HCRTP
Health Care Reform Tracking Project

Using Research to Move Forward:

A Consensus Conference
on Publicly Funded Managed Care for Children
and Adolescents with Behavioral Health Disorders
and Their Families

September 29–30, 2003

Beth A. Stroul, M.Ed.
Sheila A. Pires, M.P.A.
Mary I. Armstrong, Ph.D.

HCRTP Health Care **Reform** **Tracking Project**

Tracking Behavioral Health Services to Children and Adolescents
and Their Families in Publicly Financed Managed Care Systems

USF
UNIVERSITY OF
SOUTH FLORIDA

HCRTP

A Consensus Conference
on Publicly Funded Managed Care for Children
and Adolescents with Behavioral Health Disorders
and Their Families
September 29–30, 2003

Using Research to Move Forward:

Beth A. Stroul, M.Ed. • Sheila Pires, M.P.A. • Mary I. Armstrong, Ph.D.

Partial Contents: Background and Purpose of Consensus Conference • Essential Elements of Publicly Financed Managed Care • Recommendations for Policy, Practice and Research • Appendix A: Essential Elements of Publicly Financed Managed Care • Appendix B: Summary of Findings from the HCRTP 1995–2003 • Appendix C: Key Findings from Research on Managed Care for Children's Behavior Health • Appendix D: Participants of Consensus Conference • Publications of the HCRTP • HCRTP Publication Order Forms

Available from:
Department of Child and Family Studies
Division of State and Local Support

FMHI *Louis de la Parte*
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899   (813) 974-6271

This publication is also available on-line as an Adobe Acrobat PDF file:
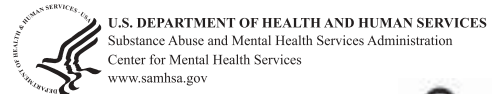
http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm   or

http://pubs.fmhi.usf.edu click **Online Publications** (By Subject)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

NIDRR

USF
UNIVERSITY OF
SOUTH FLORIDA

HCRTP
Health Care Reform Tracking Project

Using Research to Move Forward:

A Consensus Conference
on Publicly Funded Managed Care for Children
and Adolescents with Behavioral Health Disorders
and Their Families

September 29–30, 2003

Beth A. Stroul, M.Ed. • Sheila Pires, M.P.A. • Mary I. Armstrong, Ph.D.

May 2004

Tampa, Florida

Research and Training Center for Children's Mental Health
Department of Child and Family Studies

FMHI *Louis de la Parte*
Florida Mental Health Institute

University of South Florida
Tampa, FL

National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development
Washington, DC

Human Service Collaborative
Washington, DC

HCRTP Health Care Reform
Tracking Project

Tracking Behavioral Health Services to Children and Adolescents
and Their Families in Publicly Financed Managed Care Systems

Table of Contents

Table of Contents

Table of Contents

A Consensus Conference
on Publicly Funded Managed Care for Children
and Adolescents with Behavioral Health Disorders
and Their Families

September 29–30, 2003

I. Background and Purpose of Consensus Conference

Health Care Reform Tracking Project

Since 1995, the Health Care Reform Tracking Project (HCRTP) has been tracking publicly financed managed care initiatives and their impact on children with mental health and substance abuse (collectively referred to as behavioral health) problems and their families. The HCRTP is co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to incorporate special analyses related to children involved in the child welfare system. The HCRTP is conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development, and the Human Service Collaborative of Washington, D.C.

The mixed method design of the Tracking Project has involved periodic surveys of all states, in-depth impact analyses involving site visits to a selected sample of states, the identification and dissemination of promising approaches and features of managed care systems, and a consensus conference.

Consensus Conference

The consensus conference was held on September 29 and 30, 2003 in Washington, DC and was entitled: "Using Research to Move Forward: A Consensus Conference on Publicly Funded Managed Care for Children and Adolescents with Behavioral Health Disorders and Their Families." The overall objective of the Consensus Conference was:

To develop a set of agreed-upon recommendations for policy, practice, and research related to behavioral health managed care for children and adolescents, based on research results.

The Consensus Conference brought together a relatively small, targeted group of researchers, policy makers, purchasers, system managers, providers, family members, and other key stakeholders to review evidence garnered over the last decade across research efforts, consider its implications, and develop recommendations for the future. Specifically, the process involved:

- Identifying key learnings across research projects about providing publicly managed behavioral health care services to children and adolescents and their families
- Identifying the implications of such learnings for policy, practice, and research
- Identifying essential elements of effective managed behavioral health care for children and adolescents and their families
- Developing recommendations for future policy, practice, and research related to managed behavioral health care services for children and adolescents and their families

The Consensus Conference provided an opportunity for researchers to share findings and explore implications with one another and with key stakeholders who can effect policy and practice change. This report represents the product of the two-day meeting, and presents the essential elements of effective managed behavioral health care for children and adolescents and their families, and the recommendations for future policy, practice, and research derived from the participants. It is anticipated that the essential elements and recommendations will be broadly disseminated in an effort to assist stakeholders to refine and revise managed care systems to better meet the behavioral health treatment needs of children and adolescents and their families.

A detailed list of the essential elements for behavioral health managed care for children and adolescents and their families is included in **Appendix A**. In addition, key learnings from the Health Care Reform Tracking Project and other research projects are included as **Appendices B** and **C**, and **Appendix D** includes a list of Consensus Conference participants.

II. Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services

The following represents a synopsis of the essential elements for publicly funded managed care for children's behavioral health services that emerged from the discussion at the Consensus Conference. (See **Appendix A** for greater detail related to these essential elements.)

Essential Elements for Publicly Funded Managed Care for Children's Behavioral Health Services
Leadership and Expertise at the State and Local Purchaser Level for Children and Adolescents with Behavioral Health Disorders and Their Families
System of Care Values and Principles in Managed Care Design and Implementation
Broad, Flexible Benefit Design/Array of Services and Supports
Flexible Clinical Decision Making and Management Mechanisms to Support an Individualized Approach to Care
Partnership with Families and Youth at Managed Care System and Service Delivery Levels
Child Behavioral Health Stakeholder Involvement and Training
Cross-System Coordination at the Policy, System, and Service Delivery Levels
Special Provisions for Children with Serious Disorders and Special Needs
Comprehensive, Strengths-Based Assessments of Children and Families to Support Individualized Care
Evidence-Based and Promising Practices
Early Intervention
Provider Networks with Capacity to Serve Children with Behavioral Health Disorders and Their Families
Training for MCOs and Providers on Child Behavioral Health Identification, Assessment, and Service Provision
Cross-System Financing Approaches
Risk Structuring for High-Risk, High-Need Child Populations
Investment in Service Capacity Development
Specific Planning and Goal Setting for Children's Behavioral Health
Specific Accountability Mechanisms for Children's Behavioral Health
Strategies to Address Cultural and Racial Disparities

III. Recommendations for Policy, Practice and Research

Policy Recommendations (Federal, State and Local Purchasers)
Federal Policy Level

• Federal Level Coordination

Examine and realign federal funding streams to better streamline and coordinate financing for children's behavioral health services and to create a more integrated approach across agencies, including potential cross-agency waiver programs, joint and coordinated grant programs (e.g., better coordinated system of care initiatives), etc.
Federal agencies should coordinate their efforts to examine system-level issues by supporting research initiatives, making data available, and working with their state counterparts/grantees to make data available for research.

• Technical Assistance

Federal partner agencies (including SAMHSA and CMS) should provide technical assistance and consultation to one or more states that are in the process of revising or refining their managed care systems, in order to use research findings and prior experience with behavioral health managed care for children to inform their work.
Examine the CMS pilots (currently in 6 states) and use the experience of the pilots, where applicable, to provide assistance to other states in providing flexible home and community-based services and supports in place of residential care.
Provide technical assistance to states to assist them in developing risk adjusted rates for children with serious disorders and children in the child welfare and juvenile justice systems and to develop mechanisms to share liability and funds across child serving systems.
Assist states in gathering baseline information about what behavioral health services are being provided across child serving systems and what funds are being expended across systems to create a better national picture of total public expenditures on children's behavioral health care.
Share lessons learned in behavioral health managed care for children and adolescents and their families, so that others can profit from what worked and what did not work elsewhere and develop a "primer" summarizing best practices in managed behavioral health care for children and adolescents geared for decision makers and families.

Policy Recommendations
(Federal, State and Local Purchasers) continued

Federal Policy Level continued

- **Federal Level Monitoring**

  Develop a minimum set of quality measures for children's mental health services that could apply to publicly funded managed care systems (as well as to private sector managed care) and require managed care systems to monitor these. This effort should build on the work of the Children's Outcomes Roundtable, the Forum on Performance Measurement in Behavioral Healthcare and related work.

  The federal Centers for Medicare and Medicaid Services should require states with Medicaid waivers to monitor quality of care as it relates to children's behavioral health care more closely and report their findings for public scrutiny.

  Develop a monitoring guide for CMS Regional Offices relative to children's behavioral health services.

  Federal partners should create incentives to encourage and support data collection for accountability and quality improvement in behavioral health care. States should be incentivized, as well as MCOs, BHOs, providers, and families.

State and Local Purchaser Level

- **Values**

  Link to or incorporate within managed care systems comprehensive, coordinated systems of care, and incorporate system of care values and principles within managed care systems.

- **Managed Care Organizations**

  Purchasers should lengthen the contract cycle with MCOs in order to provide a more realistic implementation period and to enable improvements over time by MCOs and providers, including sufficient time to adequately build a provider network, service array, necessary administrative systems and procedures, etc.

  Explore use of Administrative Service Organizations (ASOs) with the state retaining risk as an alternative to using full-risk MCOs, and experiment with mechanisms for providing flexible, individualized services within ASO arrangements. CMS waivers may be a vehicle to test ASO structures and strategies for flexibility.

Policy Recommendations
(Federal, State and Local Purchasers) continued

State and Local Purchaser Level continued

- **Benefit Design/Array of Services and Supports**

Incorporate a broad, flexible benefit design (i.e., include coverage of a broad, flexible array of services and supports), and clearly define covered services and supports.
Broaden the definition of "services" to include supports for children and families in addition to treatment, and include these services in state Medicaid plans.
Incorporate flexibility in coverage, utilization management, and clinical decision making such that arbitrary limits are eliminated, psychosocial and environmental factors are considered, and support as well as treatment needs are addressed.
Incorporate provisions requiring services to young children and their families into managed care contracts.
Ensure allowable funding for coverage of services to family members, as well as the identified child.

- **Family/Youth Partnership**

Partner with families and youth in the design and implementation of managed care systems, including support to family organizations for playing formal roles in the design and delivery of care.
Require that families and consumers be included on planning/advisory/oversight structures for managed care systems, and consider requirements that families and consumers comprise a certain percentage of the planning/advisory/ oversight entities.
Pay family members and family organizations for consulting services to managed care systems at the state or local purchaser level, as well as at the MCO level.
Experiment with consumer-directed care approaches by which consumers and families control the purchasing of services, with special accounts to purchase home and community-based care for children with serious disorders (similar to approaches used in the mental retardation field).
Support demonstrations of "family-directed" managed care funding arrangements.

Policy Recommendations
(Federal, State and Local Purchasers) continued

State and Local Purchaser Level continued

- **Stakeholder Involvement and Training**

  Incorporate requirements for the participation of key stakeholders with knowledge and expertise in children's behavioral health services (including families, children's mental health staff, and staff of other child serving agencies) at all levels of managed care system design, implementation, operation, refinement, and oversight.

- **Cross-System Coordination at Policy, System, and Service Levels**

  Incorporate requirements and strategies for coordination of physical and behavioral health services, such as incentives for primary care practitioners to screen for behavioral health disorders, requirements for communication and referrals for behavioral health care, monitoring, etc.

  Ensure that the child welfare, juvenile justice, and Medicaid managed care systems work together closely to incorporate special provisions for these high-need populations, to analyze data, and to make system improvements.

  Create mechanisms to assess the impact of managed care on other systems, including cost shifting.

  Incorporate mechanisms into managed care systems to screen children at high-risk of emotional disorders (e.g., children in the child welfare or juvenile justice systems) and link them to needed behavioral health services.

- **Special Provisions for Children with Serious Disorders**

  Include customized provisions and arrangements for children with serious disorders and their families, including individualized service planning, intensive care management, family support services to reduce caregiver strain, access to extended care, interagency coordination, risk adjusted rates, experimentation with special case rates, risk adjustment mechanisms, provisions for the unique needs of children in child welfare and juvenile justice systems, etc.

  Incorporate requirements for individualized plans of care for children involved in multiple systems and mechanisms for payment of staff/providers for involvement in individualized service planning and care coordination meetings.

