family advocates	62%	0%	48%
Hiring families and/or youth in paid staff roles	35%	0%	27%
None	0%	29%	6%
Other	23%	29%	24%

Striking differences between carve outs and integrated systems were found with respect to all of these family involvement strategies. Between 62% and 73% of the carve outs reportedly incorporate most of the family involvement strategies, compared with none to a high of 29% of the integrated systems. In fact, 29% of the integrated reforms reported that none of the family involvement strategies are incorporated in their systems.

Requirements for Family Involvement

As noted and as shown on **Table 88**, more than half of the reforms incorporate requirements for involvement at the system management level (55%) and at the service delivery level (52%). Requirements at both levels are far more likely to be found in carve outs — 69% incorporate system-level involvement requirements compared with none of the integrated systems, and 62% include service-delivery level requirements compared with only 14% of the integrated systems.

To compare requirements for family involvement under managed care with previous systems, an item was added to the 2000 State Survey assessing whether family involvement requirements in managed care systems were stronger, weaker, or unchanged. As shown on **Table 89**, family involvement requirements reportedly are stronger in 76% of all managed care systems than they were in previous systems. A substantially higher proportion of the carve outs (85%) were reported to have stronger requirements for family involvement than integrated reforms (42%).

Table 89

Comparison of Family Involvement Requirements in Managed Care Systems Versus Previous Systems

	2000		
	Carve Out	Integrated	Total
Family involvement requirements are stronger in the managed care system	85%	42%	76%
Family involvement requirements are weaker in the managed care system	0%	29%	6%
No change	15%	29%	18%

Despite this finding that requirements for family involvement are stronger in most managed care systems than they were previously, stakeholders interviewed for the impact analyses cited discrepancies (in this, among other areas) between managed care policy requirements and what actually is occurring in implementation, raising questions as to the degree to which requirements for family involvement are operationalized.

Family Involvement at the System Management Level

Most Tracking Project activities have indicated a trend toward greater family involvement at the system level in managed care systems over time. Results of the 1999 Impact Analysis raised some questions in this area, as the trend toward increased family involvement in system planning and oversight activities was less pronounced in this sample. The 2000 State Survey further examined family involvement at the system level.

As noted, the 2000 State Survey found that families reportedly have significant involvement in planning, implementation and refinements in 48% of the managed care reforms — a 10% increase from the 1998 State Survey (see **Table 14** on page 21). A significant level of family stakeholder involvement at the system level was reported in 64% of carve outs but in none of the integrated reforms. In addition, three-quarters of the reforms (75%) provide education and training to families about the goals and operation of the managed care reform, representing a 16% increase from the 1997–98 State Survey.

The 2000 State Survey asked respondents to describe promising strategies or approaches for involving families at the system level. Previous Tracking Project findings indicated that the most common strategy for involving families at the system level was to include family representation on various state advisory structures. According to 2000 State Survey results, this still appears to be the case; 17 states described strategies centered around involving families as members of advisory structures, such as advisory committees, executive committees, and task forces related to the managed care system. Several other promising strategies for involving families at the system level were cited as well.

- In **Colorado**, consumers and family members govern an independent ombudsman program.
- Families in **Hawaii** are involved in all performance improvement committees, including the management team.
- In **Oregon**, each MCO is required to develop specific methods for involving families. Some MCOs have used advisory committees; others have integrated families on either internal or external governing bodies.
- In **Oregon**, the state has contracted with the Oregon Family Support Network to develop and test a curriculum on the enhancement of family and managed care system collaboration at the system and provider levels.
- In **Massachusetts**, a Family Advisory Council meets monthly and is co-chaired by the Director of the Parent Professional Advocacy League, the state's chapter of the Federation of Families for Children's Mental Health. The parent organization helps to organize focus groups to give feedback to the MCO. Parents review drafts of printed materials for the MCO to ensure that the materials are family friendly.
- Family members in **Pennsylvania** are required members of the state's Readiness Review Team and the Annual Review Teams.

Stakeholders interviewed for the impact analyses noted that funding family organizations to assume specific roles in managed care systems can be an effective mechanism for enhancing family involvement at the system level. As shown on **Table 90**, 47% of all reforms reportedly fund a family organization to play some role in the managed care system, a finding consistent with 1997–98 results which found that 45% of reforms funded family organizations for managed care system roles. Consistent with 1997–98 findings, more than half of the carve out reforms (52%) fund a family organization, as compared with only 29% of the integrated reforms.

Table 90
Percent of Reforms Funding a Family Organization for Managed Care System Roles

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Family organization is funded to play role in managed care system	45%	52%	29%	47%	+2%
Family organization is not funded to play role in managed care system	55%	48%	71%	53%	-2%

Respondents identified promising strategies to involve family organizations in managed care systems.

- In **Arizona**, Mentally Ill Kids In Distress (MIKID) has provided advocacy, education, and a 24-hour phone response system for families. MIKID reports data, information, and trends related to the managed care system to the state agency.
- The Federation of Families for Children's Mental Health chapter in **North Dakota** sits on the managed care system's Executive Committee. The family representatives were instrumental in incorporating parent-to-parent support services as Medicaid reimbursable services under the waiver.

Family Involvement at the Service Delivery Level

Family Involvement in Service Planning

Results of both the 1997 and 1999 Impact Analyses suggested that most reforms (around 80% of the small impact analysis samples) included requirements for family involvement at the service delivery level, mandating at a minimum that they be involved in treatment planning for their own children. The 2000 State Survey, exploring this across all reforms, suggests that such requirements are not quite so ubiquitous; only about half of the reforms (52%) reportedly incorporate requirements for family involvement at the service delivery level. Where requirements are in place, they typically address family involvement in treatment planning. For example, in Florida, the managed care system includes a requirement that families must be provided with a written explanation of the treatment plan and that the case manager must discuss the plan with the family. It is important to note, however, that stakeholders interviewed for the impact analyses emphasized that, even where such requirements are in place, implementation is spotty and varies from provider to provider.

Extent of Family Focus of Services

The 2000 State Survey included several items related to the degree of family focus in service delivery. The survey explored whether the focus of service delivery is on the family in addition to the identified child, whether family support services are covered and provided, and whether the reform pays for services to family members if only the child is covered under the managed care system.

The perception of stakeholders in all nine managed care reforms studied in the 1999 Impact Analysis was that the focus of services in managed care systems was limited to the identified child, and that family needs typically are neither considered nor addressed. The 2000 State Survey revealed a significantly different picture. As shown on Table 72, nearly two-thirds of the managed care systems (64%—73% of carve outs and 29% of integrated reforms) reportedly do include a focus on families in service delivery, in addition to focusing on the identified child. Similarly, 58% of managed care systems (65% of carve outs and 29% of integrated reforms) reportedly include coverage for family support services. In both cases, carve outs are far more likely to incorporate a greater family focus.

The 2000 State Survey also investigated whether the managed care system pays for services to family members if only the child is covered by the reform. As shown on **Table 91**, about half of all reforms reportedly pay for services to family members when only the child is covered. The issue of coverage for family members by the Medicaid managed care reform is especially important due to the relationship in many states between Medicaid and the State Children's Health Insurance Program (SCHIP). Findings from the 2000 State Survey regarding SCHIP indicate that 57% of the state SCHIP programs are based on an expansion of their state's Medicaid program, and, according to the federal SCHIP guidelines, coverage must be limited to the child only.

Table 91

Percent of Reforms Paying for Services to Family Members if Only the Child is Covered

	2000		
	Carve Out	Integrated	Total
Managed care system pays for services to family members	48%	62%	51%
Managed care system does not pay for services to family members	52%	38%	49%

Practice of Relinquishing Custody to Obtain Services

The impact analyses yielded somewhat conflicting results with respect to the impact of managed care reforms on the practice of families relinquishing custody in order to obtain needed, but expensive treatment. Stakeholders in the 1997 sample reported that managed care reforms exacerbated this practice with greater frequency than did stakeholders interviewed in the 1999 sample of states. Stakeholders in a number of states in both samples indicated that relinquishing custody in order to receive needed treatment was a pre-existing problem, and that the problem has not been made any worse by the introduction of managed care.

In order to clarify this issue, an item was added to the 2000 State Survey exploring whether managed care has improved, worsened, or had no effect on the pre-existing practice of parents' relinquishing custody in order to access behavioral health services. As indicated on **Table 92**, in the majority of cases (83%), managed care reforms reportedly have not affected, either positively or negatively, the practice of relinquishing custody in order to receive needed but expensive behavioral health services.

Table 92

Impact on Managed Care Reforms on the Practice of Relinquishing Custody to Obtain Services

	2000		
	Carve Out	Integrated	Total
Practice of relinquishing custody is worse under managed care	0%	17%	4%
Practice of relinquishing custody is improved under managed care	17%	0%	13%
No effect	83%	83%	83%

Several promising strategies address the problem of families relinquishing custody in order to access behavioral health care were described by respondents.

- The mental health authority in **New York** has received a 1915 (c) waiver from HCFA that protects parents from having to relinquish custody in order to receive services. In addition, the waiver allows the child to be considered a family of one in the determination of Medicaid eligibility. **Maryland** has also applied for a 1915 (c) waiver.
- The Disability Law Center and the Bazelon Center for Mental Health Law are working with **Minnesota** to bring practice into conformity with a law that prohibits custody relinquishment in order to access services.
- In **Pennsylvania** residential treatment facilities became reimbursable through Medicaid in 1993. This revision dramatically decreased the practice of relinquishing custody in order to obtain residential treatment services.

Program and Staff Roles for Families and Youth

Stakeholders in all reforms in the 1999 Impact Analysis sample indicated that managed care reforms had no impact on the availability of family-run programs or on the use of family members or youth as paid staff. Both practices were virtually nonexistent or infrequent prior to managed care reforms, and continued to be atypical. The 2000 State Survey examined the use of family advocates and the inclusion of other paid program and staff roles for family members or youth in managed care systems. As shown on **Table 88**, about half of all reforms (48%) reportedly use family advocates, 62% of the carve outs and none of the integrated reforms. A much smaller proportion of reforms (27%) reportedly actually hire family members and/or youth in paid staff roles. This finding is consistent with impact analysis results in that very few examples of families being hired in staff roles were identified.

Several states reported promising strategies related to incorporating family advocates and hiring family members for other program or staff roles.

- **Colorado's** contract requires the MCO to hire a parent of a child with mental health problems as a family advocate.
- In **Massachusetts** and in some counties in **Pennsylvania**, the MCO has hired parents to design and conduct parent satisfaction surveys. □

XIV. Providers

Over time, the Tracking Project has explored a range of issues related to the effects of managed care reforms on behavioral health service providers, including both provider agencies and individual practitioners. The 2000 State Survey investigated a number of provider-related issues, including how managed care reforms have affected the participation of various types of providers in provider networks, the availability of children's behavioral health providers, provider reimbursement rates, administrative burden, and the financial viability of provider agencies. Additionally, the survey assessed the extent to which front-line providers are judged to have the appropriate knowledge and skills needed to provide the types of children's behavioral health services offered by managed care systems.

Provider Inclusion and Exclusion

The 1999 Impact Analyses found that, in most states, managed care reforms have resulted in the inclusion of an expanded range of providers, but has also made it more difficult for certain types of providers to participate. The expanded range of providers included in managed care systems was attributed by stakeholders to the inclusion of new types of practitioners, new types of provider agencies, and/or new service modalities in the benefit plan (such as targeted case management, respite, in-home services, behavior management, mentors, day treatment, and others). This analysis suggested that managed care reforms are, indeed, "opening up" provider networks, a stated goal of many reforms. At the same time, stakeholders interviewed observed that smaller and nontraditional agencies were struggling to participate in managed care systems, largely due to a lack of administrative infrastructure, fiscal challenges involved in moving from grant funding to a reimbursement rate structure, and the inability to take on financial risk. In addition, credentialing requirements were reportedly impeding the participation of particular types of providers in managed care provider networks, most notably certified addictions counselors.

The 2000 State Survey further explored issues related to the inclusion or exclusion of providers from managed care provider networks. As **Table 93** indicates, managed care systems, reportedly, most frequently include culturally diverse and indigenous providers in provider networks; 82% do so. This finding is similar to 1997–98 State Survey results indicating that 80% of all reforms had provisions to address the inclusion of culturally diverse providers. The 2000 State Survey also found that about two-thirds of all reforms reportedly include certified addictions counselors (68%) and school-based behavioral health providers (62%); both are included at similar rates by carve outs and integrated managed care systems.

Table 93

Percent of Reforms Including Various Types of Providers in Provider Networks

	2000		
	Carve Out	Integrated	Total
Child welfare providers	65%	13%	53%
School-based behavioral health providers	62%	63%	62%
Certified addictions counselors	69%	63%	68%
Culturally diverse and indigenous providers	88%	63%	82%
Family members as providers	42%	0%	32%
Paraprofessionals and student interns	62%	13%	50%

For other types of nontraditional providers, carve outs were far more likely to report including them in managed care networks than were integrated reforms. For example, child welfare providers reportedly are included in 65% of the carve outs as compared with only 13% of the integrated systems, and paraprofessionals and student interns in 62% of the carve outs compared with 13% of the integrated systems. The use of family members as providers was reported for 42% of the carve outs but for none of the integrated systems. Overall, family members comprised the group least likely to be included in networks as service providers.

One noteworthy trend suggested by Tracking Project results is the increasing inclusion of certified substance abuse counselors in managed care provider networks. 1999 Impact Analysis results reflected an improvement in inclusion of certified addictions counselors over 1997 Impact Analysis results, and the 2000 State Survey upholds this trend. As shown on **Table 93**, 68% of reforms include certified addictions counselors in provider networks.

Another noteworthy finding is the discrepancy between 1999 Impact Analysis results and the 2000 survey with respect to the participation of child welfare providers. Respondents in all but one state in the 1999 Impact Analysis sample reported that agencies that traditionally have provided behavioral health services to the child welfare population were included in managed care provider networks. However, In the 2000 State Survey, their inclusion was reported for only 53% of all reforms. Given the more complete sample of states, the survey results are likely more accurate. However, given the 22% increase from the 1997–98 State Survey noted earlier in the number of reforms that cover children and adolescents in the child welfare system, it is a concern that providers experienced in working with this population may be excluded from managed care provider networks in nearly half of all reforms.

Several promising strategies for including various provider types in provider networks were identified.

- The MyCare reform in **Maine** includes all provider types that are licensed or certified to practice in the state. Paraprofessionals are certified to provide certain community-based services.

(Promising strategies continued on next page)

(Promising strategies continued)

- In **North Dakota** paraprofessionals are included in positions called case aides.
- **Missouri** contractually requires MCOs to include a mix of mental health providers with experience in treating children and adolescents. The provider network must include qualified substance abuse professionals. MCOs may utilize student interns through the hospital networks.

Availability of Particular Types of Providers

The 2000 State Survey added a new item exploring whether managed care reforms have affected (either by increasing or decreasing) the availability of any particular *type* of children's behavioral health provider. As indicated on **Table 94**, 56% of both integrated and carve out reforms reportedly have affected the availability of various types of providers.

Table 94

Impact of Managed Care Reforms on the Availability of Particular Types of Children's Behavioral Health Providers

	2000		
	Carve Out	Integrated	Total
Managed care reforms have affected the availability of particular types of providers	56%	57%	56%
Managed care reforms have not affected the availability of particular types of providers	44%	43%	44%

Explanation of these changes were offered by respondents indicating that, in most cases, availability of particular types of professionals and provider agencies reportedly has increased as a result of managed care reforms. A number of states (including Maryland, Massachusetts, New York, North Dakota, Wisconsin, and Connecticut) reported an increase in home and community-based service providers, offering services such as mentoring, crisis stabilization, respite, and in-home family stabilization. Increased availability of targeted case management providers was reported in Maryland, North Dakota, and Pennsylvania. The availability of child and adolescent psychiatrists reportedly has increased in both Colorado and Missouri, due to increased compensation and provider network requirements associated with managed care. Minnesota has experienced an increase in the availability of clinical child psychologists and social workers, largely due to requirements of the reform.