Policy Recommendations
(Federal, State and Local Purchasers) continued

State and Local Purchaser Level continued

- **Provider Networks**

  Ensure the inclusion in provider networks of safety net providers, child welfare providers, nontraditional providers, culturally and linguistically diverse providers, paraprofessionals, and families and youth.

  Develop provider network standards (e.g., provider to population ratios) and rate standards.

  Establish realistic provider reimbursement rates.

  Provide capacity building funds for providers (particularly small providers, nontraditional providers, and providers that serve minority populations) to enable providers to develop and expand needed service capacity.

  Develop service capacity for serving the early childhood population by requiring providers who have the expertise in serving this population to be included in provider networks, and providing training to providers to improve their skills in serving this population.

  Provide support to providers, particularly small and minority providers and those serving predominantly minority populations, to develop and enhance service capacity; explore the Small Business Administration as a potential source of support.

- **Training for MCOs and Providers**

  Support training in evidence-based and promising practices for MCOs and providers, and include training in the core system of care principles of community-based services, an individualized approach to care, partnering with families and youth, cultural competence, and interagency collaboration.

Policy Recommendations
(Federal, State and Local Purchasers) continued

State and Local Purchaser Level continued

- **Financing and Risk Structuring**

  Identify all appropriate behavioral health financing sources across children's systems and create mechanisms for shared funding of children's behavioral health services and/or mechanisms for coordination across financing streams that remain outside of managed care systems.

  Invest in service capacity development for children's behavioral health at federal, state, and local levels.

  Develop risk arrangements including the use of risk adjusted rates and special case rates that are based on sound risk models for children with behavioral health disorders and that support the overarching goals of the managed care system and that counteract any incentives for underserving high-need, high-cost populations.

  Require that a specific amount of capitation rates be allocated to child behavioral health care within integrated physical health-behavioral health managed care systems.

  Incorporate a dedicated minimum set-aside (a specific percentage) for children's behavioral health services within managed behavioral health care systems.

- **Planning**

  Develop projections of service costs and utilization by type of service across the service array.

  Create formal mechanisms to raise problems at the service level to the system/policy level.

  Assist child welfare agencies to estimate the costs of meeting the behavioral health needs of children involved in their system, and ensure adequate rates within managed care systems to attract and retain providers qualified to serve this population.

  Establish clear program goals and desired outcomes based on values, baseline data, and performance targets.

Policy Recommendations
(Federal, State and Local Purchasers) continued

State and Local Purchaser Level continued

- **Accountability**

Increase tracking of children's behavioral health indicators both at the state and MCO levels in quality measurement, MIS, and outcome measurement systems.
Increase the capacity of child welfare agencies to track and assess the behavioral health needs of children involved in child welfare, and increase the capacity of Medicaid managed care systems to track utilization and outcomes for these children and families.
Develop quality of care "report cards" for hospitals, residential treatment centers, and community services.
Create greater administrative capacity at state and county purchaser levels to monitor managed care as it relates to children's behavioral health care and to develop more accurate and comprehensive data.
Share information about utilization, quality, satisfaction, and outcomes related to children's behavioral health with MCOs and providers.
Ensure that the "building blocks" for research and quality improvement (services, satisfaction, costs, outcomes) are built into information systems.
Create a data infrastructure and mechanisms for collecting data from multiple agencies, including Medicaid, mental health, child welfare, juvenile justice, and substance abuse.

- **Cultural and Racial Disparities**

Monitor racial and ethnic disparities in access to and utilization of children's behavioral health services and develop strategies to address them and increase cultural competence.

Practice Recommendations
(Managed Care Organizations and Providers)

- **Family/Youth Partnership**

  Create meaningful vehicles for involvement of families, guided by protocols for family involvement, guidelines, and practice standards, and partner with families and youth (including supporting family organizations) to play a role in the development and implementation of critical management operations, such as quality assurance and appeals processes.

  Use family advocates or "navigators" to help families navigate managed care systems and grievance and appeals processes.

  Provide family and youth consumers with useful, relevant information on evidence-based treatments and promising practices.

  Develop practice standards for family and youth involvement.

- **Cross-System Coordination**

  Designate an MCO liaison to the child welfare system, ensure ready access to behavioral health assessments for children involved in child welfare, and provide assessments and service planning that address safety and permanency issues.

  Implement mechanisms for greater shared communication, problem-solving, and decision making across child serving systems.

  Implement mechanisms for better coordination and partnership with juvenile courts and juvenile court judges to improve service planning and delivery for youth involved with the juvenile justice system.

- **Special Provisions for Children with Serious Disorders**

  Provide individualized plans of care for children with serious and complex disorders and utilize "child and family teams," including the family, youth, care manager, involved providers, representatives from other involved systems, and other appropriate individuals, to develop and implement individualized plans of care.

  Pay staff and providers for involvement in individualized service planning and care coordination meetings.

Practice Recommendations
(Managed Care Organizations and Providers) continued

- **Assessment**

  Provide comprehensive, holistic, ecological assessments of both strengths and needs of children within the context of their families and communities, and address caregiver strain in service planning, authorization, and provision.

  Screen children at high risk of emotional disorders (e.g., children entering custody in the child welfare system, children whose parents are receiving mental health or substance abuse services) and link them to needed behavioral health services.

- **Management Mechanisms**

  Reduce administrative burden on providers, including re-evaluation of utilization management practices and reporting requirements.

  Broaden definitions of "medical necessity" and ensure that these criteria are interpreted broadly, to include psychosocial and environmental factors in clinical decision making and avoid arbitrary limits.

- **Early Childhood/Early Intervention**

  Incorporate preventive and early intervention strategies, particularly for young children with less intense service needs.

  Allow use of the Diagnostic Classification 0 to 3 for claims as an appropriate diagnostic approach for young children.

- **Provider Networks**

  Include in provider networks "safety net" providers, child welfare providers, nontraditional providers, paraprofessionals, families and youth.

  Pay providers adequate rates.

  Include an array of culturally and linguistically diverse providers in provider networks.

Practice Recommendations
(Managed Care Organizations and Providers) continued

- **Training and Technical Assistance**

Increase training in the use of evidence-based treatments and promising practices in professional schools and in-service contexts.
Provide training for providers and front-line staff in areas including evidence-based and promising practices, family partnership, cultural competence, nontraditional services and supports, individualized care, the use of child and family teams, children with serious disorders, children involved in child welfare and juvenile justice agencies, etc.
Train primary care practitioners to identify behavioral health disorders among children and make appropriate referrals for specialty behavioral health care.

- **Accountability (Quality and Outcomes)**

Implement tracking systems at the MCO level to track indicators related to children's behavioral health services and use child-specific quality measures.
At the MCO level, monitor the quality of care provided by providers according to child behavioral health quality measures.
Involve consumers and families in assessing quality and satisfaction, such as implementing a system whereby families rate the quality and effectiveness of providers. A report card on providers could be generated and potentially shared on a web site.
Managed care systems should engage in a continuous refinement process throughout the contract cycle, with realistic incremental benchmarks defined for each contract year.
Use information technology to disseminate information about managed care systems, how to access help, etc. to families and other key stakeholders.

- **Cultural and Racial Disparities**

Monitor racial and ethnic disparities in access to and utilization of children's behavioral health services and develop strategies to address them and increase cultural competence.
Provide culturally specific interventions and services.

Practice Recommendations
(Managed Care Organizations and Providers) continued

- **Services/Practice**

Build incentives into provider contracts and provide operational guidance (such as practice guidelines, standards, and protocols) to change provider behavior and practice to reflect best practice and the latest research and to promote home and community-based care, family involvement, cultural competence, evidence-based and promising practices, etc.
Ensure that services and treatment are family focused and address caregiver strain.
Set aside resources within managed care systems for family support/prevention services that could be provided to families that may not already have a child designated as the "identified patient" with a diagnosis.
Provide capacity building (start-up) funds to MCOs and providers in order to build and expand service capacity for children's behavioral health services.

Research Recommendations

Research Process

Use "participatory action research models" and engage key stakeholders (families, providers, MCOs, policy makers, system managers, etc.) in the research process.
Recognize the value of and utilize applied research and qualitative approaches to study behavioral health managed care systems in addition to quantitative approaches.
Include multiple perspectives in research on children's behavioral health managed care at both policy and practice levels (MCOs, private payers, mental health and other systems, families, providers, etc.)
Frame research questions and findings in ways that can inform policy and practice.
Establish mechanisms to provide access to information on a timely basis so that research findings can be used for system improvement purposes.
Create mechanisms for collecting data from multiple child-serving agencies (Medicaid, mental health, child welfare, juvenile justice, substance abuse, education, etc.).
Partner with MCOs to use tools such as the System of Care Practice Review and others for quality improvement purposes.
Federal agencies (NIH, SAMHSA, or others) should ensure a focus and resources for applied, field-based research.

Research Focus

- **Financing-Related Issues**

Study the effects of various financing mechanisms (capitation, case rates, fee for service, etc.) on the quality and outcomes of care and on the long-term viability of MCOs.
Determine the impact of coverage of a broad array of services and supports with flexible management on costs, and determine the strategies and factors associated with cost containment within a broad, flexible benefit design.
Explore risk adjusted rates and case rates for children with serious and complex disorders to determine how to build appropriate rates.
Analyze expenditures for children's behavioral health care across all child-serving systems (including Medicaid) to better understand the roles of each, expenditures, and cost shifting.

Research Recommendations continued

Research Focus (continued)

- **Service-Related Issues**

Explore the relationship between evidence-based practices and managed care and the types of strategies and incentives associated with practitioner use of evidence-based and promising practices.
Study the types and effectiveness of various incentives to MCOs and providers to develop needed service capacity.
Study the effects of "dose" (length of stay) on clinical outcomes, and examine "dose" more accurately as a mixture of dosages of different types of services.
Explore the impact of providing preventive and early intervention services on long-term service needs and costs.
Identify strategies for coordination and communication between physical health and behavioral health providers and how to overcome barriers to their implementation.
Determine how service utilization is affected by more flexible authorization and utilization management requirements.
Conduct additional research on the impact of managed care on service utilization patterns, quality of care, costs, effect on providers, cost shifting, etc.

- **Family-Related Issues**

Study the effects of family choice approaches.
Study the growing role of families and family organizations in managed care systems, including paid roles, and assess the value of family involvement.
Study the impact of family advocacy on improvements in behavioral health managed care, including the adoption of evidence-based practices.

Appendix A

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services	
Leadership and Expertise at the State and Local Purchaser Level for Children and Adolescents with Behavioral Health Disorders and Their Families	
	Leadership at the state or local purchaser level to establish values, goals, and priorities and to implement monitoring and accountability procedures to hold the system accountable.
	Inclusion of the managed care system in the comprehensive, cross-agency state plan for behavioral health services to children with emotional disorders (as recommended in the President's New Freedom Commission on Mental Health report).
System of Care Values and Principles in Managed Care Design and Implementation	
	Incorporation of system of care values and principles within the managed care system.
Broad, Flexible Benefit Design/Array of Services and Supports	
	A broad, flexible array of covered services and supports.
	A focus on the entire family, not just the identified child, in benefit design and service coverage.
	Clear definitions of covered services and supports so that all stakeholders know what is covered and how services are to be delivered.

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services continued

Flexible Clinical Decision Making and Management Mechanisms to Support an Individualized Approach to Care

Flexibility in coverage, utilization management, and clinical decision making such that arbitrary limits are eliminated, psychosocial and environmental factors are considered, and support as well as treatment needs are addressed.

An individualized approach allowing services and supports to be based on the needs of the individual child and family.

Streamlining of management mechanisms, such as preauthorization of certain services.

"Pass through" mechanisms for routine services such as outpatient services, coupled with use of technology (such as web-based portals) for registering care.

Family and Youth Partnerships at Managed Care System and Service Delivery Levels

Partnerships with families and youth at the service delivery and systems levels, including protocols for family involvement, guidelines, and practice standards.

Use of family advocates or "navigators" to help families navigate managed care systems and to help families with grievance and appeals processes.

Recognition of the "value-added" role of family organizations to managed care operations.

Recognition and inclusion of the multiple caregivers for many children, particularly those in the child welfare system, who should be involved as "family."

Child Behavioral Health Stakeholder Involvement and Training

Requirements for participation of key stakeholders with knowledge and expertise in children's behavioral health services (including families, children's mental health, and other child serving agencies) at all levels of managed care system design, implementation, operation, refinement, and oversight.

Training of key stakeholders across systems (including staff at state level, MCOs/BHOs, providers, families, etc.) in effective children's behavioral health service delivery, including training on partnering with families and youth, cultural competence, cross-system service coordination, evidence-based practices, and evaluation of quality of care.