In several states, respondents noted provider types that are less available under managed care systems. Arizona and New Mexico reported decreased availability of residential providers; in Oregon, child psychiatrists reportedly are less available, especially in rural areas.

Certification and Credentialing Requirements

The 1997–98 State Survey found that about a third of the reforms had new or revised standards or licensing requirements for behavioral health professionals or providers. Stakeholders interviewed for the impact analyses reported, in some states, that the new requirements were restrictive and limited the types of staff that could be included in provider networks. A new item was added to the 2000 State Survey to assess whether new certification or credentialing requirements impede the inclusion of particular types of providers in managed care systems.

As shown on **Table 95**, respondents in more than two-thirds of the reforms (68%) indicated that new credentialing requirements were not impeding the inclusion of particular types of providers in managed care systems. New certification or credentialing requirements that are impeding the inclusion of particular types of providers were reported for only 32% of the reforms.

Table 95

Impact of New Credentialing Requirements on the Inclusion of Behavioral Health Services Providers

	2000		
	Carve Out	Integrated	Total
New credentialing requirements are impeding the inclusion of particular types of providers	30%	43%	32%
New credentialing requirements are not impeding the inclusion of particular types of providers	70%	57%	68%

Explanatory information on how the new requirements limit the inclusion of provider types was provided by respondents in those states where limitations were noted. In Delaware, for example, certified addictions counselors are not recognized or credentialed by MCOs. Hawaii respondents reported that few licensed providers are available in rural areas, and credentialing requirements impede the participation of nonlicensed providers in these areas. Some private practitioners in New York reportedly do not want to work for a licensed agency, which has limited their participation. Providers in Vermont reportedly experience the credentialing requirements of MCOs as cumbersome and redundant, thus impeding their participation.

Respondents described promising strategies to address the challenges posed by new credentialing or licensing requirements.

- The Medicaid authority in **Pennsylvania** has added a new Medicaid provider type to include providers of alternative services.
- One provider in **New York** has contracted with individual families to provide respite services. There are plans to expand this practice to other providers.

Administrative Burden of Providers

The perception of stakeholders in all states in both the 1997 and 1999 Impact Analysis samples was that administrative and paperwork requirements had substantially increased due to managed care reforms. Included in the increased administrative burden described by stakeholders were new credentialing processes for individual practitioners and agencies, new documentation requirements for service authorization and frequent utilization reviews, and increased requirements to collect and report both encounter and outcome data.

To confirm these observations, the 2000 State Survey added a new item exploring whether administrative burden for providers is considered to be higher, lower, or unchanged from the previous system. As shown on **Table 96**, administrative burden for providers was reported to be higher under managed care than it was previously in nearly two-thirds of the reforms (61%). Administrative burden was reported to be lower in managed care systems than previously in only 12% of the reforms. In about one-quarter of the reforms (27%) managed care has reportedly resulted in no change in administrative burden for providers.

Table 96

Impact of Managed Care Reforms on Administrative Burden for Providers

	2000		
	Carve Out	Integrated	Total
Administrative burden is higher in managed care systems	56%	75%	61%
Administrative burden is lower in managed care systems	12%	13%	12%
No changes	32%	12%	27%

Promising strategies for reducing administrative burden for providers were reported by several states.

- In **California**, the mental health plans use a single administrative services organization (ASO) to authorize and pay for services delivered to children who are placed out of county. Providers serving these children need only contract with the ASO, rather than needing separate contracts with multiple mental health plans.
- In **Delaware**, the state agency and the provider network have developed a forum for reviewing concerns, including paperwork reduction. Efforts include the elimination of unnecessary or redundant forms and flexibility in permitting use of existing forms that include the minimum data set requirements.

(Promising strategies continued on next page)

(Promising strategies continued)

- **Connecticut** has adopted a uniform outpatient mental health and substance abuse treatment reporting form.
- In **Pennsylvania** and **Maryland**, consultation and ongoing training are offered to providers to assist them in such tasks as completing reports and billing claims.

Financial Viability of Providers

Provider Reimbursement Rates

Providers interviewed during the 1999 Impact Analysis reported that in some managed care systems, provider payment rates were too low to support best practices. The 2000 State Survey added a new item to determine whether provider reimbursement rates in managed care systems are higher or lower than in the previous systems. As shown on **Table 97**, in almost half of the reforms (45%), no change has taken place in provider reimbursement rates under the managed care system. In about one-third of reforms, provider reimbursement rates reportedly are lower under managed care. Provider reimbursements rates are far more likely to be lower in integrated systems — 57% of integrated systems reportedly have lower provider payment rates than under the previous system, compared with only 25% of the carve outs. In almost one-quarter of reforms (23%) provider reimbursement rates reportedly are higher under the managed care system, a finding more likely to be seen in carve outs. The finding that rates are either lower or unchanged from previous fee-for-service systems in most managed care systems, combined with the finding that administrative burden is higher as a result of most managed care reforms, suggests that providers are facing financial problems as a result of managed care.

Table 97

Impact of Managed Care Reforms on Provider Reimbursement Rates

	2000		
	Carve Out	Integrated	Total
Provider reimbursement rates are higher in managed care systems	25%	14%	23%
Provider reimbursement rates are lower in managed care systems	25%	57%	32%
No changes	50%	29%	45%

Closures or Severe Financial Hardship

The 2000 State Survey explored whether managed care reforms have resulted in closure or severe financial hardship for providers. Reports of financial hardship and closures surfaced sporadically throughout the impact analyses, but few data have been available to accurately judge the extent of the problem of providers having to close or experiencing severe financial hardship due to the shift to managed care.

Table 98 indicates that in most reforms (73%), at least according to state child mental heath directors, managed care reportedly has not led to closure or severe financial hardship for provider agencies. This finding is surprising, given the new credentialing and licensing requirements, increased administrative burden, reduced or unchanged reimbursement rates experienced by providers under managed care systems, and anecdotal information from providers interviewed for the impact analyses. The definition of "severe financial hardship" is subjective. Although the 2000 State Survey indicates that providers are not having to close their doors, findings related to rates and administrative burden also suggest that providers are experiencing some degree of hardship. This is an area that the Tracking Project will continue to explore.

Table 98
Impact of Managed Care Reforms on Financial Viability of Children's Behavioral Health Provider Agencies

	2000		
	Carve Out	Integrated	Total
Managed care reforms have led to closure or severe financial hardship for some agencies	27%	29%	27%
Managed care reforms have not led to closure or severe financial hardship for some agencies	73%	71%	73%

In those cases in which survey respondents reported that managed care has resulted in closure or severe financial hardship for provider agencies, respondents offered explanations as to why this has occurred. The reasons provided typically were rate reductions or moratoriums on rate increases, specific licensure requirements, and increased administrative burden. Additional analyses revealed that reports of closure or severe financial hardship were, in fact, more frequent in reforms reporting lower reimbursement rates. Similarly, reports of hardship were associated with reports of increased administrative burden. Closures were also noted of inpatient units, residential treatment centers, and other deep-end intensive services due to the emphasis in many managed care systems on curtailing the use of these services.

Capacity of Front-line Practitioners

Respondents in most states in both the 1997 and 1999 Impact Analyses reported that managed care reforms necessitated training for providers in new skills and approaches, including training on short-term treatment approaches, as well as on home and community-based service approaches such as wraparound and intensive in-home services.

Given the changes in service delivery associated with managed care, and the documented need for training providers in new approaches, the 2000 State Survey explored whether front-line practitioners were judged to have the skills, knowledge, and attitudes needed to meet the goals of the managed care system. As shown on **Table 99**, in most of the reforms (71%) front-line practitioners reportedly do have the skills and knowledge necessary to meet the goals of the managed care system.

Table 99

Capacity of Front-Line Practitioners to Meet Goals of Managed Care Systems

	2000		
	Carve Out	Integrated	Total
Front-line practitioners have skills, knowledge, and attitudes to function effectively in managed care system	74%	62%	71%
Front-line practitioners do not have skills, knowledge, and attitudes to function effectively in managed care system	26%	38%	29%

Respondents identified a number of approaches to improve the skills, knowledge and attitudes of practitioners, such as the provision of extensive and continuous training for providers, including such topics as cultural competence, the importance of family involvement in treatment, and changing family blaming attitudes. Respondents from other states mentioned that more rigorous licensing criteria and accreditation standards for providers have contributed to the improvement of practitioner skills and knowledge. □

XV. Accountability

Availability of Data for Managed Care Decision Making

In both impact analyses, inadequate management information systems (MISs) were considered to be a major impediment to incorporating effective and useful accountability systems into managed care systems. Stakeholders in most states reported MISs to be insufficient to meet the needs and demands of managed care systems. Even where MIS systems were judged to be adequate, a number of problems were raised with respect to obtaining and using data on managed care systems operations, such as difficulty in obtaining encounter data from MCOs and lack of staff and financial resources to analyze data in a sufficiently timely manner to inform system refinements.

The 2000 State Survey explored across all states the extent to which adequate data are available to guide decision making regarding behavioral health services in managed care systems. **Table 100** shows that, across all reforms, adequate data reportedly are available in 59% of the reforms, though adequate data for behavioral health care decision making are more likely in carve outs than in reforms with integrated designs. However, a substantial percentage of reforms (41% overall) reportedly do not have adequate data. This was the case for more than one-third of the carve outs (37%) and more than half (57%) of the integrated systems. The significance of this reported lack of adequate data for behavioral health care decision making increases when juxtaposed with the goal of many managed care reforms to enhance data-based decision making and accountability.

Table 100

Availability of Adequate Data to Guide Decision Making Regarding Behavioral Health Services In Managed Care Systems

	2000		
	Carve Out	Integrated	Total
Adequate data to guide decision making are available	63%	43%	59%
Adequate data to guide decision making are not available	37%	57%	41%

In reforms without adequate data to guide behavioral health decision making, the most frequently cited reasons (shown on **Table 101**) were inadequate MISs (cited by 57% of the reforms with inadequate data), and lack of encounter data (cited by 50% of the reforms with inadequate data). Another problem noted in more than a third (36%) of the reforms lacking adequate data is the lack of staff capacity to analyze data that are collected.

Table 101 Reasons for Lack of Adequate Data			
	2000		
	Carve Out	Integrated	Total
Lack of encounter data	50%	50%	50%
Lack of staff capacity to analyze data	40%	25%	36%
Inadequate MIS system	50%	75%	57%
Not tracking children's behavioral health services	20%	25%	21%
Other	30%	0%	21%

Several states noted promising strategies for collecting, analyzing, and using system performance data.

- In **Arizona**, MCOs are required to electronically transmit standardized data elements to the state information system periodically. Contract performance requirements are tied to data reporting.
- In **Texas**, a data warehouse equipped with modern decision making software to inform decision making is being completed.
- In **Missouri**, a mental health subgroup of the Quality Assessment and Improvement Advisory Group is used to analyze managed care system data and to establish benchmarks and set goals for utilization and quality indicators.
- "Early Warning Quarterly Reports" are a mechanism used in **Pennsylvania** to use managed care system data to refine program operations.

Types of Performance Information Tracked

The previous state surveys found that the system performance information most likely to be tracked by managed care systems focused on access, service utilization, and cost. These findings were upheld by the 2000 State Survey. As **Table 102** indicates, the three areas reportedly measured most frequently are:

- Behavioral health service utilization (measured by all reforms)
- Total cost of behavioral health services (measured by 93% of the reforms)
- Access as gauged by child behavioral health penetration rates (measured by 85% of the reforms)

Table 102
Percent of Reforms Tracking and Using Various Types of System Performance Information

System Information	Not Tracked	2000			Information is Used for System Planning
		Carve Out	Integrated	Total	
Child behavioral health penetration rates	15%	86%	83%	85%	57%
Child behavioral health service utilization	0%	100%	100%	100%	53%
Child behavioral health service utilization by culturally diverse groups	25%	79%	60%	75%	33%
Behavioral health service utilization by children in child welfare	26%	78%	50%	74%	35%
Behavioral health services utilization by children in juvenile justice	54%	45%	50%	46%	64%
Total aggregate cost of children served with behavioral health services	7%	96%	21%	93%	50%
Cost per child served with behavioral health services	21%	87%	50%	79%	48%
Cost shifting among child-serving systems	84%	13%	25%	16%	100%

Service utilization and penetration rates reportedly are measured at similar rates by carve outs and reforms with integrated designs. For the cost of children's behavioral health services, however, the difference between carve outs and integrated systems is dramatic. Nearly all carve outs (96%), but very few integrated systems (21%), track the total cost of children's behavioral health services. Though the differences are not as significant, carve outs also appear more likely to track children's behavioral health service utilization by culturally diverse groups and by children in the child welfare system, as well as cost per child served with behavioral health services.

The two types of performance information least likely to be tracked by managed care systems reportedly are behavioral health services used by children in the juvenile justice system, tracked by fewer than half of the reforms (46%), and cost shifting among child serving systems, tracked by only 16% of the reforms. Despite the failure to systematically track cost shifting in most managed care systems, allegations of cost shifting resulting from managed care reforms have been widespread and were made by stakeholders in both the 1997 and 1999 Impact Analyses as well as being reported in the 2000 State Survey.

Although very few of the managed care systems track cost shifting, all of those that do so reported that the information is used for system planning. For most of the other types of performance information, even if it is collected, respondents generally reported that the information is used for system planning in only about one-third to one-half of the reforms that collect the information. The 1999 Impact Analysis also found that, despite reports that performance information was being tracked, few data were available in states in the sample. In some states, data were not in usable form or had not been released, and little progress across states was evident in producing reports to inform further system planning and refinements. The gap between information that is tracked and information that is used for system planning that emerged from the 2000 State Survey indicates that this continues to be a problem for managed care systems — generating data in a form and in a time period that is relevant and helpful for planning and decision making.

Matrix 3 displays the types of performance information measured by managed care reforms by state.