Involvement of families in training of key stakeholders such as MCOs, providers, and staff across child-serving systems.

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services continued

Cross-System Coordination at the Policy, System, and Service Delivery Levels

Coverage of service coordination at the level of the individual child and family.
Mechanisms for service coordination across child-serving agencies and providers at the system level.
Designation of a child welfare liaison to the managed care system and from the managed care system to the child welfare system.
Requirements and strategies for coordination of physical and behavioral health services, such as incentives for primary care practitioners to screen for behavioral health disorders, requirements for communication and referrals for behavioral health care, monitoring, and training of primary care practitioners in children's behavioral health issues and service system.
Assessment of service gaps and development of service strategies in partnership with other child-serving systems (e.g., child welfare, juvenile justice, education).

Special Provisions for Children with Serious Disorders and Special Needs

Special provisions for youngsters with serious behavioral health disorders, including intensive care management, coverage of extended care, interagency service planning, risk adjusted rates, special case rates, and individualized plans of care.
Requirements for individualized plans of care for children involved in multiple systems and mechanisms for payment of staff for involvement in individualized service planning and care coordination meetings.
Special provisions for youth involved in other child-serving systems (such as child welfare or juvenile justice) or with special needs (such as physical disabilities) based upon an understanding of their unique issues and challenges related to access, utilization, and response to care.

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services continued

Comprehensive, Strengths-Based Assessments of Children and Families to Support Individualized Care

	Comprehensive, holistic assessments of both strengths and needs of children within the context of their families and communities for individualized service planning and provision.
	Interagency involvement in assessment and treatment planning such that common needs and services across child-serving systems are considered and coordinated.
	Attention to caregiver strain in the assessment and service planning process.
	Ready access to behavioral health assessments for parents and children in the child welfare system to avert out-of-home placements and ensure appropriate child welfare service planning and court decisions.
	Assessments and service planning for children involved in the child welfare and juvenile justice systems must address safety and permanency issues, as well as treatment goals.

Evidence-Based and Promising Practices

	Linking children to services and supports that have been demonstrated to produce good outcomes, including providing incentives to MCOs and providers for the use of evidence-based and promising practices (and disincentives for using ineffective approaches).
	Consideration and inclusion of services and supports with "practice-based evidence," particularly interventions and approaches developed by communities of color, in an effort to meet the behavioral health needs of children in a culturally competent manner.

Early Intervention

	Provision of preventive and early intervention care, especially to younger children with less intense needs.
	Use of EPSDT screens to identify behavioral health needs and clear procedures and incentives for appropriate specialty referrals.

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services <small>continued</small>

Provider Networks with Capacity to Serve Children with Behavioral Health Disorders and Their Families

Adequate provider networks with the necessary expertise in child and adolescent behavioral health services and adequate service capacity.
Inclusion in provider networks of "safety net" providers, child welfare providers, nontraditional providers, culturally and linguistically diverse providers, paraprofessionals, and families and youth.
Adequate reimbursement rates.
Support for providers that require additional supervision or training and provisions for network termination of inadequate providers.

Training for MCOs and Providers on Child Behavioral Health Identification, Assessment, and Service Provision

Training for providers in areas including family partnership, evidence-based and promising practices, nontraditional services and supports, individualized care, the use of child and family teams, children with serious disorders, children involved in the child welfare and juvenile justice systems, etc.
Training for primary care practitioners to identify behavioral health disorders among children and make appropriate referrals for specialty behavioral health care.
Training for MCOs about the special issues associated with serving children in the child welfare system.
Use of new information technology for training and information dissemination.

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services continued

Cross-System Financing Approaches

	Realignment of financing streams for children's behavioral health services at the federal and state levels to better coordinate and rationalize eligibility and funding requirements.
	Clear delineation of payment responsibilities across systems.
	Adequate resources for children's behavioral health care, and, in some cases, increased resources to correct historical underfunding of children's behavioral health services.
	Identification of all appropriate financing sources across child-serving systems, and coordination across those financing streams within the managed care system and those that remain outside of the managed care system.
	Mechanisms for sharing, tracking, and accounting for funds for children's behavioral health services contributed by other child serving systems (e.g. child welfare).
	Projection of service costs by type of service across the service array.

Risk Structuring for High-Risk, High-Need Child Populations

	Risk arrangements and rates that are based on sound risk models for this population and that support the overarching goals of the managed care system.
	Inclusion of risk adjusted rates for children with serious disorders and children in foster care.
	Performance-based incentives related to purchaser agency priorities.

Investment in Service Capacity Development

	Investment in service capacity development for children's behavioral health at federal, state, and local levels, including up-front, start-up funding built into contracts, capacity building grants, and other vehicles for developing and expanding services.

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services continued
Specific Planning and Goal Setting for Children's Behavioral Health

	Effective analysis and clear understanding of the needs and service utilization patterns of the covered population.
	Careful establishment of program goals and desired outcomes based on baseline data and performance targets.
	Analysis and estimation of current and projected utilization.
	Establishment of a limited number of clear, realistic, meaningful, and measurable goals and performance outcomes with fiscal incentives tied to performance measures.
	Attention to larger systemic issues, such as lack of service capacity and poor data.
	Contractual language that is both specific enough to avert service gaps and flexible enough to allow for innovation.

Essential Elements of Publicly Financed Managed Care for Children's Behavioral Health Services <small>continued</small>

Specific Accountability Mechanisms for Children's Behavioral Health	
	Quality improvement system that reflects the state or local purchaser's priorities in specific goals and objectives and that has built-in processes for revision and refinement as priorities shift.
	Monitoring and oversight of service delivery and outcomes specific to children's behavioral health, with a focus on the accountability of state purchasers, managed care entities, and providers.
	"Early warning" mechanisms specific to children's behavioral health indicators.
	Reliable data
	Monitoring of eligibility expansion and increased service demand to prevent system overload.
	Tracking service utilization, cost, quality, and outcomes at the service and systems levels, with breakouts for children with serious behavioral health disorders, children involved with child welfare and juvenile justice systems, and culturally and racially diverse children.
	Adequate management information systems and the capacity to share information across systems.
	Assurance from state and MCO/BHO levels that data submitted by providers will be utilized for evaluation of quality and outcomes and data will be shared with providers and other key stakeholders.
Strategies to Address Cultural and Racial Disparities	
	Monitoring of cultural and racial disparities in behavioral health utilization and access and development of strategies to reduce disparities.

Appendix B

Summary of Findings from the Health Care Reform Tracking Project 1995–2003

Since 1995, the **Health Care Reform Tracking Project** (**HCRTP**) has been tracking publicly financed managed care initiatives and their impact on children with mental health and substance abuse (collectively referred to as behavioral health) problems and their families. The HCRTP is co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to incorporate special analyses related to children involved in the child welfare system. The HCRTP is conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development, and the Human Service Collaborative of Washington, D.C.

The mixed method design of the Tracking Project has involved periodic surveys of all states, in-depth impact analyses involving site visits to a selected sample of states, and the identification and dissemination of promising approaches and features of managed care systems. Throughout these activities, the Tracking Project has explored and compared the differential effects of **carve out designs**, defined as arrangements in which behavioral health services are financed and administered separately from physical health services, and **integrated designs**, defined as arrangements in which the financing and administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted). This document summarizes the status of state managed care activity as of 2003 and the highlights of Tracking Project findings from 1995–2003.

i. Status of State Managed Care Activity in 2003

Extent of Managed Care Activity

- Only five states over the past decade have never implemented a managed care system. The definition of managed care used in the Tracking Project includes the use of managed care technologies on either a statewide or local basis, including managed care systems that have a Medicaid waiver as well as other initiatives using managed care technologies that do not have waivers.

- Out of 46 states that have implemented managed care over the past decade, 38 (86%) are still involved in managed care.

- Since the last survey in 2000, there has been a slight retrenchment, with only one state starting a new managed care initiative and two terminating an existing or planned managed care system. However, these are fewer terminations than between 1997/98 and 2000, when there were seven terminations, indicating a possible settling in the managed care landscape.

Characteristics of Managed Care Systems — 2003

- The 2003 state sample includes 22 carve outs and 17 integrated physical health/ behavioral health managed care systems.
- The primary focus of most (61% of sample) is Medicaid managed care, followed by a joint focus on Medicaid and public behavioral health (33%).
- Most managed care systems are statewide (62%), and an additional third (36%) affect multiple areas within a state (typically the most populated areas). Only 2% of the managed care systems (1 system) affect a single area within a state.
- Most (71%) involve a Medicaid waiver, though there has been a moderate decline in the percentage of systems with waivers since 1997/98, probably due to the Balanced Budget Act of 1997 which allowed for the implementation of managed care without a Medicaid waiver.
- Integrated systems are more likely to use 1115 waivers; carve outs, 1915 (b) waivers.
- Most managed care systems (90%) are in late stages of implementation (more than three years), with integrated systems being older than carve outs.
- Over the past decade, there has been a steady decline in the percentage of systems being planned or in early implementation stages, again suggesting a settling in the managed care landscape. Only 5% (2 systems) indicated they were in the planning or early stages of implementation.

Inclusion of Substance Abuse

- Most managed care systems in the 2003 sample (77%) include substance abuse, with integrated systems being more likely to do so (88% versus 68%).
- When substance abuse is not included, it remains fee-for-service in 78% of the systems; in the remaining systems, it is either a separate carve out or included in a physical health managed care system that does not include mental health.

Parity

- In two-thirds of managed care systems, there reportedly is parity between physical and behavioral health services, without pre-set limits or higher co-pays. However, this represents a 15% decline since 2000 in systems reporting parity.

Goals

- While cost containment has been a goal of managed care systems throughout the past decade, 18% more systems in 2003 reportedly are focusing on cost issues than was the case in 2000. In contrast, there is a reported decline in focus on all other types of goals, particularly using managed care to expand the service array and improve quality. State budget deficits may be contributing to this apparent shift in focus.

Covered Populations

- Nearly 11% fewer managed care systems cover the total Medicaid population than in 2000; fewer than half (39%) cover the total population in 2003. Carve outs are significantly more likely to cover the total Medicaid population than are integrated systems (55% of carve outs versus 19% of integrated systems).

- Eight percent fewer managed care systems are covering the SCHIP population than in 2000. Fewer than half (45%) cover the SCHIP population.
- Only carve outs (45% of them) were reported to cover non-Medicaid and non-SCHIP populations, and there has been a 15% decline in coverage of these populations since 2000.
- Over half (65%) of managed care systems cover the SSI population, and half (57%) cover the child welfare population. Carve outs are significantly more likely to cover these high-need, high-cost populations than are integrated systems.
- While coverage of high-need, high-cost populations has increased since 1995, there was a slight decrease in coverage of these populations between 2000 and 2003.

ii. Summary of Key Findings 1995–2003

Differences Between Systems with Carve Out and Integrated Designs

- The Tracking Project has found consistent differences between systems with carve out and integrated designs. Systems with behavioral health carve out designs (separate financing and administration of behavioral health care within a managed care system) in comparison to integrated systems:
    - Include coverage of a broader array of services
    - Cover more home and community-based services
    - Support a more flexible, individualized approach to care
    - Include key stakeholders to a greater extent in system planning and refinement
    - Involve families to a greater extent and in more significant roles
    - Include more planning and special provisions for children with serious and complex disorders
    - Include cross-system funding and collaboration to a greater extent
    - Tend to be supportive of systems of care and incorporate system of care values and principles to a greater extent
    - Provide training to MCOs regarding special populations, home and community-based services, and system of care values and principles to a greater extent
    - Incorporate incentives for providers to use evidence-based practices
    - Are more likely to limit MCO profits and administrative costs
    - Cover high-need, high-cost populations to a greater extent
    - Cover non-Medicaid, non-SCHIP populations

Role of State Medicaid and Mental Health Agencies

- State Medicaid agencies have been and continue to be the dominant players in publicly funded managed care systems, having lead responsibility for nearly two-thirds (65%) of the managed care systems in the 2003 survey.
- State Medicaid agencies are health care financing agencies, which generally do not have specialized expertise in children's behavioral health service delivery issues.
- State mental health agencies play significant leadership roles in systems with carve out designs, but not in integrated systems.

Key Stakeholder Involvement

- Over time, state child mental health staff and providers are the only stakeholders that are most likely to have "significant involvement" in planning, implementation, and refinement of managed care systems (63% and 56% respectively in 2003), although this occurs to a much greater extent in carve outs than in integrated systems.

- For all other stakeholder groups (child welfare, juvenile justice, education, and substance abuse staff), there has been less significant involvement.