		Matrix 3: Types of Performance Information Measured by Managed Care Reforms Related to Child & Adolescent Behavioral Health Services										
Carve Out N=27		Child Behavioral Health Penetration Rates	Child Behavioral Health Service Utilization	Child Behavioral Health Service Utilization by Culturally Diverse Groups	Behavioral Health Service Utilization by Children in Child Welfare System	Behavioral Health Service Utilization by Children in Juvenile Justice System	Total Cost of Child Behavioral Health Services	Cost per Child Served with Behavioral Health Services	Cost Shifting Among Chid-Serving Systems	Clinical and Functional Outcomes	Parent Satisfaction	Youth Satisfaction
Arizona	AZ	●	●	●	●	●	●	●	●	●	●	●
California	CA	●	●	●	●		●	●	●		●	●
Colorado	CO	●	●	●	●	●	●	●				
Delaware	DE	●	●		●	●	●	●				
District of Columbia*	DC											
Florida (BHSCN)	FL		●	●	●	●	●	●		●	●	●
Florida (PMHP)	FL	●	●		●		●			●	●	●
Hawaii	HI		●	●		●	●			●	●	●
Indiana	IN	●	●	●	●	●	●	●		●		
Iowa	IA	●	●				●	●		●	●	●
Maine	ME		●		●	●	●	●		●	●	●
Maryland	MD	●	●	●	●	●	●	●	●	●	●	●
Massachusetts	MA	●	●		●		●	●		●	●	●
Michigan	MI	●	●	●		●	●			●	●	●
Mississippi	MS	●	●	●	●		●	●		●	●	●
Nebraska	NE	●	●		●		●	●		●	●	●
New Jersey*	NJ											
New York	NY		●	●			●	●		●	●	●
North Dakota	ND	●	●		●	●	●	●		●	●	●
Oregon	OR	●	●	●	●					●	●	●
Pennsylvania	PA	●	●	●	●	●	●	●	●	●	●	●
Tennessee	TN		●	●			●			●	●	●
Texas	TX		●		●		●	●		●	●	●
Utah	UT	●	●		●	●	●			●	●	●
Washington	WA	●	●	●	●		●			●	●	●
West Virginia	WV		●		●	●	●	●		●	●	●
Wisconsin	WI	●	●	●		●	●	●				
Integrated N=8												
Connecticut	CT	●	●	●	●	●	●					
Minnesota	MN		●	●	●	●	●	●	●	●		
Missouri	MO	●	●							●	●	●
New Mexico	NM		●							●		
Oklahoma	OK	●	●				●				●	
Rhode Island*	RI											
Vermont	VT	●	●		●	●	●			●		
Virginia	VA	●	●	●		●	●				●	●
*Information not available												

Quality Measurement

The 1997–98 State Survey found that all reforms reportedly incorporated some type of quality measurement system for behavioral health services. The majority of reforms (88%) incorporated some child-specific quality measures, with carve outs more likely to do so than reforms with integrated designs. The majority of reforms responding to the 2000 State Survey also reported including some child-specific measures in their quality measurement systems for behavioral health (71%), although this represents a 17% decrease in reforms with child-specific quality measures since 1997–98 (**Table 103**). Carve outs reportedly are more likely to have child-specific quality measures — 74% as compared with 57% of the integrated reforms. These findings represent a departure from the impact analyses which found few instances of quality measures that were specific to behavioral health services for children and adolescents.

Table 103

Percent of Reforms Incorporating Quality Measures Specific to Child and Adolescent Behavioral Health Services

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Managed care system incorporates child-specific behavioral health quality measures	88%	74%	57%	71%	-17%
Managed care system does not incorporate child-specific behavioral health quality measures	12%	26%	43%	29%	+17%

Several examples of approaches to quality measurement were cited by respondents.

- Stakeholder focus groups are used in **Arizona** and **Oklahoma** as one aspect of their quality measurement processes.
- In **Hawaii**, quality of care audits and chart reviews are combined with a service testing case-based review system.
- **Utah** uses on-site quality of care reviews conducted by mental health and Medicaid agency staff (including family members on the team) combined with technical assistance protocols to work with MCOs in identified areas.
- In **Pennsylvania**, consumer/family satisfaction teams are an integral part of the approach to quality measurement.

Both the 1997–98 and 2000 State Surveys explored the extent to which and ways in which families are involved in quality measurement processes in managed care systems. In both 1997–98 and 2000, families reportedly were involved in quality measurement in some way in most reforms. Only 11% of the reforms reported no family involvement in 1997–98; similarly, only 13% of the reforms indicated no family involvement in quality measurement in 2000 (**Table 104**). Most of these are systems with integrated designs; 43% of the integrated systems

do not involve families at all in quality measurement, while only 4% of the carve outs reportedly do not involve families. The vast majority of carve outs reportedly do involve families in one or more ways in measuring the quality of the behavioral health managed care system.

Table 104
Percent of Reforms with Family Roles in Quality Measurement Process

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Not involved	11%	4%	43%	13%	+2%
Focus groups	44%	48%	43%	47%	+3%
Surveys	77%	88%	43%	78%	+1%
Design of quality measures and/or process	44%	56%	0%	44%	0%
Monitoring of quality measurement process	31%	56%	0%	44%	+13%
Other	11%	12%	0%	9%	-2%

The 2000 State Survey also explored *how* families are involved in quality measurement processes. The 2000 survey results are highly consistent with prior results in that families typically are involved in quality measurement processes for managed care systems by responding to surveys; this was reported for 78% of the reforms. All other approaches were reported in fewer than half of all reforms, with carve outs more likely to involve families in every instance. In fact, responding to surveys and participating in focus groups were the only vehicles for family involvement in quality measurement in the integrated systems. None of the integrated systems reportedly involve families in designing the quality measures and/or processes or monitoring the quality measurement process, while more than half of the carve outs reported involving families in these roles.

Measurement of Clinical and Functional Outcomes

The 2000 State Survey revealed a continuing increase in the measurement of clinical and functional outcomes in managed care systems, up from 51% in 1995 to 63% in 1997–98, with a 27% increase to 90% of the reforms in 2000 (**Table 105**).

Table 105
Measurement of Clinical and Functional Outcomes in Managed Care Systems

	1995	1997–98	2000			Percent of Change	
	Total	Total	Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Managed care reform measures clinical and functional outcomes	51%	63%	96%	71%	90%	+39%	+27%
Managed care reform does not measure clinical and functional outcomes	49%	37%	4%	29%	10%	-39%	-27%

The impact analyses suggested, however, that even where outcome measurement systems were reported to exist, they were characterized by respondents as being in early stages of development. Although the 2000 State Survey shows much increased attention to this area, the early stage of development of these outcome measurement systems is still evident (**Table 106**).

Table 106
Stage of Development of Measurement of Clinical and Functional Outcomes

	2000		
	Carve Out	Integrated	Total
In early stage of developing measurement system	41%	60%	44%
Developed but not yet implemented measurement system	5%	0%	4%
Implementing measurement system but do not yet have results	23%	40%	26%
Implementing measurement system and have results	32%	0%	26%

As shown on the table, in 44% of the reforms, outcome measurement was described as being in an early stage of development, and an additional 4% reported that the system was developed but not yet implemented. Another 26% described their outcome measurement systems as implemented, but with no results available as yet. Carve outs reportedly are ahead of integrated systems in the measurement of clinical and functional outcomes for children's behavioral health. More integrated systems are at early stages of this process or have outcome measurement systems but no results as yet. Only about one-quarter (26%) of the reforms — all carve outs — have results from the measurement of clinical and functional outcomes, according to the 2000 State Survey.

Several examples of approaches to measuring clinical and functional outcomes were cited.

- Functional assessment instruments, such as the CAFAS, are used in **Michigan**, **Maine**, **Arizona**, **Florida**, **New Mexico**, and others.
- In **California**, the state performance outcome measurement program applies to the public mental health system as a whole, and tracks Medicaid beneficiaries in managed care separately.
- In **Pennsylvania**, a Performance Outcome Measurement System (POMS) is specified in the RFP, and each county MCO implements measures in various domains of outcomes for children.

Measurement of Satisfaction

Just as increases were noted over time in measurement of clinical and functional outcomes, similar increases were reported in the measurement of parent satisfaction. **Table 107** shows that 69% of the reforms reported measuring parent satisfaction in 1995, 80% in 1997–98, and 91% in 2000 (an 11% increase since the last survey). Both carve outs and integrated systems measure parent satisfaction at high rates — 92% of the carve outs and 86% of the integrated systems.

Table 107
Measurement of Parent and Youth Satisfaction with Behavioral Health Services

	1995	1997–98	2000			Percent of Change	
	Total	Total	Carve Out	Integrated	Total	1995 –2000	1997/98 –2000
Managed care system measures parent satisfaction	69%	80%	92%	86%	91%	+22%	+11%
Managed care system measures youth satisfaction	60%	63%	68%	14%	56%	-4%	-7%

Youth satisfaction receives less attention overall; only 56% of the reforms reported assessing youth satisfaction. Further, a slight decline (7%) from the 1997–98 State Survey was noted in the proportion of reforms indicating that they assess youth satisfaction. These results are similar to the results of both impact analyses, which suggested considerable attention to the measurement of parent satisfaction but less attention to measuring youth satisfaction with behavioral health services.

With respect to youth satisfaction, the 2000 results found a distinct difference between carve outs and integrated systems. More than two-thirds (68%) of the carve outs but only 14% of the integrated systems reported measuring youth satisfaction.

Several promising strategies for the measurement of satisfaction were cited.

- In **Arizona**, a satisfaction survey conducted by direct mail now includes follow-up telephone contact by a service provider or case manager. As a result, the response rate has significantly improved.
- In **Pennsylvania**, consumer/family satisfaction teams are required in the RFP and contract involving the use of consumers and families to have direct contact with service recipients for purposes including assessing satisfaction with behavioral health services.

Child and Adolescent Focus in Formal Evaluations

A slight increase was noted in the percent of reforms reporting that their formal evaluations have a child and adolescent focus, 55% of the reforms in 2000 as compared with 47% in 1997–98 (**Table 108**). Despite this increase, however, only about half of the reforms have a special focus on children and adolescents within their evaluations.

Table 108
Percent of Reforms with Evaluations with a Child and Adolescent Focus

	1997–98	2000			Percent of Change
	Total	Carve Out	Integrated	Total	1997/98–2000
Formal evaluation has child and adolescent focus	47%	70%	12%	55%	+8%
Formal evaluation does not have child and adolescent focus	53%	30%	88%	45%	-8%

Most of the reforms with a focus on children in their evaluations are carve outs; 70% of the carve outs have evaluations with a child and adolescent focus compared with only 12% of the integrated systems. Both the 1997 and 1999 Impact Analyses also found few reforms with a focus on children and adolescents in their formal evaluations.

Impact of Managed Care Reforms on System Performance

A new area of exploration for the state surveys was implemented in 2000 by incorporating an assessment of the impact of managed care reforms on various indicators:

- Child behavioral health penetration rates
- Overall child behavioral health utilization
- Total cost of child behavioral health services
- Overall clinical and functional outcomes
- Overall family satisfaction with services

The most striking finding is that in each of these areas, substantial numbers of respondents reported that the impact of managed care reforms is not known (**Table 109**). For example, in 41% to 46% of the reforms, the impact on managed care reforms on penetration rates, service utilization, cost, quality, and family satisfaction remains unknown. In 63% of the reforms, the impact on clinical and functional outcomes is not known. As shown on the table, this problem exists both within carve outs and integrated systems. Given the managed care reform goals of increasing access, improving quality, containing costs, and improving accountability, the lack of information on system performance in these areas seems critical.

Table 109
Impact of Managed Care Reforms on System Performance

2000 System Information	Increased			Decreased			No Effect			Don't Know		
	Carve Out	Integrated	Total	Carve Out	Integrated	Total	Carve Out	Integrated	Total	Carve Out	Integrated	Total
Child behavioral health penetration rates	41%	43%	41%	5%	14%	8%	14%	0%	10%	41%	43%	41%
Overall child behavioral health service utilization	38%	14%	34%	8%	29%	12%	17%	0%	12%	38%	57%	42%
Total cost of child behavioral health services	28%	0%	24%	20%	14%	19%	16%	14%	16%	36%	71%	41%
Overall quality of child behavioral health services	43%	14%	38%	0%	29%	7%	9%	14%	10%	48%	43%	45%
Overall clinical and functional outcomes	30%	0%	24%	0%	14%	3%	9%	14%	10%	61%	71%	63%
Overall family satisfaction	35%	14%	31%	0%	0%	0%	17%	43%	23%	48%	43%	46%

Where effects were reported, however, most were in a positive direction:

- 41% of the reforms with data reported an increase in child behavioral health penetration rates
- 34% reported an increase in overall child behavioral health service utilization
- 38% reported an increase in the overall quality of services
- 24% reported an increase in overall clinical and functional outcomes
- 31% reported an increase in overall family satisfaction with services.

Negative effects reported in these areas were significantly lower, ranging from 3% to 19% of the reforms. In general, positive effects were more likely to be reported for carve outs, and negative effects were more likely to be reported for integrated managed care systems.

Although an explicit and major goal of managed care reforms is to control costs, increased aggregate costs were reported in some reforms (about 25% of the reforms), decreased aggregate costs were reported in fewer (19%), and costs reportedly remained constant in others (16% of the reforms). Mixed results on cost control also were found in the 1997 and 1999 Impact Analyses. However, stakeholders interviewed for the impact analyses pointed out that even if increased costs are reported, managed care reforms may be achieving some success in controlling the rate of growth in Medicaid costs. □

XVI. State Child Health Insurance Program (SCHIP)

In the 1999 Impact Analysis, some basic issues regarding states' implementation of SCHIP were explored – how behavioral health services were covered under SCHIP, as well as issues of coordination between SCHIP and Medicaid managed care reforms. In many of the states in the sample, behavioral health coverage under SCHIP was limited, as in an acute care commercial insurance model. Further, respondents in many of the states reported that there was little coordination between SCHIP and managed care reforms, typically when SCHIP was being implemented as a separate program from Medicaid.

The issue of SCHIP and its relationship to states' Medicaid managed care reforms was investigated more thoroughly in the 2000 State Survey. A number of items were added to the survey related to the design of SCHIP, the behavioral health benefit under SCHIP, coordination between SCHIP and the managed care system, strategies to identify SCHIP children with behavioral health needs and make appropriate referrals, and stakeholder involvement in planning and implementing SCHIP.

Design of SCHIP

States have a number of choices in their design of SCHIP– the program can be developed as an expansion of the state's Medicaid program, as a separate program, or as some combination of a Medicaid expansion and a separate program. As indicated on **Table 110**, 29 states have implemented SCHIP as a Medicaid expansion (51% of SCHIP programs), and 28 states have developed separate programs from Medicaid for their SCHIP implementation (49% of SCHIP programs). Six states have adopted a combined approach, with some subpopulations falling under a Medicaid expansion and other subpopulations covered through an additional separate program.

Table 110
Approaches to Implementing SCHIP

	Number of States*	Percent of SCHIP Programs
Medicaid expansion	29	51%
Separate programs	28	49%

*The Number of states exceeds 51 (50 states plus the Disctrict of Columbia) because of the six states with two SCHIP programs, both a Medicaid expansion and an additional separate program.

Extent of Behavioral Health Benefit Under SCHIP

In the 2000 State Survey, respondents characterized the behavioral health benefit under SCHIP as either a broad or limited benefit. As shown on **Table 111**, two-thirds of SCHIP programs were characterized as having a broad behavioral health benefit, a finding that departs from the 1999 Impact Analysis results.

Table 111 Behavioral Health Benefits Under SCHIP	
	Percent of SCHIP Programs
SCHIP includes broad behavioral health benefit	67%
SCHIP includes limited behavioral health benefit	33%

In those states where the SCHIP behavioral health benefit was not the same as Medicaid, respondents were asked to describe the SCHIP benefit. Typically, these benefits are more like commercial insurance benefits and include day and visit limits. Several states indicated that the behavioral health benefit under SCHIP is similar to the state employees' benefit package. However, a few states have incorporated some flexibility and home and community-based service options in the SCHIP behavioral health benefit.

- In **Arizona**, SCHIP includes behavioral health benefits which match those under one plan available to state employees. Generally, the benefit includes 30 days of inpatient and 30 days of outpatient services per year, plus an unlimited number of ancillary and support services.
- In **California**, SCHIP covers 30 inpatient days and 20 outpatient visits per year. If a child is determined to have a serious emotional disorder, the child is referred to the county mental health department, which provides the same services that are available under Medicaid as rehabilitative mental health services.
- Under **Indiana's** SCHIP, for children from 100% to 150% of the federal poverty level the behavioral health benefits are the same as those under Medicaid. For children from 150% to 200% of the federal poverty level, the separate insurance plan involves small premiums and co-pays.
- The **Texas** SCHIP program includes 45 days of inpatient care annually; 25 days can be converted to residential treatment, therapeutic foster care, 24-hour therapeutically planned or structured services, or subacute outpatient (partial hospital or rehabilitative day treatment) services.

Additional analyses of these data revealed that SCHIP behavioral health benefits are more likely to be broad when SCHIP programs are designed as Medicaid expansions. Limited SCHIP benefits are strongly associated with separate SCHIP programs; 82% of separate SCHIP programs were characterized as having limited behavioral health benefits, as compared with only 18% of the Medicaid expansions.

SCHIP Programs that are Separate from Medicaid

For the 28 states in which SCHIP includes a separate program from Medicaid, the 2000 State Survey examined whether the program operates as a managed care arrangement, whether SCHIP and Medicaid programs are coordinated, and whether SCHIP includes specific strategies to identify children and adolescents with behavioral health treatment needs and refer these youth to behavioral health services.

As **Table 112** indicates, more than half (57%) of SCHIP separate programs operate through a managed care arrangement.

Table 112

Percent of Separate (Non-Medicaid) SCHIP Programs Operated as Managed Care

	Percent of Separate SCHIP Programs
SCHIP is operated with managed care approaches	57%
SCHIP is not operated with managed care approaches	43%

Table 113

Percent of Separate (Non-Medicaid) SCHIP Programs that are Coordinated with Medicaid Programs

	Percent of Separate SCHIP Programs
SCHIP and Medicaid are coordinated	87%
SCHIP and Medicaid are not coordinated	13%

Table 113 above, shows that in 87% of states with a separate SCHIP program, efforts reportedly are being made to coordinate Medicaid and SCHIP programs.

Promising strategies for the coordination of SCHIP and Medicaid programs were identified by respondents in some states.

- **Arizona**, **Colorado**, **Iowa**, and **Utah** reported that eligibility determination for both Medicaid and SCHIP are coordinated. For example, in **Colorado** a single application form has been implemented for both Medicaid and SCHIP eligibility determination.
- The Medicaid Agency in **Delaware** has taken several steps to implement processes to ensure good communication with families of SCHIP-eligible children, including direct mailings and an advertising campaign. Procedures have also been put in place to prevent dropping children from services when they are found no longer eligible for Medicaid. First, a six-month presumptive eligibility period for Medicaid eligibility is in effect. Second, when a child is found to be no longer eligible for Medicaid, the child is automatically shifted to SCHIP enrollment. Notices are sent to the parents with at least two months of SCHIP coverage provided while parents decide if they will pay the SCHIP fees.
- In **Michigan**, the local community mental health services programs are the behavioral health care providers for both SCHIP and Medicaid.

In those states where SCHIP is a separate program from Medicaid, the 2000 State Survey explored whether SCHIP includes specific strategies to identify children and adolescents with behavioral health treatment needs and to refer them to behavioral health services. **Table 114** indicates that less than half (43%) of the separate SCHIP programs incorporate strategies for the identification and referral of children with behavioral health needs.

Table 114 Percent of Separate (Non-Medicaid) SCHIP Programs with Identification and Referral Strategies for Children's Behavioral Health	
	Percent of Separate SCHIP Programs
SCHIP has strategies to identify and refer children with behavioral health treatment needs	43%
SCHIP does not have strategies to identify and refer children with behavioral health treatment needs	57%

Two states reported promising strategies within SCHIP for the identification and referral of children with behavioral health needs.

- In **Florida**, the SCHIP (Florida KidCare) application includes a question regarding whether the child has any special needs.
- In **Delaware**, SCHIP includes a health benefits manager whose role is to enroll and educate the SCHIP population. When enrolling a family, the benefits manager asks the family whether there might be a child who may require mental health and/or substance abuse services and makes referrals as appropriate.

Effects of SCHIP On the Delivery of Children's Behavioral Health Services

The 2000 State Survey attempted to assess the effects that SCHIP has had on children's behavioral health services. As shown on **Table 115**, more than half of the states (57%) reported that no data are available regarding the impact of SCHIP on the delivery of children's behavioral health services. About one-third of states (35%) indicated that more children and adolescents are receiving behavioral health services as a result of SCHIP.

Table 115 Impact of SCHIP on Children's Behavioral Health Service Delivery	
	Percent of SCHIP Programs
No data	57%
More children and adolescents are receiving behavioral health services	35%
Fewer children and adolescents are receiving behavioral health services	2%
No change	4%

Stakeholder Involvement in Planning and Implementing SCHIP

The 2000 State Survey also investigated whether stakeholders with expertise in children's behavioral health services were involved in planning and implementing SCHIP in their states. **Table 116** indicates that about two-thirds (65%) of states reportedly have included children's behavioral health stakeholders in the planning and implementation of SCHIP. With managed care reforms, the Tracking Project has found that stakeholder involvement, while not as extensive during initial implementation, has tended to increase over time. This has been partly attributable to problems and challenges that have arisen in implementing and operating the system. Based on this experience, it might be predicted that, over time, as implementation challenges are identified regarding children with behavioral health needs, the level of involvement in SCHIP implementation of stakeholders with expertise in children's behavioral health is likely to increase as well. □

Table 116 Percent of SCHIP Programs Involving Stakeholders with Children's Behavioral Health Expertise in Planning and Implementation	
	Percent of SCHIP Programs
Stakeholders with child and adolescent expertise are involved	65%
Stakeholders with child and adolescent expertise are not involved	35%

XVII. Concluding Observations

Through the three state surveys and two impact analyses conducted to date, the Tracking Project has identified some areas of progress — primarily in the policy and system design areas — suggesting that managed care systems have taken some steps to be more responsive to the needs of children and adolescents with behavioral health treatment needs and their families. Examples of these areas of progress include the following:

- There has been a trend toward increased stakeholder involvement in managed care planning, implementation, and refinement activities, with reports of increased involvement of key stakeholder groups, including families and state agency staff from child mental health, substance abuse, child welfare, and juvenile justice systems.
- Planning for special populations in managed care systems has increased over time. Most managed care systems now report discrete planning processes for children with serious emotional disorders and for children involved with the child welfare systems.
- Most states are reportedly engaged in efforts to educate and train MCOs in a variety of areas. Training related to children and adolescents with serious emotional disorders and to children and adolescents involved with the child welfare system are areas of focus for more than half of the managed care systems.
- There is a trend toward including both acute and extended care in managed care systems, and, in addition, a trend toward covering a broader service array. Coverage for home and community-based services has been expanded in more than half of the reforms, and in the majority of reforms, respondents indicated that it is easier to provide flexible/individualized care — both results more likely in carve outs.
- There have been significant increases in the incorporation of special provisions for children and adolescents with serious emotional disorders in managed care systems; nearly all reforms reported incorporating such provisions as interagency service planning, intensive case management, an expanded service array, family support services, or wraparound services. Most managed care systems also reported having special provisions for children in the child welfare and juvenile justice systems.
- The majority of managed care systems now have medical necessity criteria that allow for the consideration of psychosocial and environmental factors in clinical decision making.
- Most reforms now allow certain behavioral health services to be provided without prior authorization, a practice that reportedly reduces the perceived burden associated with prior authorization processes and makes them less onerous.
- Initial access to behavioral health services is considered to be improved by managed care reforms in about 70% of the total sample.
- Improved coordination between physical health and behavioral health services was reported for 60% of the reforms, suggesting that states may be devoting increasing attention to this need and implementing specific strategies to address this area. Improved interagency coordination among child-serving systems as a result of managed care reforms was noted in two-thirds of the reforms, largely attributed to the need for solving problems.

- Requirements for cultural competence and for family involvement at the service delivery and system levels are reportedly stronger under managed care systems than they were under previous systems.
- The 2000 State Survey revealed a more encouraging picture with respect to the degree of family focus in service delivery than previous Tracking Project findings had suggested. Nearly two-thirds of the managed care systems reportedly include a focus on families in service delivery, in addition to focusing on the identified child. Half or more include coverage for family support services and pay for services to family members when only the child is covered.
- There is a continuing increase in the measurement of clinical and functional outcomes for children's behavioral health service delivery in managed care systems, although most of these efforts are in early developmental stages and few results are available. Similar increases in the measurement of parent satisfaction are evident.

Despite these areas of progress, a number of areas of concern remain, particularly at the implementation level, leaving questions as to the quality and appropriateness of behavioral health services for children and adolescents and their families within managed care systems. Examples include the following:

- Despite increased involvement of key stakeholder groups in planning, implementation, and refinement activities related to managed care systems, most of these stakeholder groups still lack *significant* involvement in managed care implementation, oversight, and refinement activities.
- Although most managed care systems reportedly cover both acute and extended care, other child-serving systems still retain both responsibility and resources for extended care behavioral health services, and some Medicaid resources for behavioral health services are left outside of the managed care system in most states. As a result, the potential for fragmentation of services, as well as cost shifting, is perpetuated.
- Although managed care reforms may have expanded coverage of home and community-based services, the actual availability of these services remains problematic. Very little expansion in the availability of services or no service capacity expansion at all has occurred in nearly half of the reforms.
- Although managed care systems increasingly are incorporating special provisions for high need populations (children with serious emotional disorders and children in the child welfare and juvenile justice systems), few reforms include higher capitation or case rates for these youth, suggesting that the resources to provide these additional services may not be sufficient. In addition, very few reforms use risk adjustment mechanisms of any kind. The minimal use of risk adjusted rates or other risk adjustment mechanisms, coupled with increased enrollment of high need populations in managed care systems, suggest that safeguards to protect against underservice may be inadequate.
- While medical necessity criteria reportedly are sufficiently broad to allow consideration of psychosocial and environmental considerations in clinical decision making, MCOs, particularly in systems with integrated designs, may still be interpreting and applying these criteria narrowly, without sufficient attention to these issues.

- Despite perceived improvements in initial access to behavioral health care, access to extended care remains more problematic. In nearly two-thirds of the reforms with integrated designs, access to extended care was characterized as more difficult post-managed care reforms. (Access to extended care has not reportedly become more difficult in carve outs, and, in fact, was reported to be better in about 40% of the carve outs.)
- Lengths of stay in inpatient settings are shorter in most managed care systems, and a host of problems associated with this change was reported. More evident in integrated systems, reported problems include: premature discharge before stabilization, children discharged without needed services, placement in community programs without the clinical capacity to service them, and inappropriate use of child welfare and juvenile justice facilities. Though most reforms reported developing alternatives to hospitalization, nearly 40% of the reforms reportedly are not developing alternatives to hospitalization.
- Despite stronger requirements for cultural competence and family involvement under managed care systems, stakeholders cited discrepancies between managed care policy requirements and what actually is occurring. Thus, questions remain as to the extent to which such requirements are actually operationalized.

Publicly financed managed care continues to present opportunities and challenges for children's behavioral health care. States and counties are becoming more sophisticated designers and purchasers, and, particularly in the case of carve outs, often incorporate specifications that would seem to benefit children needing behavioral health care. However, managed care implementation continues to lag behind policy intentions. Broad benefit designs are hampered by lack of service capacity; broad medical necessity criteria designed by states are rendered meaningless by narrow interpretation at the MCO level. Greater attention is paid to special needs populations in planning and policy as states increasingly enroll these populations in managed care, but training of MCOs about these populations and changes in financing to guard against underservice does not necessarily follow.

The design and implementation of managed care is a developmental process. States are beginning to turn their attention to implementation problems, and most have made mid-course corrections in policy and design. Particularly in states with integrated designs, children with behavioral health disorders typically have not emerged initially as a priority population. Through the efforts of family members, advocates, and researchers, and as a result of their own quality improvement activities, states are beginning to look more closely at how this population experiences managed care and at approaches that may be more effective. As part of this developmental process, the Health Care Reform Tracking Project, while it will continue to survey managed care developments, also is moving to a new phase of identifying promising approaches and features of managed care reforms. The 2000 State Survey captured (and describes throughout the report) a number of promising approaches that states are undertaking on behalf of children with behavioral health disorders and their families. The Tracking Project will be studying and reporting on promising practices in greater depth in future activities. These efforts will be directed toward providing information to states and communities to demonstrate how managed care systems, or aspects of them, can be refined to improve behavioral health service delivery to children and adolescents and their families. □

Child Welfare Special Analysis

Prepared by Jan McCarthy

I. Introduction

Background and Purpose of the Child Welfare Component

Children and families served by the child welfare system typically need extensive and intensive physical and behavioral health services. The tightened timelines for decision making that resulted from the passage of the Adoption and Safe Families Act in 1997, coupled with individual state child welfare reforms, make it even more important to ensure that appropriate services are available for children and their families. Since Medicaid is the primary funding source for many of the behavioral health services received by children and families involved with the child welfare system, this population is directly impacted by public sector managed care initiatives.

For these reasons, the Tracking Project has included a specific focus on children and families served by the child welfare system since 1996, and has conducted special analyses of the effects of health care reform initiatives on this group of children and families.[1] The purposes of the child welfare component of the Tracking Project are to:

- Determine the impact of public sector managed care reforms on children and adolescents with behavioral health disorders who are involved with the child welfare system, and their families.
- Identify positive policies, practices, and quality improvement strategies that states use within managed care initiatives to meet the mental health treatment needs of children served by the child welfare system, and their families.

[1] Support for the child welfare component of the Tracking Project was provided by the David and Lucile Packard Foundation from 1996 to 1999. In 2000, the Center for Health Care Strategies in Princeton, New Jersey began funding the child welfare component. Ongoing supplemental support for the child welfare component is provided by the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center through a cooperative agreement among the Child, Adolescent, and Family Branch of the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration and the Children's Bureau, Administration on Children, Youth, and Families of the Administration for Children and Families in the U.S. Department of Health and Human Services.

Methodology of the Child Welfare Component

A specific focus on child welfare issues has been, and will continue to be, incorporated into all aspects of the Tracking Project, including the state surveys and impact analyses and activities planned for the future.

State Surveys

The Tracking Project incorporated items into both the 1997–98 and 2000 State Surveys addressing the impact of managed care initiatives, specifically behavioral health managed care reforms[2], on children in the child welfare system and their families.

Since 1996, the Child Welfare League of America Managed Care Institute (CWLA) has also been conducting surveys of states to track emerging trends in management, financing, and contracting that affect child welfare service delivery. In 2000, the Tracking Project and CWLA began coordinating their survey activities. Both the Tracking Project and CWLA surveys included similar items to assess respondents' views of the effects of health and behavioral health managed care reforms on children and families served by the child welfare system. The primary respondents in the survey conducted by CWLA in 2000 were state and county child welfare administrators, whereas the primary respondents to the Tracking Project's 2000 State Survey were directors of children's mental health services in all 50 states and the District of Columbia.

In this special analysis, *preliminary* findings from the CWLA survey (based on data from 24 states submitted by March 2001) are summarized and compared with Tracking Project findings. A combined report presenting the final results of the CWLA 2000 Management, Finance and Contracting Survey and comparing these results with the findings from the Health Care Reform Tracking Project 2000 State Survey will be published.[3]

[2] References will be made throughout this summary to "behavioral health managed care" and to "child welfare managed care." Behavioral health managed care refers to reforms, primarily within state Medicaid programs, that apply managed care technologies to the administration and delivery of behavioral health services. Child welfare managed care refers to a type of child welfare reform in which states or communities apply some managed care tools to the organization, provision, and funding of child welfare services. These child welfare reforms primarily use funds allocated to the child welfare system, and may or may not include some behavioral health services.

[3] This report will be available on several websites: Georgetown University Child Development Center (gucdc.georgetown.edu), Child Welfare League of America (www.cwla.org) and the Center for Health Care Strategies (www.chcs.org).