- With respect to families, significant involvement has been consistently found in fewer than half of the managed care systems, and the latest survey found some decreases in significant family involvement (35% of systems in 2003) and in requirements for family involvement. This is the case despite increased national attention to the need for family involvement and to the concepts of consumer and family-driven care.

- Where families are significantly involved, there are meaningful examples — involvement in paid family roles, quality monitoring, child and family teams, readiness assessments, and others.

Types of Managed Care Organizations

- Most managed care systems use for-profit managed care entities — either for-profit health managed care organizations (MCOs) or for-profit behavioral health managed care organizations (BHOs). The use of government entities as management entities is more likely in systems with carve out designs.

- Though there has been some improvement (particularly among the BHOs) resulting from greater experience, the Tracking Project has consistently found a reported lack of understanding of the needs of children with serious emotional disorders among these for-profit entities. This is likely due to the fact that commercial managed care companies historically did not serve populations with serious disorders.

- This finding has implications for reaching commercial MCOs and BHOs and working with them to increase knowledge and expertise on customizing care for children with serious disorders and their families.

- Over time, the Tracking Project has found significantly more problems associated with the use of multiple MCOs statewide or within regions than with the use of a single MCO statewide or within regions, specifically, multiple and confusing procedures for every aspect of system operation – billing and reimbursement, credentialing, utilization management, service authorization, and reporting; inconsistency in clinical decision making; and difficulties in monitoring.

Managed Care Financing

- Medicaid and mental health agencies are the primary sources of funding for managed care systems (Medicaid in 100% systems in 2003, mental health in 50% — all carve outs).

- The level of financial participation of other child-serving agencies is significantly lower. Other agencies participate in financing the managed care system primarily in carve outs.

- Systems with carve out designs are more likely to draw on multiple funding streams from multiple agencies, whereas systems with integrated designs are more likely to rely on Medicaid and SCHIP dollars from the Medicaid agency.
- Medicaid dollars are left outside of the managed care system in all cases (100% of the systems in 2003). The child welfare, mental health, education, juvenile justice, mental retardation/developmental disabilities, and substance abuse agencies are all likely to have Medicaid dollars for behavioral health services. Even though more managed care systems 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 may create a safety net for children unable to access needed service through the managed care system, but may also perpetuate opportunities for fragmented care and cost shifting.

Cost Shifting

- Cost shifting has reportedly been occurring as a result of the implementation of managed care in about half of the systems (50% in 2003), though the perception in 2003 is that there is some decline in cost shifting.
- There has been little systematic tracking or monitoring of cost shifting, so that these reports are difficult to substantiate (only 11% of the systems reported any tracking of this phenomenon in 2003).
- Cost shifting is more likely to be reported from the managed care system to other child serving systems in integrated managed care systems (in 57% of integrated systems in 2003).

Risk Structuring

- Most managed care systems use risk-based financing (81% in 2003), with the majority using capitation financing (78% in 2003) and relatively little use of case rate financing (19% in 2003). Over time, the Tracking Project found carve outs less likely to use capitation than integrated systems, but the gap appears to be narrowing. This may reflect an increasing sophistication with managed care on the part of state purchasers and/or may be an outgrowth of state budget problems.
- Over time, in about half of the managed care systems (46% in 2003) MCOs have all the risk and benefit, with state sharing or retaining risk and/or benefit in the other half. Providers share risk in about half of the managed care systems (47% in 2003).
- Few managed care systems use risk adjustment mechanisms such as stop-loss arrangements, risk corridors, reinsurance, and risk pools, and few use bonuses or penalties tied to performance (23% in 2003).
- None of the integrated managed care systems require that a certain specified percentage of the capitation rate (which covers both health and behavioral health) be allocated to behavioral health care.

Service Coverage and Capacity

- There has been a consistent and continuing increase in managed care systems that cover both acute and extended care (95% in 2003), whereas many more managed care systems initially limited coverage to acute care, similar to a commercial insurance model. Currently in 2003, no carve outs and only 12% of integrated systems limit coverage to acute care, although the services actually provided depend on a variety of factors beyond simple coverage. In most managed care systems, other agencies retain responsibility and resources for behavioral health extended care in addition to coverage within the managed care system (92% in 2003).

- Over time, about half the managed care systems (55% in 2003 — mainly carve outs) reportedly have broadened the array of covered services as compared with pre-managed care, specifically expanding coverage of home and community-based services. In the 2003 survey, some retrenchment in service coverage was found to the 97/98 levels, perhaps due to the current fiscal crises and resultant modifications in health and behavioral health services.

- Despite the reported expansion in service coverage, the reported availability of services has not expanded significantly in most systems. Most managed care systems do not consider service capacity to provide home and community-based services in their state to be highly adequate or even mostly adequate. In 2003, no system rated capacity highly adequate, and only 19% rated capacity as mostly adequate.

- Over time, there has been a decline in systems that require reinvestment of savings back into the system to increase service capacity (only 32% of the systems require this in 2003). Those requiring reinvestment are predominantly carve outs. In 2003, however, most systems reported that there are no savings to reinvest. State investment in service capacity development (apart from the managed care system) declined over time (53% of the systems reported state investments in 2003, a decline of 26% over 2000).

- Nearly all carve outs (91% in 2003), but only about half of the integrated systems (53%) reported that managed care has made it easier to provide flexible/individualized services.

- Nearly two-thirds (63% in 2003) of the managed care systems reportedly encourage or incorporate incentives for providers to use evidence-based practices. This is far more likely to occur in carve outs. The most commonly used strategies to promote evidence-based practices include providing training and/or consultation, developing practice guidelines, or monitoring through quality improvement protocols.

- Most managed care systems reportedly provide few services to young children and their families, despite a reported increase in EPSDT screening and increased national attention to early childhood mental health issues (74% in 2003 provide few services).

Attention to Children with Serious Behavioral Health Disorders

- The Tracking Project has identified many barriers to serving children with serious and complex disorders and their families (children with serious emotional disorders and children in the child welfare and juvenile justice systems). These include rigid and stringently applied medical necessity and clinical decision making criteria; fiscal incentives to underserve high-need populations; a tendency to emphasize short-term, time-limited treatment in managed care; lack of understanding of the special legal, logistical, coordination, and treatment needs of these groups; lack of risk adjustment mechanisms; lack of family focus in service delivery; and lack of special provisions, in particular higher capitation or case rates.

- Over time, more managed care systems engage in discrete planning for children with serious emotional disorders (74% in 2003), but fewer for children in child welfare or juvenile justice (47% and 35% respectively). Discrete planning for these populations is significantly more likely to occur in carve outs than in integrated systems.

- There has been an increase in managed care systems that reportedly incorporate special provisions for children with serious and complex behavioral health needs, such as intensive case management, wraparound process, interagency treatment and service planning, and an expanded service array. In 2003, 81% of the systems reportedly include special provisions for children with serious emotional disorders (compared with only 44% in 1995), 63% for children in child welfare, and 50% for children in juvenile justice. However, few managed care systems incorporate risk adjusted rates for these populations (31% in 2003).

- The majority of carve outs (90% in 2003) but less than half of the integrated systems (44% in 2003) facilitate and support the development and operation of local systems of care for children with serious behavioral health disorders.

- Carve outs are far more likely to incorporate system of care values and principles in the managed care system — broad service array, family involvement, individualized services, care management, and cultural competence.

Access

- Initial access to behavioral health services reportedly has improved in comparison to pre-managed care (86% of the systems in 2003).

- Over time, the Tracking Project has identified more problems associated with access to extended care services, though recent findings indicate some improvements in access to extended care, at least in carve outs. Improved access to extended care was reported in 71% of the carve outs but only 46% of the integrated systems in 2003. Still, one-third of the carve outs and half of the integrated systems report no change or more difficult access to extended care.

- Initial access to inpatient care typically is not reported as more difficult in managed care systems in comparison with pre-managed care; only 11% of the systems reported access to inpatient care as more difficult. However, lengths of stay reportedly are substantially shorter (in 80% of the systems in 2003). These reduced lengths of stay have resulted in a host of problems, such as premature discharge before stabilization, children discharged without needed services, placement of children in community programs lacking appropriate clinical capacity, and inappropriate use of child welfare shelters or juvenile justice facilities. Some declines in reports of these problems were noted in 2003.
- There has been an increase in the development of alternatives to hospitalization (11% increase from 2000 to 2003), such as crisis respite, crisis stabilization, mobile crisis response, partial hospitalization, wraparound, home-based services, therapeutic home beds, and intensive outpatient services. Carve outs are more likely to have developed alternatives to hospitalization.

Clinical Decision Making

- Over time, there has been a broadening of medical necessity criteria in managed care systems such that most now have medical necessity criteria that allow consideration of psychosocial and environmental factors in clinical decision making (89% in 2003). A problem identified by the Tracking Project was that, despite broad criteria, MCOs, particularly in integrated systems, continued to interpret and apply criteria narrowly. Improvement in this has been found; in most systems, criteria are now interpreted broadly (77% in 2003).
- There has been a steady increase in the percent of managed care systems that use child-specific clinical decision making criteria (94% in 2003) Almost all managed care systems use level of care criteria for children's mental health (97% in 2003), and about two-thirds use patient placement criteria for adolescent substance abuse (65% in 2003).
- Most systems continue to report using various management mechanisms. The most frequently used mechanism is prior authorization, although most systems now allow certain services without prior authorization (86% in 2003). Other widely used mechanisms are concurrent and retrospective reviews.

Service Coordination

- Improvement in coordination between physical and behavioral health care has been found in comparison with pre-managed care. Improvement was reported in systems with both carve out and integrated designs (67% overall in 2003) substantiating ongoing observations that improvement in physical-behavioral health coordination is not related to system design. Such improvements are related to specific strategies and provisions directed at coordinating physical and behavioral health care that are implemented regardless of design. Thus, contrary to common beliefs, simply adopting an integrated design does not guarantee that physical and behavioral health will be coordinated.

- Coordination between mental health and substance abuse reportedly has improved with managed care implementation, though more in carve outs than in integrated systems. A new area of exploration in 2003 suggests that coordination between mental health and child welfare also has improved, again more so in carve outs. In general, the Tracking Project has found improved interagency coordination as a result of managed care, attributed to the need to problem solve, particularly in carve outs.

Early Identification and Intervention

- The majority of systems (76% in 2003) conduct EPSDT screens within the managed care systems, and most EPSDT screens reportedly include some type of behavioral health component (90% in 2003).
- However, only about half (58% in 2003) of the systems reportedly include incentives or strategies to encourage primary care practitioners to conduct EPSDT screens and make appropriate referrals for behavioral health services.

Family Involvement

- Most carve outs (62–86% in 2003) reportedly include various strategies to involve families at the system and service delivery levels in managed care systems, such as requirements in RFPs and contracts for family involvement at the system level, requirements to involve families in planning and delivering services for their own children, family focus in service delivery, coverage for family supports, use of family advocates, and hiring families in paid staff roles. In contrast, nearly half of the integrated systems (44%) do not incorporate any of these strategies for family involvement.
- About half (49%) of the systems pay for services to family members if only the child is covered.
- Many carve outs (71% in 2003), but few integrated systems (19% in 2003), fund family organizations to play a role in managed care systems.
- Over time, the Tracking Project has found that managed care systems have had no particular impact (positive or negative) on the practice of relinquishing custody to access behavioral health services.
- Families reportedly are involved in quality measurement activities in some way in most managed care systems. The most frequently used mechanisms for involving families are completing surveys and participation in focus groups. More significant involvement through such mechanisms as involvement in the design and monitoring of quality processes reportedly occurs less frequently, and virtually only in carve outs.

Cultural Competence

- Most managed care systems include general requirements, as well as specific strategies, related to cultural competence. Most systems include translation and interpreter services (86% in 2003). Other strategies are found to a greater extent in carve outs than in integrated systems, such as requirements in RFPs and contracts related to cultural competence, training of MCOs and providers on cultural competence, including culturally diverse providers in networks, and including specialized services needed by culturally diverse populations.
- There has been a reported increase over time in planning for culturally diverse populations within managed care systems (56% in 2003, up 23% since 2000).

Providers

- In nearly two-thirds of the managed care systems, provider reimbursement rates reportedly are higher than pre-managed care (66% in 2003, a 43% increase since 2000).

- Reportedly, managed care implementation has not resulted in closure or severe financial hardship for provider agencies in most managed care systems, contrary to the frequent assertion that managed care has created wholesale financial hardship for providers. Reports of provider financial hardship or closure have decreased from 27% in 2000 to 14% in 2003.

- There have been complaints about increased administrative burden for providers identified through the Tracking Project, but some decrease in reports of increased administrative burden were found in 2003.

Accountability

- About one-third (30% in 2003) of all managed care systems (more than half of the integrated systems) reportedly do not have adequate data for behavioral health care decision making, attributed to a lack of adequate MIS systems, lack of encounter data, and lack of staff capacity to analyze data that exist.