Impact Analyses

Members with extensive experience in the child welfare field were added to the teams that visited each of the states included in the 1997 and 1999 Impact Analysis samples. These team members interviewed a range of stakeholders involved in child welfare, including state and local child welfare administrators; child welfare supervisors and caseworkers; child welfare providers; advocates; and birth, foster, and adoptive parents. For the 1999 Impact Analysis, additional interviews were conducted in the three states that were in the process of planning or implementing a child welfare managed care initiative. Child welfare findings from the 1999 Impact Analysis and these three child welfare managed care initiatives are described in a separate document, as well as in a special analysis included in the 1999 Impact Analysis report.[4]

Future Activities

During the next phases of the Tracking Project, the focus on children and families served by the child welfare system will be continued in three major components of the Tracking Project:

- State survey to be conducted in 2003
- Study of promising strategies and approaches within managed care systems to meet the needs of children and adolescents with behavioral health disorders and their families through a series of site visits to states and communities as well as telephone interviews
- Consensus conference bringing together a range of researchers and stakeholders to review findings on the effects of behavioral health managed care reforms across projects and to consider promising strategies

All of these Tracking Project activities will be coordinated with the activities of CWLA. Another partner in future activities is the Center for Health Services Research and Policy at George Washington University (GWU). GWU is conducting a project involving analysis of managed care contracts and sites visits to provide insights on "what works" when children are enrolled in multiple public managed care initiatives (e.g., child welfare and Medicaid). Representatives from both the Tracking Project and CWLA will participate in GWU site visits and in the analysis of findings.

Lessons Learned from Previous Tracking Project Results

Findings from the 1997–98 State Survey and from the 1997 and 1999 Impact Analyses demonstrated that the following must occur if behavioral health managed care is to work positively for children and families involved in the child welfare system:

- **Access —** There must be easy access to appropriate behavioral health services. Complex enrollment, authorization, and eligibility determination procedures; restrictive medical necessity criteria; and too frequently repeated utilization reviews were identified as managed care technologies that restrict access to care.

[4] McCarthy, J. and Valentine, C. *1999 Child Welfare Impact Analysis*, *Health Care Reform Tracking Project: Tracking State Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families*. National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, Washington, DC, December 2000.

- **Services for Family Members —** Behavioral health services must be available for family members, as well as for the identified child. In order to preserve family units or enhance reunification possibilities, it is critical that family members receive needed mental health and substance abuse services.
- **Continuous Care —** Care must be coordinated and continuous, especially when children change placements. Managed care planners must be cognizant of the frequent moves children experience and design a system that does not require children to change plans and providers at the time of placement changes.
- **Commitment to Serve Children and Families in the Child Welfare System —** MCOs and providers must understand how the child welfare system works and the special needs of the children and families it serves.

Drawing upon their own experiences in managed care, child welfare respondents from the eight states in the 1999 Impact Analysis sample provided the following recommendations and advice for others:

- **Special Needs —** Address the special needs of the child welfare and juvenile justice populations in planning and implementing managed care systems with respect to the design of the managed care system, contracts and agreements, higher or risk adjusted capitation and/or case rates, the makeup of the provider network, and special provisions and services to meet the unique needs of children and families involved in these systems.
- **Training about Managed Care —** Provide adequate education and training for all child welfare stakeholders in the operation of the managed care system, including the grievance and appeals process.
- **Training about the Child Welfare System —** Provide adequate education and training for MCOs and providers regarding the service and system requirements of the child welfare system.
- **Enrollment Process —** Offer a specialized enrollment process for children entering foster care so that they do not have to wait for service provision or change providers once they have been enrolled.
- **Medical Necessity Criteria —** Ensure that medical necessity criteria allow for consideration of psychosocial and environmental factors in clinical decision making.
- **Authorization —** Reduce the use of prior authorization processes for outpatient services and make authorization and reauthorization processes less burdensome.
- **Problem Solving Mechanisms —** Create mechanisms for resolving ongoing problems that will inevitably occur.
- **Service Array —** Develop the array of intermediate services before phasing in populations of children with more serious and complex needs.
- **Payment Responsibilities —** Resolve issues among public agencies and MCOs regarding who pays for what services as the RFP and contract are developed. Do not wait until after the contract is awarded to make these decisions.
- **Tracking Outcomes —** Create methods for tracking outcomes for children and families involved in the child welfare system.

II. Results of the 2000 State Survey

In this section, findings from the 2000 State Survey[5] related to the child welfare population are summarized. When helpful, findings from previous Tracking Project surveys and impact analyses are cited for purposes of comparison. Some preliminary findings from the CWLA Survey also are provided when applicable. Differences in the findings between the Tracking Project and the CWLA Survey can be attributed primarily to the fact that the respondents for each survey were different. State children's mental health administrators responded to the Tracking Project's 2000 State Survey, and state and county child welfare administrators responded to the CWLA Survey. Different responses, indicating different perspectives among these two stakeholder groups, make for interesting comparisons in perceptions. However, differences in findings should be viewed with caution due to the preliminary nature of the CWLA data.

Inclusion of Children in the Child Welfare System in Behavioral Health Managed Care Systems

As **Table 117** indicates, 82% of the reforms analyzed for the 2000 State Survey reportedly include children in the child welfare system. The three state surveys show that the number of managed care reforms including children and adolescents served by the child welfare system has increased over time. Results from both the 1997 and 1999 Impact Analyses support this finding.

Table 117
Reforms Covering the Child Welfare Population

1995 State Survey	45%
1997–98 State Survey	60%
2000 State Survey	82%
1997 Impact Analysis (N=10)	90% (children in state custody)
1999 Impact Analysis (N=9)	89% (children in state custody)

As suggested earlier in this report, states are at the end stage of phasing in coverage of Medicaid populations in managed care and appear less reluctant to cover populations that need more intensive and costlier services. However, in a few states, children in state custody (a subset of children in the child welfare population) are kept outside of any public managed care plan, and the child welfare system provides behavioral health services through a fee-for-service arrangement. Child welfare stakeholders explained that this is done when there is a belief, or at least a fear, that the managed care system would not be able to meet the unique needs of children in state custody.

[5] As indicated previously, complete survey data in response to the 2000 State Survey were provided for 35 reforms. Percentages listed in this special analysis are based on these 35 reforms, unless otherwise noted.

Preliminary findings from the CWLA Survey indicate that, according to child welfare respondents, a lower percentage (approximately 51%) of behavioral health reforms reportedly include the child welfare population. Data from other tracking projects suggest that inclusion of the child welfare population in managed care systems is closer to the higher percentage reported in the 2000 survey than to the lower percentage reported by child welfare stakeholders. The discrepancy in these findings relates, in part, to which states have responded to each survey. Some of the states reported by the other surveys to include children in the child welfare system in their behavioral health reforms are not counted in the preliminary findings from the CWLA Survey.

Involvement of Child Welfare Stakeholders Planning, Implementing, and Refining Behavioral Health Managed Care Systems

Significant involvement of state child welfare staff in planning, implementing, and refining behavioral health managed care reforms has, reportedly, increased slightly. The 2000 State Survey found significant involvement in 46% of the reforms, as compared with 37% in 1997–98 (**Table 118**). However, in more than half of all behavioral health managed care reforms (54%), child welfare administrators still are not significantly involved (some involvement was reported in 43% of the reform; no involvement in 11%).

Table 118
Child Welfare Stakeholder Involvement

	None	Some	Significant
1997–98 State Survey	7%	56%	37%
2000 State Survey	11%	43%	46%

Discrete Planning and Special Provisions for Children in the Child Welfare System

Seventy-two percent (72%) of the reforms reported that they engaged in a discrete planning process for children in the child welfare system, representing a 24% increase since 1997–98 State Survey when 48% of the reforms reported discrete planning for the child welfare population. However, according to preliminary CWLA data, respondents in less than 50% of the states indicated that the behavioral health managed care reforms in their state included a discrete planning process for children in the child welfare system.

Respondents to the 2000 State Survey also reported that most reforms (87%) incorporate some special provisions for children in the child welfare system. Examples of these provisions are shown on **Table 119**.

Table 119 Special Provisions for Children in Child Welfare	
	Percent of All Reforms Reporting Provisions
Interagency treatment/service planning	67%
Expanded service array	63%
Wraparound services	57%
Intensive case management	53%
Family support services	43%
Higher capitation or case rates	13%
Other	11%

While it is encouraging that a significant number of reforms recognize the need for special services and provisions for the child welfare population, very few have provided any fiscal incentives through rate adjustments to ensure access to these special services and provisions. When MCOs agree to serve a child for a fixed rate, the purpose of risk adjusted rates is to better match the level of risk taken by the managed care entities to the level of need for service. This reduces significantly the incentive for underservice, since financial losses generated by high users of behavioral health services are minimized or eliminated. Although the 1997 and 1999 Impact Analyses clearly show that children in the child welfare system need and use an extensive amount of services, in the 2000 State Survey, respondents for only 11% of all reforms reported that rates are adjusted for children in the child welfare system.

Education and Training on Managed Care for the Child Welfare System

The 2000 State Survey found that education and training about the goals and operations of the behavioral health managed care system are reportedly being provided for the child welfare system in nearly three-quarters of the reforms. A similar percentage of the reforms are providing education and training to other child serving systems as well, as shown on **Table 120**.

The 2000 State Survey also found that training and education is being provided to MCOs in order to increase their knowledge base related to serving children and adolescents in the child welfare system in about half of the reforms (52%). This is comparable to the percentage of reforms that provide training to MCOs related to children with serious emotional disorders (55%), but significantly exceeds the proportion of reforms that provide training related to children in the juvenile justice system (36%).

Table 120 Education and Training on Managed Care Provided to Child Serving Systems	
Child Serving System	**Percent of Reforms Providing Education/Training**
Child welfare system	72%
Juvenile justice system	63%
Other child serving systems	72%

Service Coverage in Behavioral Health Managed Care Systems

Managed care reforms cover a wide variety of mental health services. The following services are those most likely to be covered (reportedly covered by approximately 85% of the reforms):

- Assessment and diagnosis
- Outpatient psychotherapy
- Crisis services
- Medical management
- Day treatment/partial hospitalization
- Inpatient hospital services

The services least likely to be covered (reportedly covered by approximately 50% of the reforms) include:

- Therapeutic foster care
- Respite services
- Therapeutic group care
- Residential treatment

Because all of the services in the category “least likely to be covered” by the managed care system are critical service components for children in the child welfare system, in many states, children in the child welfare system are forced to access these services from sources outside of the managed care system. In most states, the child welfare system itself may be the provider or the purchaser of these services. This again underscores the need for close coordination between the child welfare and managed care systems, particularly if a state is engaged in a child welfare managed care initiative that includes similar services.

Financing

Funding Sources for Behavioral Health Managed Care

Although there is a slight increase in the percentage of reforms (5%) in which agencies other than Medicaid and mental health are used to fund managed care systems, the percentage of reforms that include child welfare funds has decreased from 32% in

1997–98 to 21% in 2000. In spite of this decrease, among child-serving agencies, the child welfare system is a more significant contributor to managed care systems than other child-serving systems such as juvenile justice and education. Medicaid is the most frequent source of financing for managed care systems, providing funds for 85% of the reforms; mental health is second, contributing funds in 73% of the reforms. Child welfare is a distant third, with child welfare resources contributed to managed care systems in 21% of the reforms. Less than 10% of the reforms include funds from juvenile justice, and none of the reforms are using funds from the education system.

Funding Sources for Child Welfare Managed Care

The CWLA Survey analyzed funding sources for child welfare managed care systems and found that, while child welfare initiatives increasingly are using multiple funding sources, the core funding for services still comes from the child welfare system. Based on preliminary data from 17 states, funding from outside of the child welfare system most often is provided by Medicaid (53% of the these states) and by the mental health system (47% of these states).

Use of Medicaid Outside of Managed Care

In 91% of the managed care reforms analyzed for the 2000 State Survey, some Medicaid funds for behavioral health services remain outside of the managed care system. In 72% of the reforms, the child welfare system has access to these Medicaid funds. It is important to note that, even though 82% of the managed care reforms include children served by the child welfare system, child welfare is not contributing substantial amounts of funds to managed care systems. Rather, resources apparently are being kept within child welfare systems to meet behavioral health treatment needs beyond what is provided through managed care systems. When children in the child welfare system require services outside of the managed care system, the child welfare system generally uses Medicaid funds under its control and other resources to provide these services. While having access to multiple funding streams creates a safety net for children in the child welfare system, it also presents an opportunity for cost shifting and fragmentation and can lead to confusion for families seeking services.

Cost Shifting

Only 16% of the managed care reforms in the 2000 State Survey reported that they actually track cost shifting among child-serving agencies; however, respondents in 79% of the reforms believed that cost shifting was occurring. Cost shifting was perceived to flow both ways — from the managed care system to other child-serving systems (36% — reported primarily by integrated reforms) and from other child-serving systems to managed care (43% — reported primarily by carve outs).

Preliminary findings from the CWLA Survey indicate that child welfare respondents view cost shifting differently. Similar to 2000 State Survey data, very few states claimed to have the ability to actually track cost shifting to or from the child welfare system. However, child welfare respondents were more likely to believe that managed care reforms have led to a shift of costs *to* the child welfare system. None of the child welfare respondents perceived cost shifts from child welfare to the managed care system.

Clinical Decision Making Criteria

In the majority of reforms (82%), medical necessity criteria are sufficiently broad to allow for the consideration of psychosocial and environmental factors in determining the appropriate types, levels, and duration of treatment and supports. This is an encouraging finding for the child welfare system due the multiple needs of children and families involved with the child welfare system and the concomitant need to consider multiple factors in treatment planning and in planning for permanent placements. Despite the fact that consideration of psychosocial and environmental factors is allowed in most reforms, the 2000 State Survey found that in some managed care systems, MCOs continue to interpret and apply these criteria narrowly, with particularly negative consequences for children and families involved with the child welfare system.

Criteria for making clinical decisions are standardized statewide in 54% of the reforms; however, they differ with each MCO in 46% of the reforms. When criteria differ with each MCO, continuity of care becomes compromised for children and families served by the child welfare system due to the multiple placement changes experienced by many children in this system. When children move to a different area that is served by a different MCO, they may not be considered eligible for services and supports that they had access to through the previous MCO.

Access to Behavioral Health Services

Initial Access to Services and Access to Extended Care Services

As **Table 121** indicates, improvement in *initial* access to a basic level of behavioral health services was reported in most reforms (70% in the 2000 State Survey), but improved access to extended care services (services beyond short-term stabilization) was less likely to be noted (reported in only 36% of the reforms). Shorter waiting lists for behavioral health services were reported for nearly half of the reforms (48%). However, in the remaining half wait lists were reported to be either longer or unchanged from pre-managed care systems.

CWLA Survey preliminary findings differed from the 2000 State Survey. Approximately half of the respondents to the CWLA Survey reported that they did not know whether initial access to behavioral health services and access to extended behavioral health services had improved as a result of the managed behavioral health reform. For those who did know, only one respondent noted improvement in initial access to basic services, and none cited improvement in extended care services. Some respondents reported that access was worse (20% cited decreased access to basic services, 27% cited decreased access to extended care). Some also reported no change in access (12% reported no change in access to basic services, 20% reported no change in access to extended care).

Table 121 Access to Behavioral Health Services			
	Better	Worse	No Change
Initial access to behavioral health services	70%	15%	15%
Access to extended behavioral health services	36%	14%	50%
Wating lists for behavioral health services	48%	20%	32%

The 2000 State Survey found that most reforms (88%) reportedly are now covering both acute and extended care services (see **Table 122**). Extended care was defined for survey respondents as care extending beyond short-term stabilization. This represents good news for the child welfare system, since many children involved with child welfare require extended care behavioral health services, and especially because the child welfare agency is the primary agency providing extended care services outside of the managed care system (reported for 94% of the reforms). However, because in almost all the reforms both the managed care system and the child welfare system are responsible for some behavioral health extended care services, coordination between the systems is critical.

Table 122 Percent of Reforms Including Acute and Extended Care		
	1997-98	2000
Acute care only	26%	9%
Acute and extended care	74%	88%
Extended care only	0%	3%

Access to Behavioral Health Inpatient Services

The 2000 State Survey results show that in 20% of the reforms initial access to inpatient care reportedly is more difficult, and in 63% average lengths of stay are shorter. Respondents reported a number of problems resulting from decreased access and truncated inpatient lengths of stay, including inappropriate use of child welfare emergency shelters (reported for 21% of the reforms with decreased inpatient access or length or stay) and discharge without a safe placement for children in the child welfare system (cited as a problem in 8% of the reforms with decreased inpatient access or length of stay). The most frequently reported problem associated with changes in access to inpatient care was children being discharged without needed services, an issue in a third of the reforms with decreased inpatient access/length of stay (33%). These findings have major implications for the child welfare system due to the serious emotional problems faced by many children involved with child welfare. Given these results, when children are hospitalized, child welfare workers and families need to coordinate discharge plans carefully with the managed care system.

Survey results also underscore the need to create alternatives to hospitalization, step-down services, and family and community supports. In sixty-two percent (62%) of the reforms, such alternatives to hospitalization reportedly have been developed to some extent.

Preliminary findings from the CWLA Survey show similar results. Approximately half of the respondents cited more difficult access to inpatient or residential care, shorter lengths of stay in psychiatric inpatient and residential settings, and premature discharge before stabilization. Several also noted inappropriate use of child welfare emergency shelters, juvenile justice facilities, and discharge without the assurance of a safe placement.

Eligibility Based on Placement Setting

Respondents to the 2000 State Survey were asked whether there were any types of placements in which children in the child welfare or juvenile justice systems would lose eligibility for (and, thus, access to) services from the managed care system. Respondents for nearly three-quarters of the reforms (73%) indicated that there are placements that result in loss of access to care through the managed care systems. The types of placements that can result in loss of eligibility across reforms include:

* Residential treatment facilities
* State or county operated public institutions
* Nursing homes
* Juvenile detention homes
* Any juvenile justice placement
* Any placement, if child is in state custody
* Out-of-state placement
* Return home (depending on income)

This list of placements demonstrates how difficult it is for children in both the child welfare and juvenile justice systems to obtain consistent and continuous care. Policies and practices that force changes in type of coverage, providers, and services can lead to ineffective services, increased trauma, and poor outcomes for children and families.

Service and Interagency Coordination

The 2000 State Survey included items that addressed the impact of managed care reforms on service and interagency coordination, and results demonstrated a promising trend — coordination at both the service and system levels appears to be improving. For more than half of the reforms (60%), respondents indicated that coordination between physical health services and behavioral health services has improved. This is extremely important for the child welfare system, in which a major goal is child well-being and addressing a child's physical health and mental health needs are of equal importance. Respondents also indicated improvement in coordination between mental health and substance abuse services in 52% of the reforms and improved interagency coordination among child-serving systems in 65% of the reforms. It is noteworthy that coordination in each of these areas is reportedly worse in only 3% to 7% of the reforms.

Cultural Competence

It has been well documented that there is a significant over-representation of children of color in the child welfare system. Additionally, children of color tend to be in more restrictive placements and to stay in care or custody longer. The level of cultural competence of managed care systems, as one system serving these children, could potentially impact these problems.

The 2000 State Survey explored whether, according to respondents, cultural competence requirements had changed in managed care systems as compared with the previous system. In nearly two-thirds of the reforms (64%), requirements under the managed care system were characterized as stronger than in the previous system; requirements were considered weaker in only 3% of the reforms. In a third of the reforms, there reportedly has been no change in cultural competence requirements as a result of managed care reforms.

The most frequently cited strategies used by managed care systems to address cultural competence include the incorporation of requirements related to cultural competence in RFPs and contracts (used in 85% of the reforms), the provision of translation and interpretation services (82%), the inclusion of culturally diverse providers in networks (64%), and outreach to culturally diverse populations (58%). Only about a third of the reforms (36%) reportedly track service utilization and/or outcomes by culturally diverse groups.

Family Focus

In the child welfare system, successful prevention of placement and reunification of families and children depend upon adequate services for both children *and* their parents. A highly significant finding in the 2000 State Survey is that in 64% of the reforms, the service delivery focus reportedly is on families in addition to the identified child. This reflects an improvement over the findings from the 1999 Impact Analysis in which respondents in all nine reforms in the sample felt that the managed care system focused treatment planning and services on the identified child rather than on the entire family. The 2000 State Survey also found that more than half (51%) of the reforms pay for services to family members, even if only the identified child is covered. While this is a hopeful sign, in half of the reforms, finding funds to provide services for family members continues to be an issue.

Generally, respondents to the 2000 State Survey felt that managed care reforms have had no effect on the pre-existing practice of families having to relinquish custody in order to access behavioral health services for their children; this was reported for 83% of all reforms. In only 13% of the reforms has managed care reportedly improved this situation, and in 4% of the reforms managed care reportedly has exacerbated the practice of relinquishing custody in order to receive needed services. These findings are consistent with preliminary results of the CWLA Survey in which approximately half of the respondents acknowledged that there are instances in their states in which parents do relinquish custody to gain access to behavioral health services for their children. However, none of the respondents knew what percent of children were in custody for this reason, and most respondents to the CWLA Survey did not know how, or if, managed care has affected this practice.

Inclusion of Child Welfare Providers in Behavioral Health Managed Care Systems

In the 2000 State Survey respondents indicated whether various types of providers were included in managed care system provider networks. A significant finding is that only about half of the reforms (53%) reportedly include child welfare providers (i.e., providers who traditionally have provided behavioral health services to the child welfare population) — a finding with both fiscal and clinical implications. If a provider is not in the managed care system network, the child welfare agency may be faced with the decision of either paying for that provider's services or obtaining care from a provider who may not be considered to be as familiar with the child welfare population and its treatment needs. The inclusion of child welfare providers also affects continuity of services, as children may have to change providers when they move in and out of the child welfare system.

Another noteworthy finding is that, since the 1997–98 State Survey, managed care systems reportedly are sharing risk with providers to a greater extent. The 2000 survey data revealed a 25% increase since 1997–98, with 75% of the reforms sharing risk with providers either through subcapitation, case rates, or bonuses/penalties tied to performance. In comparison, the CWLA Survey asked respondents whether the child welfare reform initiative shared financial risk with individual child welfare providers. Preliminary findings indicate that child welfare initiatives reportedly share risk with individual providers in only five states.

Accountability and Data

Tracking Utilization of Behavioral Health Services

Most of the managed care reforms (74%) reportedly track the use of behavioral health services by children in the child welfare system. Although these data could be used in determining system performance and in making decisions about needed services, only 35% of those reforms that track this information actually use it for system planning (a result not dissimilar to reported use of other data that are collected). This gap between the information that is tracked and the information that is used may be due to the form and the timeframes in which data are generated. Further exploration is needed to determine why this information is not used in system planning.

Preliminary findings from the CWLA Survey suggest that fewer than half of the states responding have the capacity to track the prevalence of mental health needs of children in the child welfare system. Only a third have the capacity to assess the degree to which parental mental health or substance abuse problems are a primary reason for initial referral and/or placement of children in out-of-home care.

Adequacy of Data and Data Systems

The 2000 State Survey found that 59% of the reforms reportedly have adequate data to guide decision making regarding behavioral health services; 41% reportedly do not have adequate data. The major reasons cited for the lack of data are inadequate management information systems (75% of the reforms with inadequate data) and lack of encounter data (50% of the reforms with inadequate data). Lack of staff capacity to analyze the data was also cited (25% of the reforms with inadequate data). About a quarter the reforms (25%) simply are not tracking children's behavioral health services.

Similarly, the CWLA Survey found lack of data and inadequate data systems to be a problem in child welfare managed care systems. Few public or private agencies have the capacity to monitor client-specific cost, utilization, and outcomes data over an entire episode of care or across public multiple systems.

Child Welfare Managed Care Activity

The 2000 State Survey explored whether the child welfare system was implementing or planning to implement (at the state or county level) reform related to the management, financing, or delivery of child welfare services. The discrepancy on this item between the 2000 State Survey and the CWLA Survey raises some questions as to the level of interagency communication and coordination in many states.

In response to the 2000 State Survey, respondents for 14 states indicated that child welfare managed care initiatives were being implemented or planned. Preliminary findings from the CWLA Survey (which include responses from only 24 states) identified child welfare reforms in 16 states, a number expected to increase when final CWLA results are tabulated. This suggests some lack of knowledge about child welfare managed care activities on the part of the respondents from mental health systems, although discrepancies may also be due to differences in definitions of managed care.

On the 2000 State Survey, 55% of those who were aware of child welfare managed care initiatives indicated that the child welfare and behavioral health managed care reforms were, in fact, being coordinated. Though it is encouraging that coordination was reported in more than half of the cases, a legitimate concern is the lack of coordination between child welfare and behavioral health managed care reforms in the remainder of instances.

III. Summary

It is noteworthy that the results of the 2000 State Survey demonstrate that many of the recommendations made by child welfare stakeholders who were interviewed in the 1999 Impact Analysis (which were cited previously) reportedly are being addressed in managed care systems across states. For example:

- Most reforms have special provisions for children in the child welfare systems (87%).
- Most reforms provide training for the child welfare system about managed care (72%).
- More than half of the reforms train MCOs about the unique needs of children and families in the child welfare system (52%).
- Most reforms include medical necessity criteria that allow for consideration of psychosocial and environmental factors in clinical decision making (82%).
- Nearly two-thirds of the reforms have incorporated strategies for clarifying responsibilities for service provision and payment across child-serving systems (64%).
- Most reforms are able to track the use of behavioral health services for children in the child welfare systems (74%).

On the other hand, a number of concerns reported have not as yet been addressed:

- In 54% of the reforms, the child welfare system is not significantly involved in planning, implementing, and refining, the behavioral health managed care system.
- Only 11% of the reforms have an enhanced capitation or case rate for children in the child welfare system.
- Children in the child welfare and juvenile justice systems can lose eligibility for the managed care system based on being in particular types of placement in 73% of the reforms.
- Fundamental services used by children in the child welfare system are not covered in nearly half of the managed care systems (e.g., therapeutic foster care, therapeutic group homes, respite services, and residential treatment).
- Although most reforms track utilization for children in the child welfare system, only 35% actually use this information for system planning.
- Child welfare providers are not included in provider networks in 47% of the reforms.
- Even with broadened medical necessity criteria, in 46% of the reforms, the criteria for making clinical decisions differ with each MCO (which is especially problematic for children who move frequently).
- Half of the managed care systems do not pay for services to family members of the identified child unless the family is covered.

Both the 2000 State Survey and the preliminary findings from the CWLA Survey suggest that the results related to managed behavioral health care for children in the child welfare system are, at best, mixed. It is apparent that child welfare agencies must increase their capacity to track and assess the behavioral health needs of the children and families they serve, and that managed care systems must better track utilization and outcomes for this population of children and families. Collaborative efforts to analyze these data and use it to make system improvements are essential. Only with joint planning and coordination among the child welfare system, mental health system, Medicaid agency, managed care organizations, and the families they all serve, can effective services be provided and positive outcomes achieved by children involved with the child welfare system and their families. □

Appendix A

Technical Assistance Materials/Information

Requests for Proposals

State	Contact Person	Phone Number
Arizona	Valinda Mores	(602) 381-8999
Arkansas	Anne Wells	(501) 686-9489
Colorado	Bill Bush	(303) 866-7411
Connecticut	James Gaito	(860) 424-5137
Delaware	DCMHS	(302) 577-4900
Florida	Wendy Smith	(850) 487-2618
Georgia	Dawne Morgan	(404) 657-2157
Hawaii	Mary Brogan	(808) 733-9344
Kentucky	Randy Oliver	(502) 564-7610
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
Mississippi	Brenda Scafidi	(601) 359-1288
Missouri	Gregory Vadner	(573) 751-6922
New Mexico	Ken Martinez	(505) 827-7659
New York	Diana Marek	(518) 474-1704
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992
Texas	Perry Young	(512) 206-5748
Vermont	Brenda Bean	(802) 241-2630

Medical/Clinical Necessity Criteria

State	Contact Person	Phone Number
Arizona	Valinda Mores	(602) 381-8999
California	Dee Lemonds	(916) 654-3001
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Kentucky	Randy Oliver	(502) 564-7610
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
Minnesota	Glenace Edwan	(651) 215-1382
New Mexico	Ken Martinez	(505) 827-7659
New York	Diana Marek	(518) 474-1704
	James MacIntyre	(518) 473-6902
	Mike Bigley	(518) 474-1704
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992

Standards for Professionals

State	Contact Person	Phone Number
Georgia	Dawne Morgan	(404) 657-2157
Kentucky	Randy Oliver	(502) 564-7610
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
New York	Diana Marek	(518) 474-1704
Oklahoma	Vickie McEntire	(405) 522-7102
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992

Standards for Programs

State	Contact Person	Phone Number
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Kentucky	Randy Oliver	(502) 564-7610
Maine	James Yoe	(207) 287-8982
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
New York	Diana Marek	(518) 474-1704
Oklahoma	Vickie McEntire	(405) 522-7102
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992
Vermont	Brenda Bean	(802) 241-2630

Level of Care Criteria

State Phone Number		Contact Person
Arizona	Valinda Mores	(602) 381-8999
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Hawaii	Mary Brogan	(808) 733-9344
Maine	James Yoe	(207) 287-8982
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
Minnesota	Glenace Edwan	(651) 215-1382
Mississippi	Brenda Scafidi	(601) 359-1288
New York	James Maclntyre	(518) 473-6902
	Mike Bigley	(518) 474-1704
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992

Quality Measurement Criteria

State	Contact Person	Phone Number
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
New York	Diana Marek	(518) 474-1704
	James MacIntyre	(518) 473-6902
	Mike Bigley	(518) 474-1704
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992
Vermont	Brenda Bean	(802) 241-2630

Grievance and Appeals Procedures

State	Contact Person	Phone Number
Arizona	Valinda Mores	(602) 381-8999
California	Dee Lemonds	(916) 654-3001
Connecticut	James Gaito	(860) 424-5137
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Kentucky	Randy Oliver	(502) 564-7610
Maine	James Yoe	(207) 287-8982
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
New York	Diana Marek	(518) 474-1704
	James MacIntyre	(518) 473-6902
	Mike Bigley	(518) 474-1704
Oklahoma	Vickie McEntire	(405) 522-7102
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992
Vermont	Brenda Bean	(802) 241-2630

Capitation or Case Rate Setting Methods

State	Contact Person	Phone Number
Delaware	DCMHS	(302) 577-4900
New York	Diana Marek	(518) 474-1704
	James MacIntyre	(518) 473-6902
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992

Risk Adjustment Methods

State	Contact Person	Phone Number
Delaware	DCMH	(302) 577-4900
Pennsylvania	Mike Root	(717) 772-7992

Contracts with Managed Care Entities

State	Contact Person	Phone Number
Arizona	Valinda Mores	(602) 381-8999
California	Dee Lemonds	(916) 654-3001
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
New York	Diana Marek	(518) 474-1704
	James MacIntyre	(518) 473-6902
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992

Health Care Reform Legislation

State	Contact Person	Phone Number
Connecticut	James Gaito	(860) 424-5137
Massachusetts	Laurie Ansorge Ball	(617) 210-5461
New York	Diana Marek	(518) 474-1704
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992
Vermont	Brenda Bean	(802) 241-2630

Outcome Measures for Children and Adolescents with Emotional and Behavioral Needs and their Families

State	Contact Person	Phone Number
California	Dee Lemonds	(916) 654-3001
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Hawaii	Mary Brogan	(808) 733-9344
New Mexico	Ken Martinez	(505) 827-7659
New York	Diana Marek	(518) 474-1704
	James MacIntyre	(518) 473-6902
	Mike Bigley	(518) 474-1704
Pennsylvania	Mike Root	(717) 772-7992
Vermont	Brenda Bean	(802) 241-2630
West Virginia	Dave Majic	(304) 558-0998

Quality or Outcome “Report Card”

State	Contact Person	Phone Number
New Mexico	Ken Martinez	(505) 827-7659
Pennsylvania	Mike Root	(717) 772-7992
West Virginia	Dave Majic	(304) 558-0998

Medicaid Waiver Applications

State	Contact Person	Phone Number
California	Dee Lemonds	(916) 654-3001
Connecticut	James Gaito	(860) 424-5137
Delaware	DCMHS	(302) 577-4900
Georgia	Dawne Morgan	(404) 657-2157
Missouri	Gregory Vadner	(573) 751-6922
New York	Diana Marek	(518) 474-1704
North Dakota	JoAnne Hoesel	(701) 328-2335
Oregon	Ralph Summers	(503) 945-9827
Pennsylvania	Mike Root	(717) 772-7992
Texas	Perry Young	(512) 206-5748
Washington	Judy Gosney	(360) 902-0827

Other

State	Resource	Contact Person	Phone Number:
Massachusetts	1999 Annual Report Mass. Title XIX	Laurie Ansorge Ball	(617) 210-5461
Minnesota	Cultural Competence requirements	Glenace Edwan	(651) 215-1382
New York	Family Handbook	James Maclntyre	(518) 473-6902
Utah	Preferred Practice Guidelines	Mary Ann Williams	(801) 538-4568
Washington	Parent Guide to the Public Mental Health	Judy Gosney	(360) 902-0827

Appendix B

2000 Survey of State Managed Care Reform Initiatives Affecting Behavioral Health Services for Children and Adolescents and their Families

Respondent Information:

Respondent Name: _____ State _____
Title/Agency: _____ Date_____
Phone _____ Fax:_____ E-Mail:_____

If you are planning to describe more than one managed care reform affecting behavioral health services (i.e, mental health and/or substance abuse services) for children and adolescents, please duplicate this form and complete a separate survey for each reform.