- The most frequently tracked performance information includes child behavioral health service utilization and cost of child behavioral health services (92% and 66% in 2003).

- Most managed care systems (82% in 2003) measure family satisfaction, but only about half (55% in 2003) reportedly assess youth satisfaction.

- Most managed care systems reportedly are measuring clinical and functional outcomes (86% in 2003), but over half (53% in 2003) continue over time to remain in early stages of implementing their measurement systems in this area, indicating that systems are finding this challenging. Less than one-quarter of all managed care systems report having results from these efforts to date (22% in 2003).

Impact of Managed Care Systems

- A consistent finding, upheld in the most recent survey, is that most managed care systems do not as yet know what impact they are having on children's behavioral health care.

- About half or more of the systems do not know the impact of managed care on cost, quality, clinical and functional outcomes, or incorporation of evidence-based practices. Over a third do not know their impact on child behavioral health penetration rates or family satisfaction.

iii. Summary of Findings Related to Child Welfare Population

Inclusion of Children in the Child Welfare System in Managed Care

- Over time, more systems have included the child welfare population in managed care systems, with the exception of a slight decrease in inclusion of this population in 2003. Still, in 2003, nearly three-quarters (74%) of the systems include the child welfare population.

- The Tracking Project consistently has found that, in most systems, children in the child welfare and juvenile justice systems may lose eligibility for the managed care system based on their placement type, such as state-operated facilities, raising continuity of care issues for these children.

Planning, Coordination, and Special Provisions for Child Welfare

- Less than half of the systems (47%) reported a discrete planning process for children in the child welfare system, a decrease of 25% since 2000. However, the majority of systems include special provisions for children in the child welfare system (63% in 2003), although the percentage of systems with special provisions for children in child welfare has declined since 2000.

- About half of those with special provisions include interagency treatment and service planning, intensive case management, an expanded service array, and wraparound services/process, but only a third (33%) offer family support services for families involved with the child welfare system, and only 15% (6 systems) incorporate higher capitation or case rates for children in child welfare.

- Almost half of the managed care systems (42%) are responsible for screening children who enter state custody to identify mental health problems and treatment needs.

- About half of the systems provide training for MCOs about the specialized needs of children in the child welfare system (57% in 2003), and about half of the managed care systems include child welfare providers in managed care provider networks (54% in 2003).

- Nearly two-thirds (61%) of the systems noted that coordination between mental health and child welfare has improved; the remainder saw no effect of managed care on coordination between the two systems.

Service Coverage and Utilization for Child Welfare

- Consistently over time, the services least likely to be covered by managed care systems (i.e., they are covered by less than half of the systems) continue to be critical services for children/adolescents in the child welfare system — therapeutic group homes, behavioral aide services, respite services, and crisis residential services. Therapeutic foster care is covered by about half (59%) of the systems.

- Although most managed care systems cover both acute and extended care, consistently over time, the child welfare system is the system most likely to have resources and responsibility for providing extended care behavioral health services outside of the managed care system (83% in 2003).

- Nearly two-thirds of the managed care systems are tracking behavioral service use by children in the child welfare system (63% in 2003), the vast majority being carve outs.

Child Welfare Funding

- Child welfare agencies contribute more to the financing of managed systems, particularly in carve outs, than other child-serving systems with the exception of child mental health and, in 2003, substance abuse, contributing funds in 29% of the systems in 2003 (an 8% increase since 2000).
- In most managed care systems, child welfare reportedly has access to Medicaid outside of the managed care system (72% in 2003).

iv. General Update and Future Plans

Impact of Current Fiscal Climate

- Over three-quarters of managed care systems (78%) reportedly are experiencing detrimental effects as a result of the current fiscal climate in the country.
- Of the systems experiencing detrimental effects, about a third or more are reporting each of the following: reduction of services to non-Medicaid eligible children; elimination of specific populations from eligibility for the managed care system; reduction or elimination of coverage for certain services; incorporation or raising co-pays; decreased capitation rates paid to MCOs; implementation of more stringent management mechanisms; changes in drug formularies; lowered federal poverty level eligibility cut-off; or lowered provider reimbursement rates.
- The current fiscal climate may be associated with other findings of the 2003 survey, including:
  - A decline in parity
  - An increased focus on cost containment goals
  - Less coverage of the total Medicaid population, the SCHIP population, non-Medicaid populations, and high-cost/high-need populations
  - A decline in the percentage of systems to which the mental health agency contributes dollars
  - More use of full blown capitation
  - Fewer rate increases for MCOs
  - A decline in the use of risk adjusted rates and other risk adjustment mechanisms
  - More use of management mechanisms
  - Decline in investments in service capacity development

Perceptions of Success of Managed Care in Achieving Desired Goals

- Perceptions of state child mental health directors and Medicaid agency staff that responded to the 2003 survey are that managed care has been, on balance, moderately to mostly successful in achieving its goals. Carve outs reportedly have had greater success.

Future Managed Care Plans

- Not one respondent indicated that there were state plans to phase out managed care.

- In most cases (89%), the state plans to continue to use managed care technologies to manage behavioral health services. One state indicated it planned to move to a non risk-based system, and four states indicated they were planning to increase the use of ASO arrangements.

Appendix C

Key Findings from Research on Managed Care for Children's Behavioral Health

Sarah Hurley, M.A.
Youth Villages, Inc.
Memphis, TN

Tim Goldsmith, Ph.D.
Youth Villages, Inc.
Memphis, TN

Examining Behavioral Health Care Carve Outs: Differences in Costs, Services, and Outcomes Among Medicaid Recipients from Three States

In the mid-1990s, common wisdom held that the need in mental health services was for service coordination, in short, a managed care system (Behar, Macbeth, and Holland, 1993; Layne, 1994; Bickman, 1996a; Bickman, 1996b; Heflinger, 1996; Foster, Saunders and Summerfelt, 1996; and Morrisey, et al, 1997). It was widely thought that a managed care approach would not only be cost-effective (Behar, Macbeth, and Holland, 1993; Bickman, 1996b; and Foster, Saunders, and Summerfelt, 1996) but that treatment outcome would improve as well (Heflinger, 1996; Layne, 1994; Axelson, 1997). With the publication of the Fort Bragg Child and Adolescent Mental Health Demonstration (CAMHD) (Bickman, et al, 1995) the usefulness of the managed care model was questioned, specifically arguing that the model was no more effective than a fragmented model (Bickman, et al, 1996b). In this paper, we compare and contrast three managed care models implemented by a single service provider with funding from different state Medicaid programs.

While the effects of funding source on program participation (both length of stay and program mix) and outcome have been extensively discussed in the literature (Beck, et. al, 1998; Behar, et, al, 1993; Heflinger and Northrup, 2000), this study provides a unique comparison of clients in three different managed care systems receiving services from a single provider. Funding source often dictates programming available to recipients, the maximum allowed length of stay in the programs, and the setting in which the programs are delivered (Pandiani, et. al., 1997). Program mix, length of stay, and setting, in turn, have a profound impact on client outcome, as well as on client status at follow-up (Heflinger and Northrup, 2000; Pandiani, et al, 1997). This study examines data that were gathered from all clients discharged from a large behavioral health provider between July 1999 and June 2002, focusing on those who received Medicaid funding from one of three states. Following a description of the organization and the nature of the various Medicaid programs, program participation variables are examined, as are outcome and follow-up information. Also included is an analysis and discussion of the cost data related to provision of these services. This summary provides a brief overview of each of those sections.

The organization from which data were gathered provides a variety of behavioral health services to approximately 2,500 children per year in a five-state region. Programs include residential treatment centers, community-based group homes, therapeutic foster care, in-home intensive therapy, and adoption services. Funding for all services is provided by a wide variety of state and local public agencies, private insurance companies, and corporate and private donors.

Contractual agreements with state Medicaid programs assured that services were available to recipients, but also set the boundaries for program participation, length of stay, and rates of pay for each level of care. Children served by this organization from State A received treatment in a residential center, with limited aftercare provided in their home community by the organization. State B allowed funding for a limited number of recipients to receive in-home services, but most clients from that state received treatment in a residential center only. State C, which has a Medicaid waiver program, provided funding for innovative services in non-traditional settings, such as intensive in-home counseling utilizing an evidence-based treatment model (Multisystemic Therapy). While children from State C were eligible to receive services in residential facilities, most of the children from this state were served in their homes.

Children from the three states appeared to be quite similar at admission. In all three states, the largest percentage of children was diagnosed with Mood Disorders, the next largest category of diagnoses was Conduct Disorders, and in all states, the third largest category of diagnoses was ADHD and related Disorders. Evidence from several assessment instruments used at admission also pointed to the similarities of children from all three states. Examination of the Child Behavior Check List (CBCL) indicated that the mean score from all three states fell within the clinical range, although State B had a higher mean score than the other states. Data from the Youth Self Report (YSR) also pointed to similarities, with only insignificant differences between the states, and with mean scores from all three states falling within the area defined as "borderline". Scores from the Family Adaptability and Cohesion Scale (FACES-III) showed the mean score from all states to be within the clinical category on the dimension of "cohesion", and all to be within the normal range on the dimension of "adaptability". Of the nine dimensions of the Family Assessment Measure — General Scale (Fam-III:Gen), mean scores from each state fell within the "normal" range on six of them. However, the similarity of these children seemed to end there.

Findings demonstrated significantly different lengths of stay for children from the three different states. Despite the fact that State C children were more likely than children from other states to participate in more than one program during an admission, both the residential length of stay and the overall length of stay were shorter for these children. Program mix also differed by state, with children from State A receiving services only in a residential treatment setting from this provider, while children from State C most often received therapy in their home. Over 90% of children from State B received services only in a residential treatment center setting, while the remainder received both residential and in-home therapy.

Cost analysis showed a great disparity in the amount spent by the three different states on services from this provider. State A spent an average of $69,404 per child, State B spent $36,963 on average per child, and State C spent $12,584 per child on average. These differences are clearly mirrored in the different costs of the types of services

provided. State A's entire expenditure went to pay for residential treatment services, which are more costly than in-home therapy. The lion's share of State C's expenditures purchased in-home therapy for recipients. State B purchased mostly residential treatment, although some children from that state received in-home therapy. However, expenditures, by themselves, tell us little about the impact of the services on children and families.

Data concerning outcome at discharge and status at follow-up showed a clear pattern for the three Medicaid programs. At three data points (discharge, six months post-discharge, and twelve months post-discharge), children from State C were most likely to be at home or in a home-like setting. Over 91% of children from State C who received services from this provider were successfully discharged; 77.3% were still in successful placements twelve months post-discharge. This contrasts to 88.8% of the children from State A who were successfully discharged. At twelve months, 71.3% of the State A children were still in successful placements. Children from State B fell between the other two states: 89.9% were successfully discharged, and 72.7% were still in successful placements at twelve months post-discharge. While the differences are not statistically significant, they point to a clear pattern.

Other measures of success, such as out-of-home placement, trouble with the law, and school success were also examined for the three groups. These measures do not show as clear a pattern as placement, but do lend some support to the notion that State C, with its more innovative approach, had more success with children. For example, at both six and twelve months post-discharge, State C had the lowest percentage of children who reported being in trouble with the law (10.7% and 8.5% respectively). Also, State C had the highest percentage of children either in school or graduated at twelve months post-discharge. Children from State C had the lowest percentage of children who had out-of-home placements (including placements in residential treatment center, psychiatric hospital, group home, diagnostic center, or drug & alcohol treatment center) between discharge and six months. State C also had the lowest rate of children placed in correctional facilities both between discharge and six months, and between six and twelve months post-discharge. Taken together, these measures describe a substantially higher level of success for children from State C.

The mechanisms responsible for the seemingly higher level of success for State C's children warrant further study. It can be argued that, given the comparability of the children from the three different states upon admission into the program, the innovative approach of State C is at least partially responsible for the increased success of children from that state. However, it remains to be discovered why this approach seems to produce more favorable results. Also, it is important to examine the effects this approach might have on different populations of children. Such variables as mental health service utilization both prior to and following treatment, familial support, and availability and use of community supports would be important additions to this discussion. In addition, further analysis of the differences in the structure of the managed care systems in each state, and of the cost-effectiveness of services would significantly contribute to policy discussions concerning provision of mental health services to children.

John Landsverk, Ph.D.