I. GENERAL INFORMATION ABOUT MANAGED CARE REFORM

1. Name of Reform:_____

   Implementation Date of Reform: _____

   Briefly describe this reform:

2. Does the reform cover physical health and behavioral health or behavioral health only? (Check only one.)
   _____ Behavioral health only
   _____ Physical health and behavioral health

3. Which of the following best characterizes the focus of the reform? (Check only one.)
   _____ Medicaid reform
   _____ Public sector behavioral health system reform
   _____ Medicaid and public behavioral health system reform
   _____ Children's interagency reform
   _____ Other, Specify _____

Return completed survey to: Mary Ann Kershaw
Research & Training Center for Children's Mental Health
13301 Bruce B. Downs Blvd. Tampa, FL 33612

4. What are the current goals of the managed care reform? (Check all that apply.)
   _____ Cost containment
   _____ Increase access
   _____ Expand service array
   _____ Improve quality
   _____ Improve accountability
   _____ Other, Specify _____

5. Does this reform involve the use of a Medicaid waiver?
   _____ Yes _____ No If yes, specify type of waiver _____

6. Which of the following best characterizes the design of this reform? (Check only one.)
   _____ Integrated design (i.e., administration and financing of physical health and behavioral health are integrated, including instances where physical health plans subcontract with behavioral health plans)
   _____ Behavioral health carve out (i.e., behavioral health financing and administration are separate from physical health financing and administration)
   _____ Integrated with partial carve out (i.e., some behavioral health services are integrated with the physical health system while splitting out others for separate management and financing)

7. Are substance abuse services included in this reform?
   _____ Yes _____ No
   If no, how are the administration and financing of substance abuse services handled? (Check only one.)
   _____ There is a separate substance abuse carve out
   _____ Substance abuse is integrated with physical health
   _____ Substance abuse remains fee for service

8. If this reform includes both physical health and behavioral health services, is there parity between physical and behavioral health services?
   _____ Yes _____ No
   If no, check all of the following choices that apply.
   _____ Behavioral health services are subject to higher co-payments and deductibles
   _____ There are lifetime limits on behavioral health services
   _____ There are day and/or visit limits on behavioral health services
   _____ Other, specify _____

9. Who at the state level has the lead responsibility for planning and overseeing implementation of behavioral health services for this reform? (Check only one.)
   _____ Governor's office
   _____ State health agency
   _____ State Medicaid agency
   _____ State mental health agency
   _____ State substance abuse agency
   _____ Other, Specify _____

10. In your judgment, to what extent are each of the following involved in planning, refinements, and implementation of this reform?

	Not Involved	Some Involvement	Significant Involvement
Families			
State child mental health staff			
State substance abuse staff			
State child welfare staff			
State juvenile justice staff			
State education staff			
Providers			

11. Describe promising strategies or approaches for involving families in planning, implementation, and refinements of the managed care system.

    Describe promising strategies or approaches for involving other child-serving systems in planning, implementation, and refinements of the managed care system.

12. For which of the following populations has the reform included a discrete planning process? (Check all that apply.)
   _____ Adolescents with substance abuse disorders
   _____ Children and adolescents with serious emotional disorders
   _____ Children and adolescents involved with the child welfare system
   _____ Culturally diverse children and adolescents

13. In conjunction with the managed care reform, is education and training about the goals and operation of the managed care system provided to any of the following groups? (Check all that apply.)
    _____ No training
    _____ Families
    _____ Providers
    _____ Child welfare system
    _____ Juvenile justice system
    _____ Other child-serving systems
    _____ Other, Specify _____

14. Describe promising strategies or approaches for education, training, and orientation related to the managed care system.

II. POPULATIONS INCLUDED

1. What is the population covered by this reform? (Check all that apply.)
    _____ Total Medicaid population
    _____ Portion of Medicaid population
    _____ SCHIP population
    _____ Non-Medicaid, non-SCHIP population

2. If the total Medicaid population is not covered, which of the following subgroups are covered? (Check all that apply.)
    _____ TANF population
    _____ Poverty related population
    _____ Aged, blind, and disabled population (SSI)
    _____ Pregnant women and children
    _____ Children and adolescents in the child welfare system
    _____ Children in child welfare who are in state custody
    _____ Children in child welfare who are not in state custody
    _____ Children and adolescents in the juvenile justice system
    _____ Other, Specify _____

3. Are there any types of placements in which children in the child welfare or juvenile justice systems would lose eligibility for services from the managed care system?
    _____ Yes _____ No Specify placements _____

III. MANAGED CARE ORGANIZATIONS

1. What types of entities are used as managed care organizations (MCOs) for behavioral health services under the reform? (Check all that apply.)
   _____ For-profit managed health care organizations
   _____ Nonprofit managed health care organizations
   _____ For-profit behavioral health managed care organizations
   _____ Nonprofit behavioral health managed care organizations
   _____ Private, nonprofit agencies
   _____ Government entities, Specify _____
   _____ Other, Specify _____

2. How many MCOs are used in the reform to manage behavioral health services? (Check only one.)
   _____ One MCO statewide
   _____ One MCO per region
   _____ Multiple MCOs statewide or within regions

   Describe promising strategies and approaches to address the challenges related to using multiple MCOs statewide or within regions (e.g., standardized authorization or level of care criteria).

3. In conjunction with the reform, is training or education being provided to increase the knowledge base of MCOs related to serving the following populations? (Check all that apply.)
   _____ No training
   _____ Training related to children and adolescents with serious emotional disorders
   _____ Training related to adolescents with substance abuse disorders
   _____ Training related to children and adolescents involved with the child welfare system
   _____ Training related to children and adolescents involved with the juvenile justice system
   _____ Training related to the Medicaid population in general
   _____ Training related to home and community-based service approaches
   _____ Training related to system of care values and principles

   Describe promising strategies and approaches used to increase the knowledge base of MCOs.

IV. SERVICE COVERAGE AND CAPACITY

1. For each type of service, indicate how the service is covered. (Check all that apply.)

Service	Covered Under Reform	Covered Outside Reform by Another Funding Source	Not Covered by the State through any Source
Mental Health Services			
Assessment and diagnosis			
Outpatient psychotherapy			
Medical management			
Home-based services			
Day treatment/partial hospitalization			
Crisis services			
Behavioral aide services			
Therapeutic foster care			
Therapeutic group homes			
Residential treatment centers			
Crisis residential services			
Inpatient hospital services			
Case management services			
School-based services			
Respite services			
Wraparound services			
Family support/education			
Transportation			
Mental health consultation			
Other, Specify			

2. Has the reform expanded coverage of home and community-based services for children and adolescents in comparison with the pre-managed care system?
   _____ Yes _____ No

   Specify services that have been added.

3. To what extent has the managed care reform expanded the availability of home and community-based services by bringing about the development of new service capacity?
   _____ Not at all
   _____ Very little
   _____ Somewhat
   _____ Significantly

4. On a scale of 1 to 5, characterize the adequacy of home and community-based service capacity for behavioral health services for children and adolescents in general in your state.

   Highly developed 1 2 3 4 5 Poorly developed

5. Does the state require reinvestment of savings from the managed care reform back into behavioral health services for children and adolescents?
   _____ Yes _____ No

   If yes, describe how savings are reinvested.

6. Besides reinvestment of savings from the managed care system, is the state investing in service capacity development for behavioral health services for children and adolescents and their families?
   _____ Yes _____ No

   Describe promising service capacity development strategies, including those for rural and frontier areas.

7. Has the reform made it easier to provide more flexible/individualized services?
   _____ Yes _____ No
   Explain

8. To what extent are behavioral health services to infants, toddlers, and preschoolers provided through the managed care system? (Check only one.)
   _____ None are provided
   _____ Few are provided
   _____ Many are provided

   Describe promising strategies and approaches to providing services to young children through the managed care system.

9. Does the reform include coverage for both acute (i.e., episodic, short-term) and extended (longer-term) behavioral health care services? (Check only one.)
   _____ Acute care only
   _____ Acute and extended care
   _____ Extended care only

10. What other systems also are responsible, and have behavioral health service dollars, for extended behavioral health service provision? (Check all that apply.)
   _____ Child mental health system
   _____ Child welfare system
   _____ Juvenile justice system
   _____ Education system
   _____ Substance abuse system
   _____ Other, Specify _____

11. Describe promising strategies or approaches to ensure smooth transitions between acute and extended care.

V. SPECIAL PROVISIONS FOR CHILDREN AND ADOLESCENTS WITH SERIOUS AND COMPLEX BEHAVIORAL HEALTH NEEDS

1. Which of the following special provisions, if any, does the managed care system include for each of the following populations of children with serious and complex behavioral health needs. (Check all that apply.)

Special Provisions	For children with serious behavioral health disorders	For children involved in the child welfare system	For children involved in the juvenile justice system
Expanded service array			
Intensive case management			
Interagency treatment and service planning			
Wraparound services or flexible service dollars			
Family support services			
Higher capitation or case rates			
Other, specify			

2. Describe promising strategies or approaches for meeting the needs of children and adolescents with serious and complex behavioral health needs and their families through the managed care system.

   Describe promising strategies or approaches for meeting the needs of children and adolescents in the child welfare system through the managed care system.

3. What effect has the managed care reform had on the provision of case management/care coordination services for children with serious and complex behavioral health needs? (Check only one.)

   _____ Increased case management/care coordination services
   _____ Decreased case management/care coordination services
   _____ No effect

   Describe promising strategies or approaches within the managed care system to providing case management/care coordination for children with serious and complex behavioral health needs.

4. From the following list, check the system of care values and principles that are incorporated into the reform's RFPs and contracts. (Check all that apply.)
   _____ Broad array of community-based services
   _____ Family involvement
   _____ Individualized, flexible care
   _____ Interagency treatment and service planning
   _____ Case management
   _____ Cultural competence

5. Does the managed care reform facilitate and support the further development of local systems of care (defined as organized delivery systems for children with serious and complex behavioral health disorders that incorporate the above values and principles)?
   _____ Yes _____ No
   Explain

VI. FINANCING AND RISK

1. What behavioral health dollars contribute to financing the managed care system? (Check all that apply)

Agency Source	Type of Revenue						
	Medicaid	General Revenue	Block Grant	Child Welfare (e.g. Title IV–E, IV–B)	TANF	SCHIP	Other, Specify
Medicaid Agency							
Mental Health Agency							
Child Welfare Agency							
Juvenile Justice Agency							
Education Agency							
Substance Abuse Agency							
Health Agency							
MR/DD Agency							
Other							

2. Which systems are using Medicaid dollars for behavioral health services outside of the managed care system? (Check all that apply.)
   _____ Mental Health
   _____ Child Welfare
   _____ Juvenile Justice
   _____ Education
   _____ Substance Abuse
   _____ Health
   _____ MR/DD
   _____ Other, Specify _____

3. Is cost shifting occurring between the managed care system and other children's systems? (Check all that apply.)
   _____ Cost shifting is not occurring
   _____ Cost shifting is occurring from the managed care system to other child-serving systems
   _____ Cost shifting is occurring from other child-serving systems into the managed care system

   Describe promising strategies or approaches to prevent cost shifting.

   Describe promising strategies or approaches to track and monitor cost shifting.

4. Does the managed care system incorporate strategies to clarify responsibility for providing and paying for services across child-serving systems?
   _____ Yes _____ No
   Describe promising strategies or approaches for clarifying responsibility across systems.
5. Does this reform involve use of capitation or case rate financing? (Check all that apply.)
   _____ Capitation
   _____ Case rates
   _____ Neither

6. Have the capitation or case rates increased or decreased over the past two years?
   _____ Rates have increased
   _____ Rates have decreased
   _____ Rates have stayed the same
   Explain reasons for changes in rates.

7. Does the managed care system assess the sufficiency of rates for behavioral health services to children and adolescents, including high need populations?
   _____ Yes _____ No

   If yes, have rate adjustments been made based on these assessments?
   _____ Yes _____ No
   Explain

   Describe promising strategies or approaches to assess the sufficiency of rates for behavioral health services to children and adolescents within the managed care system.

8. If capitation or case rates include both physical and behavioral health, does the state require that a specified percentage of the rate be allocated to behavioral health care?
   _____ Yes _____ No If yes, specify percentage _____

9. If capitation or case rates are used, please complete the following matrix as applicable.

Population	Amount of Capitation Rate (Specify if annual or monthly)	Amount of Case Rate (Specify if annual or monthly)	Basis for Rate (e.g., prior utilization, etc.)
Adults and children and adolescents-physical and behavioral health			
Children and adolescents–physical and behavioral health			
Adults and children and adolescents–behavioral health only			
Children and adolescents–behavioral health only			
Adults–behavioral health only			
Children and adolescents with serious emotional disorders			
Adults with serious and persistent mental illnesses			
Adolescents with substance abuse disorders			
Children and adolescents in the child welfare system			
Children and adolescents in the juvenile justice system			
Other, Specify			

10. Does the managed care system incorporate risk adjusted rates for any of the following populations? (Check all that apply.)
    _____ Children involved in the child welfare system
    _____ Children involved in the juvenile justice system
    _____ Children with serious behavioral health disorders

11. Does the managed care reform incorporate other types of risk adjustment mechanisms? (Check all that apply.)
    _____ Stop loss
    _____ Risk corridors
    _____ Reinsurance
    _____ Risk pools
    _____ Other, Specify _____

12. In what way do the state and MCOs share the financial risks and benefits? (Check only one.)
    _____ MCOs have all the benefit and all the risk
    _____ State has all the benefit and all the risk
    _____ MCOs and state share risk and share benefit
    _____ MCO and state share risk only
    _____ MCO and state share benefit only

13. In what ways is risk shared with providers? (Check all that apply.)
    _____ Providers have no risk
    _____ Subcapitation
    _____ Case rates
    _____ Bonuses/penalties tied to performance

14. Does the state put a limit on MCO profits?
    _____ Yes _____ No Specify limit _____

15. Does the state put a limit on MCO administrative costs?
    _____ Yes _____ No Specify limit _____

16. Does the reform incorporate bonuses or penalties for MCOs based on performance related to behavioral health service delivery to children and adolescents?
    _____ Yes _____ No

    Describe promising strategies and approaches to performance-based incentives in the managed care system.