Child and Adolescent Services Research Center, Children's Hospital, San Diego, CA
School of Social Work, San Diego State University, San Diego, CA

Caring for Children in Child Welfare: A National Study of the Impact of Organization and Financing Policy on Mental Health Service Provision

Overview for Linked Studies

This presentation describes the goals, methods, and early findings related to mental health care provision from two linked studies, Caring for Children in Child Welfare (CCCW) and the National Survey of Child and Adolescent Well-Being (NSCAW). NSCAW and CCCW provide nationally representative data of children investigated for child abuse and neglect in the United States, and the child welfare agencies that processed their cases.

NSCAW is the first national study of child welfare to collect data from children and families, and the first to relate child and family well-being to family characteristics, experience with the child welfare system, community environment, and other factors. The NSCAW protocol at baseline, 12, 18, and 36 months collects reported services use and outcomes data on mental health and developmental problems from several sources, such as parents, teachers, case workers, and youth themselves. However, NSCAW collects little information on how mental health services are organized, financed, or supplied in the study areas, thereby preventing any attempt to improve services through benchmarking, analyses of regional variation, or examination of mental health and child welfare policies related to mental health care. CCCW is a supplemental study to NSCAW that is funded by the NIMH and is collecting detailed contextual data at the state and local levels on the organization and financing of mental health care for children and adolescents involved with the child welfare system. It is linking this contextual information to the individual level survey data collected in NSCAW. Additionally, CCCW is collecting similar information on physical health and developmental services.

Methods for Linked Studies

The NSCAW sample design involved "a stratified two-stage sample, with the Primary Sampling Units (PSUs) being county CPS agencies and the Secondary Sampling Units being selected from lists of closed investigations or assessments from the sampled agencies." For the NSCAW study, children, age birth to 14, were randomly selected from those children who had contact with the child welfare system identified with the Primary Sampling Units (PSUs) within a 15 month period from October, 1999 through December, 2000. The 92 PSUs were sampled proportionate to size in 97 counties within 38 states across the United States. In almost all cases, the PSU and the county were identical. The multi-stage NSCAW sampling design will generate national estimates for the full population of children and families entering the child welfare system. The NSCAW cohort includes 6,231 children, age birth to 14 at the time of sampling, who had contact with the children welfare system within a 15-month period. These children were selected from two groups: 5,504 from those entering the system during the reference period following a child

protection investigation, and 727 from children who had been in out-of-home placement for about 12 months at the time of sampling. Both children who remain in the system and those who leave the system are being followed for the full study period of 36 months with face-to-face interviews at baseline, 18 and 36 months and a 12 month telephone interview.

The CCCW study has collected 780 key informant interviews in all states and counties that were randomly sampled and participated in the NSCAW parent study. The interview data include information on linkages between child welfare and mental health agencies as well as funding sources such as Medicaid, the structure of enrollment and benefits for mental health care financing, mental health screening and assessment protocols, and training in mental health issues for caregivers of children involved in child welfare. The CCCW contextual data will generate national estimates for the full population of child welfare agencies in the United States that agreed to participate and allowed first contact by research personnel.

Study Findings on Mental Health Care

All selected findings are presented as weighted estimates for the full national population of children involved with child welfare.

- Analyses of both the full baseline cohort and the 12 month out-of-home care cohort confirm prior findings from local studies that children involved with child welfare exhibit high rates of need for mental health care and also relatively high rates of use of such care. Almost half of children age 2 to 14 years were in the clinical range on the Child Behavior Checklist. In the baseline CPS cohort, only one-fourth received any specialty mental health care within the past 12 months. In the 12 month out-of-home cohort, over half were reported by their caregiver to have received specialty mental health care over the past 12 months. Clinical need as measured by the CBCL was highly related to receipt of services in both study cohorts. Effects of race (less use for African-American youth) and having a parent with severe mental illness (greater use) were found. These appear in two papers under review with Barbara Burns as the lead author for the baseline report and Laurel Leslie as the lead author for the 12 months in foster care report.

- Analysis of specialty mental health service use over the first 12 months since child welfare investigation has examined the impact of contextual variation in the 92 PSUs (mostly counties). The degree of coordination between local child welfare and mental health agencies, as measured by a count of 26 concrete indicators of linkage (e.g., co-location, MOUs) had a significant interaction effect on the use of specialty mental health services. In counties with strong interagency linkages, children and adolescents above the CBCL clinical cut-point were significantly more likely to receive services while those below the clinical cut-point were significantly less likely to receive services as compared to counties with weaker interagency ties. Additionally, in counties with stronger linkages, differentials in service utilization between African-American youth and white youth were diminished from the disparities observed in counties with weaker linkages. These findings suggest coordination between child welfare and mental health agencies is associated with a more efficient delivery system that shows greater impact of clinical factors and less impact of non-clinical factors (e.g., race) use of mental health care. The analysis is reported in a paper under preparation with Michael Hurlburt as lead author.

- An analysis of the impact of Medicaid managed care policies on access to outpatient mental health care has been conducted by Ramesh Raghavan as a dissertation in health policy at the UCLA Department of Health Services in collaboration with the CCCW study team. Youth in child welfare in counties that enrolled such populations into managed behavioral health plans showed lower use of specialty mental health care compared to youth in counties that did not. However, when the behavioral health plan was carved out, youth showed higher use of mental health care when compared to when the mental health benefits were part of the physical health benefit package, suggesting the complex impact of managed care.
- A paper published in Pediatrics (July, 2003, lead author Laurel Leslie) reports on CCCW data regarding comprehensive assessments for youth entering foster care. The percent of PSUs with policies promoting comprehensive mental health and developmental assessments was much lower (47.8%–57.8%) than the percent of PSUs who assessed all children for physical health problems (over 94%), with only 42.6% of PSUs reporting comprehensive physical, mental health, and developmental exams for all children entering out-of-home care.

Neva Kaye
Program Director
National Academy for State Health Policy

States Requiring Medicid Beneficiaries
Substance Abuse Services in State Medicaid and SCHIP Programs
Early Warning System (EWS)
Building Capacity

Study Intent

I have conducted and am conducting several studies of interest. The intent of these studies is to:

1. Identify which states require Medicaid beneficiaries, including children to receive behavioral health services from managed care organizations and whether those organizations deliver only behavioral health services or deliver behavioral health services as part of a comprehensive package of care.

2. Identify what mental health and substance abuse services are covered in State Medicaid and SCHIP programs.

3. Examine state experience in using the Early Warning System (EWS) developed by SAMHSA or a similar type of system to monitor the care delivered by managed care organizations.

4. Assist states in building the capacity of Medicaid programs to deliver care that supports children's healthy mental development. This project is more focused on children with less intense needs.

Study Method

The studies identified above use multiple methods, including:

1. Surveys of all 50 states regarding their Medicaid coverage and use of managed care. The managed care survey is now in the field for the sixth time.

2. A one-day summit of stakeholders from states that were identified as using an EWS or EWS-like system to discuss their experience implementing and operating such systems.

3. Development and support of a four-state learning collaborative to assist states.

Salient Findings

Regarding Coverage

The study of Medicaid and SCHIP coverage is still being conducted, but preliminary (draft) findings indicate that:

- All state Medicaid programs cover mental health services and almost all cover substance abuse services.

- Most states offer extensive coverage of mental health services in Medicaid and many have designed special benefits for crisis situations or to provide community support.
- Medicaid state plans usually report this coverage as a "rehabilitative" service and fewer report coverage as a "clinic" service.
- Plans for separate SCHIP programs do not define mental health and substance abuse coverage as specifically as Medicaid plans.
- Some separate SCHIP programs specify that the SCHIP program coverage mirrors Medicaid coverage, but others strictly limit coverage to commercial coverage.

Regarding Delivery System

Overall the number of States using managed care to deliver behavioral health services declined between 1998 and 2000. However, most of the decline is not attributable to a state decision to remove behavioral health services from a comprehensive package or the dismantling of a program that delivered only behavioral health services. Rather, most of the decline can be attributed to the dismantling of a comprehensive risk-based managed care program in four states (Georgia, Mississippi, Montana, and Vermont).

Delivery of Mental Health Services in Risk Programs: 1996–2000												
	1996				1998				2000			
	Outpatient		Inpatient		Outpatient		Inpatient		Outpatient		Inpatient	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Prepaid health plan	12	39%	11	38%	14	36%	15	38%	15	42%	16	48%
Full benefit in comprehensive MCO	14	45%	14	48%	16	41%	18	46%	14	39%	14	42%
Limited benefit in comprehensive MCO	11	35%	9	31%	16	41%	11	28%	15	42%	10	30%
Number of states covering service in risk programs	31	100%	29	100%	39	100%	39	100%	36	100%	33	100%

In 2000, nine states reported using multiple arrangements for outpatient and/or inpatient mental health services. Eight states reported using multiple arrangements for delivery of outpatient mental health services. Finally, seven states reported using multiple arrangements for the delivery of inpatient mental health services.

In some states (such as Missouri) the specific arrangement available to a beneficiary varied by geography. In others, such as Minnesota, it varied by eligibility group. Finally, some states, such as Massachusetts, required MCO enrollees to obtain mental health services from their MCO and PCCM program enrollees to obtain mental health services from the PHP.

Delivery of Substance Abuse Services in Risk Programs: 1996–2000						
	1996		1998		2000	
	Number	Percent	Number	Percent	Number	Percent
PHP	10	36%	10	27%	11	32%
Full benefit in comprehensive MCO	11	39%	19	51%	21	62%
Limited benefit in comprehensive MCO	11	39%	11	30%	11	32%
Number of states covering service	28	100%	37	100%	34	100%

In 2000, nine states reported using multiple arrangements for the delivery of substance abuse services.

Regarding use of EWS

The Summit, held in May 2002, revealed eight key findings regarding state experience implementing and operating EWS or EWS-like systems:

1. It is important that monitoring efforts can both (a) rapidly identify and address potential problems and (b) assess achievement of long term health and societal outcomes, outcomes that may not be measurable for several years.

2. Most of the tools needed to develop a system to rapidly identify and address potential problems that already exist.

3. Stakeholders are likely to identify three issues as being particularly important for early warning systems to focus on: (1) enrollee access to care, (2) the timeliness of provider payments, and (3) the cost of providing care. The relative importance of these three issues will change as a program is implemented and becomes established.

4. A need exists for standard reporting among states to provide comparative data, but states will also always need the flexibility to address local concerns.

5. An effective system to identify potential concerns must be able to identify unanticipated problems.

6. States have to balance the need to rapidly identify problems with the need to ensure that the data they use to make decisions accurately reflect contractor and program performance.

7. States must also balance the need for consistent reporting with the need to keep up with an evolving program and focus on issues that are currently important.

8. Routinely sharing performance data creates a starting point for working with consumers and advocates.

Regarding Building the Capacity of Medicaid Programs

This project is just getting underway. But already it has identified a huge interest among state Medicaid programs in improving their capacity to ensure young children's healthy mental development. Even in the midst of budget crises 26 states submitted letters of intent describing proposed projects and 11 of these were invited to prepare full proposals.

Colleen Sonosky
Senior Director of Programs and Policy
Children's Defense Fund

D. Richard Mauery, MPH, DrPh (cand.)
Senior Research Scientist
GWU Department of Health Policy
Center for Health Services Research & Policy

Negotiating the New Health System: Overview of Studies and Analyses of the Implications of Managed Care Contractual Relationships for the Delivery of Publicly Financed Behavioral Health Care Services to Children and Their Families

Intent of Study

In 1994, supported by grants from several funders,[1] a group of lawyers, health policy analysts, and health services researchers from The George Washington University Center for Health Services Research and Policy (CHSRP) began a project to map the evolving nature and structure of managed care. The material that formed the basis of this research consisted of the service agreements and requests for proposals (RFPs) between group health purchasers and managed care organizations (MCOs), as well as subsidiary agreements between MCOs and primary care and specialty network providers (e.g., behavioral health providers). The central purpose of the project was to investigate and document the ways in which stakeholders use contracts—the primary tools for demarcating the legal structure and boundaries of relationships—to attempt to influence the direction of the evolution of the modern health system. Four separate editions of Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts have been published to date. Two in-depth special reports that analyze contractual provisions in Medicaid managed care contracts for the delivery of mental illness and addiction disorder services to children and adults have also been published.[2]

Since its inception, the managed care contracting project (as it has come to be known) has grown beyond the study of Medicaid-sponsored plans to encompass a variety of managed care arrangements, including plans sponsored by the State Children's Health Insurance Programs (SCHIP), state and county mental health agencies, child welfare agencies, and employers. The project's studies have been used by Congress to restructure the managed care component of the Medicaid statute, as well as by the Centers for

---

[1] The original funders of the project were the Pew Charitable Trusts, the Annie E. Casey Foundation, the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Throughout the years, the roster of funders expanded to include: the David and Lucile Packard Foundation (for core support), the Health Resources and Services Administration (HRSA), the Center for Health Care Strategies, Inc., the Commonwealth Fund, and the Henry J. Kaiser Family Foundation.

[2] Rosenbaum, S., Shin, P., Zakheim, M., Shaw, K., and Teitelbaum, J. *Special Report: Mental Illness and Addiction Disorder Treatment and Prevention. Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 2nd Edition.* March 1998. Rosenbaum, S., Teitelbaum, J., Mauery, D.R. *Special Report: Mental Illness and Addiction Disorders and Medicaid Managed Care. Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Edition.* May 2000. Available at: http://www.gwhealthpolicy.org/bhib_series.html.

Medicare and Medicaid Services (CMS), other federal agencies and state Medicaid, public health, and mental health agencies. Federal and state agencies have used the research and tools generated by the project to guide managed care-related policy development and program formulation, particularly in the areas of public health policy and practice, behavioral health, and health services for underserved and vulnerable populations. Numerous focused reports have emanated from this effort, including a recent issue brief that analyzed behavioral health coverage for children in free-standing SCHIP contracts.[3]

A second phase of the project, added in 1998 in response to multiple requests for "model" contract language, developed a series of sample purchasing specifications for use in both general service and behavioral health contract development. The contract studies, as well as the purchasing specifications, also function as a means for helping state and local health officials, consumer organizations, and others understand the nature and structure of managed care and its effects on the larger world of public health policy and practice. Two sets of sample purchasing specifications have been developed and posted on CHSRP's website for children with behavioral health care needs and for children in substitute care (e.g., child welfare systems).[4]

A third phase of related health services research is currently underway to gain a greater understanding of the effects of contracting practices. For example, we recently conducted a study for the Center for Health Care Strategies, Inc. to assess how states' experiences as embodied in their contract documents are actually happening during program implementation and to identify promising approaches and creative problem-solving techniques for delivery of coordinated behavioral health care services.[5]

Study Methods

Contract Reviews

The project's work initially centered on a series of nationwide point-in-time studies of contractual arrangements between purchasers and MCOs, and between MCOs and their provider networks. The project examined two basic sets of master agreements: general service agreements and agreements governing behavioral health "carve-out" plans.[6] Generally, with the aid of expert reviewers, detailed analytic instruments that tracked the domains and sub-domains of each type of contract were developed. Lawyers trained in managed care contract analysis then reviewed the contracts against the instruments, tabulating the results and extracting the actual language of the agreements to permit comparative analysis. The result of these reviews was the creation of a large database (available on the Center's website) containing actual provisions of each agreement based on the review instrument.

---

[3] Rosenbaum, S., Sonosky, C., Shaw, K., and Mauery, D.R. *SCHIP Policy Brief #5: Behavioral Health and Managed Care Contracting Under SCHIP.* September 2002.

[4] *Purchasing Specifications For Children with Behavioral Health Needs.* December 2000. Available at: http://www.gwhealthpolicy.org/newsps/cbhn/. *Purchasing Specifications: Medicaid Managed Care for Children in Substitute Care.* December 2001. Available at: http://www.gwhealthpolicy.org/newsps/childwelf/.

[5] Mauery, D.R., Collins, J., McCarthy, J., McCullough, C., Pires, S. *Contracting for Coordination of Behavioral Health Services in Privatized Child Welfare and Medicaid Managed Care.* Center for Health Care Strategies, Inc. June 2003. Available at: http://www.chcs.org/publications/pdf/ips/childwelfare.pdf.

[6] Many reports emanating from this project have been published by CHSRP. See: http://www.gwhealthpolicy.org/managed_care.htm.

Purchasing Specifications

The process for developing over 25 sets of purchasing specifications began with guidance from experts in the field including federal and state officials, as well as representatives from state purchasers, private employers, managed care organizations, health policy researchers, consumers, and other federal agencies. Draft specifications were reviewed by a working group of the experts listed above and through a series of vetting meetings involving state Medicaid and public health officials, providers, MCO representatives, consumers, and experts in the service delivery of Medicaid managed care. The changes suggested at the vetting meetings were incorporated into the specifications. The specifica-tions are available on-line at http://www.gwhealthpolicy.org/newsps/.

Qualitative Research on Contracts Project

The research methods used in these types of studies generally include an assessment of the findings from the contract reviews or a particular analysis of documents for a specified delivery system (e.g., child welfare). These findings are then supplemented by case studies (including on-site interviews) with key stakeholders in Medicaid and the service delivery system at issue to illustrate how contractual expectations are playing out in practice.

Salient Findings

- Free-standing SCHIP contracts contain a much more limited level and scope of behavioral health services than do Medicaid managed care contracts, largely due to the absence of any EPSDT-type requirements in SCHIP. The families of SCHIP-enrolled children may be forced to "spend down" to meet Medicaid eligibility levels when their children's conditions grow sufficiently severe as to require intensive services not covered by SCHIP.

- Changing practice patterns and encouraging interagency and cross-system collaboration require contract language and visions that support system flexibility and agility as well as the willingness of agency heads, supervisors, direct line workers, providers, courts, schools, and families to adapt to both changing ways of managing agencies and of conducting care management that embraces both permanency and behavioral health treatment issues and priorities.

- Multiple categorical funding and reimbursement streams can create treatment "silos" that can hamper care coordination when children are perceived as "belonging" to one funding stream or another.

- Contract specifications, while critical, are only an essential first step to ensure effective care coordination for children with behavioral health needs and their families. Ongoing attention must be paid to implementation issues, how contract requirements are playing out in actuality, and to the factors that impede adherence to contract specifications.

Cynthia Fontanella, Ph.D.
University of Maryland, School of Social Work

The Impact of Maryland's Medicaid Managed Care Program on Rates and Patterns Psychiatric Readmission Among Adolescents

Summary Description

The growth of Medicaid managed care in the 1990s has led to substantial changes in the financing and delivery of behavioral health services for children and adolescents. Despite this rapid shift to managed care, few studies have investigated the effect of these changes on service provision for children with serious emotional disturbances. The primary aim of this study was to evaluate the effect of Maryland's behavioral health plan on patterns of psychiatric readmission of adolescents. Specifically, the primary aim of this study was to determine whether the rates and frequency of readmissions differed before (Fiscal year 1997) and after (Fiscal year 1998) the implementation of Maryland's Medicaid managed care program.

To achieve this objective, a non-concurrent prospective design was used. The sampling frame consisted of 881 Medicaid eligible adolescents consecutively admitted to three private psychiatric hospitals between July 1, 1996 and June 30, 1998. Adolescents were followed up for one year past their index admission to determine whether they were readmitted to any psychiatric hospital in Maryland. Data was drawn from hospital case records, Medicaid claims data files, and the Area Resource File.

Study findings indicated that there were no significant differences in the overall rates of readmission before and after the implementation of Maryland's Medicaid managed care program. The highest risk period for both years was within the first 15-30 days post-discharge (14% in 1997 and 13% in 1998). The cumulative one year rate of readmission was 33% for fiscal year 1997 and 38% for fiscal year 1998. There were, however, significant differences in the frequency of readmissions before and after the implementation of the managed care program. Adolescents who were admitted after the managed care were more likely to experience multiple readmissions. The proportion of adolescents who had two readmissions increased by 69% (5.1% in FY 1997 to 8.6% in FY 1998) and by 102% for adolescents who were readmitted three or more times (3.9% in FY 1997 to 7.9% in FY 1998).

Adolescents who were readmitted were likely to be younger, had more severe emotional and behavioral disturbances and/or comorbid mental retardation, came from higher risk families and had histories of childhood abuse. Type of aftercare services and living arrangements post-discharge were also important determinants of readmission. Across the continuum of mental health services, youths who were discharged to partial hospital programs, therapeutic foster care, or group homes were at increased risk for readmission compared to those who were discharged to residential treatment centers. It is noteworthy that one third of the youths who were discharged to partial hospitalization programs were readmitted within 30 days of discharge, suggesting that these type of

programs may fail to compensate for premature discharge. Moreover, youths who were discharged to therapeutic foster care were four times more likely to be readmitted. Overall, these findings highlight the need for research on "best practices" and evaluation of fidelity of treatment.

These findings have important policy implications and suggest that the managed care reforms may have failed to address the specific needs of youths with serious emotional disturbances who are high users of inpatient care and may require intensive longer-term services. The high incidence of 30 day readmissions, differing rates of readmission across hospital providers, and effect of different types of aftercare on readmission in this study suggest that youths may be prematurely discharged from inpatient facilities without adequate stabilization and/or that community-based services are inadequate.

Craig Anne Heflinger, Ph.D.

Associate Professor, Human and Organizational Development
Fellow, Vanderbilt Institute for Public Policy Studies
Vanderbilt University

Findings from the Managed Care for Vulnerable Populations Study

Adolescents with Substance Abuse

Vanderbilt has participated in two research projects sponsored by SAMHSA in the Managed Care for Vulnerable Populations Study to study the impact of managed care Medicaid.[7] This study consisted of 21 research sites in 10 states across the country, examining children with SED, adolescents with substance abuse, and related adult populations. We contributed to two of the major components: (1) a prospective study focusing on service use and outcomes of individuals enrolled in managed care and fee-for-service comparison groups, and (2) an administrative data study focusing on patterns of service use. The basis of the research findings described below are from our participation in the cross-site study of adolescents (ages 12–17) with Medicaid who were entering publicly funded substance abuse services: (1) interview data with 650 Medicaid adolescents across TN, PA, OR, and WA; (2) population-level Medicaid enrollment and encounter data for substance abuse services in TN, MS, OR, and WA.; and (3) implementation studies of the publicly-funded adolescent substance abuse treatment systems in these states.

The following is a summary of our findings:

- In adolescent substance abuse services funded by Medicaid, fee-for-service states had higher access than managed care states. However, all states were serving youth with substance abuse problems at a level far below the need.

Managed care, in this regression study of 1994–2000 Medicaid encounter data, had a negative impact on access to adolescent substance abuse services, with youth in managed care Medicaid states having a lower probability of use of services. The pattern of results also suggested strong regional variation in access for adolescents in the Medicaid system. All of the states served substantially fewer youth than national estimates of "need" for treatment, as defined by rates of abuse or dependence (7.7% or 77 per 1000) in the National Household Survey of Drug Abuse.[8] Oregon and Washington came the closest at 14 and 18 per 1000, respectively. Tennessee and Mississippi were below 10 per 1000, or a 1% annual access rate. Interestingly, the states that had the most substantial Medicaid

---

[7] See http://www.hsri.org/coord/coord.html.

[8] SAMHSA, 2000, reference forthcoming.

benefits packages, Tennessee and Mississippi, exhibited the least access among the groups. Generosity of Medicaid benefits packages, therefore, may be a poor proxy for assessing the accessibility of services for youth .[9]

- There are many critical players in the publicly funded system of adolescent substance abuse treatment.
    – In adolescent substance abuse services, Medicaid is joined by the SAMHSA Substance Abuse and Prevention Block Grant and other state sources to make up the publicly funded service system. However, these funding streams are poorly coordinated across the states.

Although most states have both Medicaid and a SAMHSA Substance Abuse Prevention and Treatment Block Grant to provide treatment for adolescents, the services covered and the roles of each payer differ widely across the states. However, these funding streams often are administered by separate state agencies and there is little coordination in planning or service delivery for this population.[10,11]

    – The juvenile court is the most frequent referral source for publicly funded substance abuse treatment.

Not only is the juvenile court a major referral source for publicly funded substance abuse treatment in both managed care and fee-for-service systems, they often refer directly to residential treatment.[12] Subsequent treatment and transition to aftercare services is poorly coordinated. As with state agencies, the juvenile justice system is seldom included in comprehensive planning for service delivery at the system or individual treatment level.[6]

Findings from the Managed Care for Vulnerable Populations Study: Children and Adolescents with Serious Emotional Disturbance

Vanderbilt has participated in two research projects sponsored by SAMHSA in the Managed Care for Vulnerable Populations Study to study the impact of managed care Medicaid.[13] This study consisted of 21 research sites in 10 states across the country, examining children with SED, adolescents with substance abuse, and related adult populations. We contributed to two of the major components: (1) a prospective study that compared service use and outcomes of individuals enrolled in Medicaid managed care and fee-for-service systems, and (2) an administrative data study focusing on patterns of service use for Tennessee (TN) (managed care) and Mississippi (MS) (fee-for-service).

[9] Heflinger, C.A., Saunders, R.C., Mulkern, V., Hughes, D., Gabriel, R., Deck, D., Wamber-Lacey, D., & Perry, P. (in review). Access to Medicaid-financed substance abuse treatment services for adolescents. Nashville, TN: Vanderbilt University.