VII. CLINICAL DECISION MAKING AND MANAGEMENT MECHANISMS

1. Do medical necessity criteria allow for consideration of psychosocial and environmental considerations in clinical decision making?

   _____ Yes _____ No

   If yes, characterize the interpretation and application of medical necessity criteria by MCOs . (Check only one.)

   _____ Medical necessity criteria are interpreted narrowly by MCOs
   _____ Medical necessity criteria are interpreted broadly to include psychosocial and environmental consideration

2. Does the managed care system incorporate the following clinical decision making criteria? (Check all that apply.)

   _____ Level of care criteria specific to children's mental health services
   _____ Patient placement criteria specific to adolescent substance abuse treatment

   Specify criteria used

3. Overall, has the use of clinical decision making criteria improved consistency in clinical decision making?

   _____ Yes _____ No If no, explain.

4. Are clinical decision making criteria standardized across the state? (Check only one.)

   _____ Criteria are standardized across the state
   _____ Criteria differ with each MCO

5. Which management mechanisms, if any, are utilized in the delivery of behavioral health services under this reform? (Check all that apply.)

   _____ Prior authorization
   _____ Concurrent review
   _____ Retrospective review
   _____ Case management
   _____ Other, Specify _____

6. Does the managed care system allow for the provision of certain services up to a specified amount without prior authorization?

   _____ Yes _____ No

   Describe promising strategies or approaches to allowing a certain level of service provision without prior authorization within the managed care system.

7. Does the managed care system utilize specific strategies for managing the use of more intensive services, such as residential treatment services?
   _____ Yes _____ No

   Describe promising strategies or approaches for managing the use of intensive services.

8. Does the managed care system incorporate strategies to help families navigate the grievance and appeals process and how to use it?
   _____ Yes _____ No

   Describe promising approaches for assisting families to understand and navigate the grievance and appeals process within the managed care system.

VIII. ACCESS

1. How has initial access to a basic level of behavioral health services been affected by the managed care reform? (Check only one.)
   _____ Initial access to behavioral health services is better
   _____ Initial access to behavioral health services is worse
   _____ No change

   Describe promising strategies or approaches for improving initial access to a basic level of behavioral health services within the managed care system.

2. How has access to extended care services (i.e., care extending beyond short-term stabilization) been affected by the managed care reform? (Check only one.)
   _____ Access to extended care behavioral health services is better
   _____ Access to extended care behavioral health services is worse
   _____ No change

   Describe promising strategies or approaches for improving access to extended care behavioral health services.

3. In general, what effect has the managed care reform had on waiting lists for children's behavioral health services? (Check only one.)
   _____ Waiting lists are shorter
   _____ Waiting lists are longer
   _____ No change
   Explain

4. Has the managed care reform had either of the following effects on access to behavioral health inpatient services for children and adolescents? (Check all that apply)
   _____ Initial access is more difficult
   _____ Average lengths of stay are shorter

   If so, indicate which, if any, of the following have resulted. (Check all that apply.)
   _____ Premature discharge before stabilization from inpatient settings
   _____ Children discharged without needed services
   _____ Placement in community-based services lacking appropriate clinical capacity to serve them
   _____ Increased use of residential treatment services as a substitute for inpatient
   _____ Inappropriate use of child welfare emergency shelters
   _____ Inappropriate use of juvenile justice facilities
   _____ Discharge without a safe placement for children in child welfare

5. Has the managed care reform led to the development of alternatives to hospitalization?
   _____ Yes _____ No

   Describe promising strategies and approaches to providing alternatives to hospitalization.

IX. SERVICE COORDINATION

1. What effect has the managed care reform had on coordination between physical health and behavioral health services? (Check only one.)
   _____ Coordination between physical health and behavioral health services is improved
   _____ Coordination between physical health and behavioral health services is worse
   _____ No effect

   Describe promising strategies or approaches within the managed care system to improve coordination between physical health and behavioral health services.

2. What effect has the managed care reform had on coordination between mental health and substance abuse services? (Check only one.)
   _____ Coordination between mental health and substance abuse services is improved
   _____ Coordination between mental health and substance abuse services is worse
   _____ No effect

   Describe promising strategies or approaches within the managed care system to improve coordination between mental health and substance abuse services.

3. What effect has the managed care reform had on interagency coordination among child-serving systems? (Check only one.)
   _____ Interagency coordination has improved
   _____ Interagency coordination is worse
   _____ No effect

   Describe promising strategies or approaches within the managed care system to improve coordination among child-serving systems.

X. EARLY IDENTIFICATION

1. Are EPSDT screens conducted within the managed care system?
   _____ Yes _____ No

2. Is there a behavioral health component to the EPSDT screening process within the managed care system?
   _____ Yes _____ No
   Describe

3. Describe promising strategies, if any, to encourage primary care practitioners and/or others to conduct behavioral health screens and make appropriate referrals.

XI. CULTURAL COMPETENCE

1. Which of the following strategies related to cultural competence are incorporated in the managed care system? (Check all that apply.)
   _____ Specific planning for culturally diverse populations
   _____ Requirements in RFPs and contracts related to cultural competence
   _____ Training of MCOs and/or providers on cultural competence
   _____ Outreach to culturally diverse populations
   _____ Inclusion of specialized services needed by culturally diverse populations
   _____ Inclusion of culturally diverse providers in provider networks
   _____ Translation/interpreter services
   _____ Tracking utilization and/or outcomes by culturally diverse groups
   _____ None
   _____ Other, specify_____

2. Characterize the cultural competence requirement in the managed care system as compared with the previous system. (Check only one.)
   _____ Cultural competence requirements are stronger in the managed care system
   _____ Cultural competence requirements are weaker in the managed care system
   _____ No change

3. Describe promising strategies to enhance cultural competence within your managed care system.

XII. FAMILY INVOLVEMENT

1. Which of the following strategies related to family involvement are incorporated in the managed care system? (Check all that apply.)
   _____ Requirements in RFPs and contracts for family involvement at the system level
   _____ Requirements in RFPs, contracts, and service delivery protocols for family involvement in planning and delivering services for their own children
   _____ Focus in service delivery on families in addition to the identified child
   _____ Coverage for and provision of family supports
   _____ Use of family advocates
   _____ Hiring family and/or youth in paid staff roles
   _____ None
   _____ Other, specify_____

   Describe promising strategies or approaches to enhance family involvement within your managed care system.

2. Characterize the family involvement requirements in the managed care system as compared with the previous system. (Check only one.)
   _____ Family involvement requirements are stronger in the managed care system
   _____ Family involvement requirements are weaker in the managed care system
   _____ No change

3. Does the managed care system pay for services to family members if only the child is covered?
   _____ Yes _____ No

4. What effect has the managed care reform had on the pre-existing issue of families having to relinquish custody to access behavioral health services? (Check only one.)
   _____ Practice of relinquishing custody has worsened under managed care
   _____ Practice of relinquishing custody has improved under managed care
   _____ No effect

   Describe promising strategies or approaches to address the problem of families having to relinquish custody to access care.

5. Is the state funding a family organization to play some role in the reform?
   _____ Yes _____ No

   Describe promising strategies or approaches to involving family organizations in managed care systems.

XIII. PROVIDERS

1. Are the following types of providers included in provider networks in the managed care system? (Check all that apply.)
   _____ Child welfare providers
   _____ School-based behavioral health providers
   _____ Certified addictions counselors
   _____ Culturally diverse and indigenous providers
   _____ Family members as providers
   _____ Paraprofessionals and student interns

   Describe promising strategies or approaches for including any of the above types of providers in provider networks in the managed care system.

2. Are new certification or credentialing requirements in the managed care system impeding the inclusion of particular types of behavioral health service providers?
   _____ Yes _____ No
   If yes, explain

   Describe promising strategies or approaches to address problems created by changes in credentialing requirements.

3. In general, are provider reimbursement rates in the managed care system higher or lower than in the previous system? (Check only one.)
   _____ Provider reimbursement rates are higher in the managed care system
   _____ Provider reimbursement rates are lower in the managed care system
   _____ No change

4. Is administrative burden for providers in the managed care system higher or lower than in the previous system? (Check only one.)
   _____ Administrative burden is higher in the managed care system
   _____ Administrative burden is lower in the managed care system
   _____ No change

   Describe promising strategies for reducing administrative burden for providers.

5. Has the managed care reform affected (either increased or decreased) the availability of any particular types of children's behavioral health providers?
   _____ Yes _____ No
   If yes, explain

6. Has the managed care reform resulted in closure or severe financial hardship for particular types of children's behavioral health agencies?
   _____ Yes _____ No
   If yes, explain

7. Do front-line practitioners have the skills, knowledge, and attitudes to function effectively to meet the goals of the managed care system?
   _____ Yes _____ No
   If yes, explain

   Describe promising strategies and approaches to improve the skills, knowledge, and attitudes of front-line practitioners.

XIV. ACCOUNTABILITY

1. Does the managed care system have adequate data to inform decision making with respect to behavioral health services for children and adolescents and their families?

   _____ Yes _____ No

   If adequate data are not available, indicate the reasons why. (Check all that apply)

   _____ Lack of encounter data
   _____ Lack of staff capacity to analyze data
   _____ Inadequate MIS system
   _____ Not tracking children's behavioral health services
   _____ Other, Specify _____

   Describe promising strategies or approaches for collecting, analyzing, and using system performance data in the managed care system.

2. Indicate by checking which, if any, of the following system performance information is tracked by the managed care system and whether data are being used to inform decision making. (Check all that apply.)

System Information	Not Tracked	Tracked	Information is Used for System Planning
Child behavioral health penetration rates			
Child behavioral health service utilization			
Child behavioral health service utilization by culturally diverse groups			
Behavioral health service utilization by children in child welfare			
Behavioral health service utilization by children in juvenile justice			
Total cost of child behavioral health services			
Cost per child served with behavioral health services			
Cost shifting among child-serving systems			

3. Does the managed care system incorporate quality measures specific to behavioral health services for children and adolescents and their families?

   _____ Yes _____ No

   Describe measures, instruments, or approaches to measuring the quality of behavioral health services for children, adolescents, and their families within the managed care system.

4. How are families involved in the quality measurement process? (Check all that apply.)

   _____ Not involved
   _____ Focus groups
   _____ Surveys
   _____ Involved in the design of the quality measures and/or process
   _____ Involved in monitoring the quality measurement process
   _____ Other, Specify _____

5. Characterize the stage of development of the measurement of clinical and functional outcomes specific to behavioral health services for children and adolescents. (Check only one.)

   _____ Not measuring clinical and functional outcomes
   _____ In early stage of developing measurement system
   _____ Developed but not yet implemented measurement system
   _____ Implementing measurement system but do not yet have results
   _____ Implementing measurement system and have results

   Describe promising instruments and approaches to measuring clinical and functional outcomes for children and adolescents in the managed care system.

6. Does the managed care system measure parent and youth satisfaction with behavioral health services? (Check all that apply.)

   _____ Not measuring parent or youth satisfaction
   _____ Measuring parent satisfaction
   _____ Measuring youth satisfaction

   Describe promising instruments and approaches to measuring the parent and/or youth satisfaction with behavioral health services in the managed care system.

7. What has been the impact of the managed care reform on the following system performance indicators?

System Information	Increased	Decreased	No Effect	Don't Know
Child behavioral health penetration rates				
Overall child behavioral health service utilization				
Total cost of child behavioral health services				
Overall quality of child behavioral health services				
Overall clinical and functional outcomes				
Overall family satisfaction with services				

7. If there is a formal evaluation of the reform, does it include a focus on children and adolescents with behavioral health disorders and their families?
   _____ Yes _____ No

XV. STATE CHILD HEALTH INSURANCE PROGRAM (SCHIP)

1. In what way is SCHIP implemented in your state? (Check only one)
   _____ Medicaid expansion
   _____ Medicaid look-alike
   _____ Separate program

2. Characterize the behavioral health benefit under SCHIP. (Check only one.)
   _____ Includes broad behavioral health benefit
   _____ Includes limited behavioral health benefit

3. If the behavioral health benefit is not the same as under Medicaid, describe the behavioral health benefit under SCHIP.

4. If SCHIP is a separate program from Medicaid, is it being operated through a managed care arrangement?
   _____ Yes _____ No

5. If SCHIP is a separate program from Medicaid, are the two programs being coordinated?

   _____ Yes _____ No

   Describe promising strategies or approaches for coordinating SCHIP and Medicaid programs.

6. If SCHIP is a separate program from Medicaid, are there specific strategies within SCHIP to identify children and adolescents with behavioral health treatment needs and refer them for behavioral health services?

   _____ Yes _____ No

   Describe promising strategies or approaches for identifying and referring children and adolescents with behavioral health treatment needs within SCHIP.

7. What effect has SCHIP had on the delivery of behavioral health services to children and adolescents? (Check only one.)

   _____ No data
   _____ More children and adolescents receiving behavioral health services
   _____ Fewer children and adolescents receiving behavioral health services
   _____ No change

8. Were stakeholders with expertise in children's behavioral health services involved in planning and implementing SCHIP?

   _____ Yes _____ No

XVI. PROMISING APPROACHES

1. Identify below ***state or local*** public sector financing reforms using managed care technologies that are significantly improving behavioral health service delivery to children and adolescents and their families, ***other than the reform described in this survey.***

   _____

   _____

   _____

2. Describe briefly the most promising features that make this system worthwhile to study and disseminate information about to the field.

   _____

   _____

   _____

3. Whom can we contact for in-depth information about this promising approach?

   Name: _____ Phone: _____

   Title: _____ Agency: _____

XVII. CHILD WELFARE MANAGED CARE

1. In your state, is the child welfare system implementing or planning to implement reform related to the management, financing, or delivery of child welfare services at the state or county levels?

   _____ Yes _____ No

   Is this reform initiative being coordinated with the behavioral health managed care reform?

   _____ Yes _____ No

   Explain

XVIII. TECHNICAL ASSISTANCE MATERIALS/INFORMATION

On the list below, please indicate the types of material/information related to behavioral health service delivery for children and adolescents that you have in your state that may be useful to other states undertaking health care reforms.

_____ Requests for proposals
_____ Medical/clinical necessity criteria
_____ Standards for professionals
_____ Standards for programs
_____ Level of care criteria
_____ Quality measurement criteria
_____ Grievance and appeals procedures
_____ Capitation or case rate setting methods
_____ Risk adjustment methods
_____ Contracts with managed care entities
_____ Health care reform legislation
_____ Outcome measures for children and adolescents with emotional and substance abuse disorders and their families
_____ Quality or Outcome “report card”
_____ Medicaid waiver applications
_____ Other, specify _____

Indicate the contact person and phone number who could provide the above materials on request.

Name: _____ Phone: _____

Research and Training Center for Children's Mental Health
Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida

National Technical Assistance Center for Children's Mental Health
Center for Child Health and Mental Health Policy
Georgetown University Child Development Center
Washington, D.C.

Human Service Collaborative
Washington, D.C.