[10] Adolescent Managed Care Study Group. (2001). *Meeting the Needs of Adolescents with Substance Abuse Problems in Managed Care and Fee-for-Service systems.* Cambridge, MA: Human Services Research Institute.

[11] Northrup, D. & Heflinger, C.A. (2000, December). *Substance Abuse Treatment Services for Publicly-Funded Adolescents in the State of Tennessee.* Nashville, TN: Vanderbilt Institute for Public Policy Studies, Center for Mental Health Policy. [available on line at www.vanderbilt.edu/VIPPS/CMHP/pdfs/TNPublicAOD.pdf

[12] Heflinger, C.A., Deck, D.D., Jernigan, J.C., & Hughes, D. (in revision). Which youth get residential treatment? Level of treatment restrictiveness by referral source for adolescents in substance abuse treatment. Nashville, TN: Vanderbilt University.

[13] See http://www.hsri.org/coord/coord.html.

The basis of the research findings described below are from our study of Medicaid children ages 4–17 in TN and MS: (1) interview data with 980 Medicaid children; and (2) population-level Medicaid enrollment and encounter data for behavioral health services.

The following is a summary of our findings:

- **High level of behavioral health needs**: We documented high levels of need among publicly funded children and adolescents in both managed care and fee-for-service settings. We selected a stratified random sample of children from the enrollment and encounter data and applied sampling weights to provide statewide estimates. The levels of health problems, serious emotional disorders, and co-occurring problems were found to be higher in the Tennessee and Mississippi Medicaid child populations than other estimates available through the literature on the general population. Overall, 26.2% of the TennCare and 22.2% of the Mississippi Medicaid population met the two-part criteria for having SED, with an additional 21.1% in Tennessee and 14.1% in Mississippi having significant emotional/behavioral of functioning problems, but not meeting criteria for SED.[14]

- **High levels of caregiver strain** were present for caregivers of children with SED, whether in MC or FFS programs. Caregiver strain has been shown in our and other studies to influence service use, with children of more strained caregivers more likely to receive restrictive care and more services, after controlling for child problems. Similar levels of caregiver strain were found in caregivers of youth with SED and caregivers of youth with substance abuse problems.[15] In addition, with the rise in kinship care among the general population and Medicaid children specifically, we found that other relative caregivers experienced similar levels and types of caregiver strain as did parents when they were caring for a child with SED.[16]

- **Overall access rates improved** over time in both MC and FFS states, but initial differences persisted, with TN remaining lower. TN substantially enrolled more children in Medicaid under the MC waiver and slightly increased access (measured as proportion of eligible children who used a service) to behavioral health for services during the time period when managed care was implemented.[17] However, overall access in TN (from 6.5 to 6.7% of the eligible population) remained lower than through the fee-for-service program in MS during the same time period (7.4 to 8.4%). Black and female children used services at a lower rate.[18]

---

[14] Heflinger, C.A., & Saunders, R.C. (in review). Physical and behavioral health needs of Medicaid children: High levels of needs and implications for policy and service delivery. Nashville, TN: Vanderbilt University.

[15] Heflinger, C.A., & Brannan, A.M. (in review). Differences in the experience of caregiver strain between families caring for youth with substance use disorders and families of youth with mental health problems. Nashville, TN: Vanderbilt University.

[16] Heflinger, C.A., & Richardson (in review). Caregiver strain in families of children with serious emotional disorders: Does relationship to child make a difference? Nashville, TN: Vanderbilt University.

[17] Saunders, R.C., & Heflinger, C.A. (in press). Access to and patterns of use of behavioral health services among children and adolescents in TennCare. *Psychiatric Services.*

[18] Saunders, R.C., & Heflinger, C.A. (2003). Medicaid behavioral health performance indicators for children: Effects of capitated managed care in the south, 1994-2001. Presented at Academy Health Services Research Conference, Nashville.

Patterns of service delivery differed between MC and FFS.

- **Specialized therapy service showed a decline in TN**. Children in TN had lower access than those in MS to inpatient/residential, day treatment, individual outpatient therapy, and group therapy, as well as lower average number of service days per child.[7,19]

- **TN increased access to support services**. TN increased access to case management (from 0.2% to 2.1% of the eligible population) at a greater rate than in MS, but TN started at a lower level and did not reach the same access rate as MS (from 2.7% to 4%).[7] TN increased access to family therapy, and there was a dramatic upswing in the use of medication management.[6] The access rate for medication management rose from 0.4% to 2.6%. This may reflect greater utilization of medication in the treatment of childhood mental disorders or an improvement in quality by providing a supportive service to match existing rates of medication treatment. In combination with the decreasing IP, OP, DT, and group therapy in TN, it may show the substitution of these support services for actual therapy/specialized services.

- **Caregiver strain was a powerful predictor of service use, especially in TN**. The child and family factors that influenced service use varied between TN and MS.[8] While child clinical issues were usually the most influential factor of both probability of any service use and the number of days used, caregiver strain was a more powerful predictor overall and in specific types of service use in TN compared to MS – perhaps this is an indication that when there are restrictions to service use, the amount of strain experienced by the caregiver becomes a more powerful determinant.

- **Access in both states remained far below the need**. With TN and MS demonstrating a rate of SED at 22–26%,[3] yet overall access at 7–8%, less than one-third of children "in need" received a service.[7]

- **Parents of children with SED were less satisfied in MC Medicaid programs**. In a cross site study that included parents of children with SED in TN, MS, and PA, parents of children with SED in MC Medicaid programs were significantly less satisfied with Medicaid than were parents of children with SED in FFS Medicaid programs.[20]

[19] Brannan, A.M., Heflinger, C.A., & Schweitzer, T. (2001). Child and family predictors of service use in two service systems: Role of caregiver strain. Presented at the Children's Mental Health Services Conference, Tampa.

[20] Heflinger, C.A., Simpkins, C.G., Scholle, S.H. & Kelleher, K. (in press). Parent/caregiver satisfaction with their child's Medicaid plan and behavioral health providers.

Julie Collins
Child Welfare League of America

Intent of the CWLA Management, Finance and Contracting Surveys

Study Summary

In 1996, CWLA began to systematically identify, track, and describe child welfare initiatives that changed the management, finance and delivery of child welfare services, with a focus on examining initiatives that incorporated tools or technologies common to managed care. The goals were to identify how public child welfare agencies were planning and implementing managed care financing models for child welfare services; to track and report changes that were occurring; and to identify and promote promising approaches under new financing and management arrangements.

Through a five-year grant from the Center for Health Care Strategies (CHCS), CWLA was given the opportunity, beginning in 2000, to expand its research activities related to behavioral health issues and to collaborate more closely in reporting findings with two other related research projects funded in part by the CHCS—the Health Care Reform Tracking Project (HCRTP) and with the George Washington University Center for Health Services Research and Policy (GWU). In addition to support for the CWLA 2000–2001 Management, Contracting, and Finance Survey and the publication of findings, CHCS also funded the development of two issue papers.

Methodology

In October 2000, CWLA mailed the survey to all state child welfare administrators or their designees and to county contacts in county-administered states. Information was gathered between October 2000 and September 2001.

Survey data were supplemented by telephone and additional information from public documents, such as requests for proposals (RFP) or contracts that were provided by the respondent, and from other national studies, including those of the HCRTP partners. Several states also have ongoing independent evaluations under way, and findings from several of these reports were incorporated. In fall 2001, aggregate data were analyzed, and narrative profiles developed for each state and county that responded to the survey.

Because Medicaid is the primary funding source for many of the behavioral health services that children and families involved with the child welfare system receive, they are directly affected by the proliferation of public sector managed care initiatives. The 2000 survey instrument was revised and expanded from previous years to better address health and behavioral health issues. The survey included an expanded section on the perception of respondents about how well managed care systems were working to meet the health needs of children in the child welfare system. The intent was to understand better the linkage between child welfare initiatives and various managed behavioral health care reforms and to assess the level of child welfare involvement implementing health care reforms. The findings from this portion of the CWLA survey were compared to findings

from the 2000 HCRTP survey. The HCRTP surveyed state child mental health representatives, and the CWLA survey respondents were state or county child welfare administrators. Findings related to broad trends from both surveys were compared. However, many of the states responding to the HCRTP survey did not respond to the CWLA survey. In total, information was collected from 42 states, but only 17 states were analyzed by both surveys.

This session highlights the behavioral health findings from the CWLA 2000–2001 Management, Contracting, and Finance Survey report.

Salient Findings Related To Behavioral Health

The CWLA survey asked whether child welfare respondents had knowledge of the prevalence of behavioral health problems in the children and families served by child welfare. For the most part, states and counties reported they do not have the capacity to track or report key data related to behavioral health needs. For example:

- Less than 40% of the respondents indicated that their states or counties have the capacity to assess and report the percentage of children and adolescents served by the child welfare system with serious and complex mental health care needs.

- Less than one-third of respondents reported the capacity to assess the degree to which parental mental health and substance abuse problems are a primary reason for referral and placement of the child.

- More than half of the states reported that parents relinquish custody for the purpose of accessing behavioral health services, but only one state could report how often this practice occurs. Managed care reforms appear to have had little effect on this practice.

The CWLA 2000 survey included an expanded section on the perceived effects of managed care on children and families involved with the child welfare system.

- More than 60% of respondents to the CWLA survey indicated that children in the child welfare system are included in Medicaid managed care plans for physical health care services. It is not clear what effect managed care plans have on the ability to obtain needed health care services for children in the child welfare system.

- Both the CWLA and HCRTP surveys found that eligibility for managed care plans may change as the child moves into and out of different placement types, creating the potential for gaps and fragmented services.

- Most child welfare respondents do not know how managed care reforms have affected access to acute and extended care services, but 25% of those that did respond believe that managed care has made it more difficult to access both types of services. This finding is partially supported by the HCRTP survey, in which agreement was found about the difficulties in accessing extended care services.

- Managed care plans may create unintended consequences for child welfare populations, including making it more difficult to access inpatient care, inappropriately shortening lengths of stay, and increasing the likelihood that children will not get the services they need.

- Both surveys found that child welfare providers are often included in the behavioral

health reform networks (53% of the HCRTP respondents and 43% of the CWLA respondents) but they are still excluded almost half the time.

- Only 26.7% of CWLA respondents noted an improvement in coordination as a result of managed care; that is double the number of respondents who believed it has worsened. The HCRTP survey found more than 65% of its respondents reporting improvement, attributed mostly to the urgent need to problem-solve during implementation. Both surveys showed that cross-training between the MCOs and child-serving agencies is occurring in most initiatives.

With the broadening of the eligible population in managed care reforms, there comes an increased likelihood that initiatives are using blended funds from diverse sources. Specifically, there has been a blurring of lines between what are "child welfare" and what are "behavioral health" initiatives for children. In fact, many of the initiatives reported in the CWLA survey overlap with those described in the HCRTP survey. It is quite a promising finding that both child welfare and mental health representatives identified the initiatives as "theirs." Both the CWLA and the HCRTP surveys asked a number of questions about funding for managed care systems.

- Both surveys found that few (less than 14%) managed care reforms reportedly include financial incentives to account for the special needs of this population.
- Child welfare funds contributed to about a quarter of the behavioral health managed care reforms. Most child welfare systems continue to have access to behavioral health funding outside the managed care plans, including Medicaid.
- Respondents in both surveys believe that cost shifting occurs, but few states or counties reported that they have mechanisms to actually track it.
- Whereas 64% of HCRTP respondents indicated that the reforms included clarification of payment and service responsibility, only 14% of CWLA respondents thought managed care reform had actually clarified these issues.

Charlotte McCullough
McCullough Associates

Reporting and Collaboration for Findings of Behavioral Health and CWLA

Study Summary

Through a five-year grant from the Center for Health Care Strategies (CHCS), CWLA was given the opportunity, beginning in 2000, to expand its survey related to behavioral health issues and to collaborate more closely in reporting findings with two other related research projects funded in part by the CHCS—the Health Care Reform Tracking Project (HCRTP) and with the George Washington University Center for Health Services Research and Policy (GWU). In addition to support for the CWLA 2000–2001 Management, Contracting, and Finance Survey and the publication of findings, CHCS also funded the development of two issue papers. The purpose of the Issue Papers is to distill findings from the CWLA surveys and from the related activities of the HCRTP and the GWU contracting study into a technical assistance resource for states and communities as they develop or refine their child welfare initiatives or Medicaid managed care reforms to better serve children and families involved with the child welfare system.

Methodology for Capturing Information on Risk-Based Contracting Options

No single feature is more identifiable with Medicaid managed care reforms or dominant in child welfare initiatives than new financing and contracting arrangements. Both the CWLA surveys and the HCRTP activities have examined funding sources and risk-based financing arrangements that are used in Medicaid reforms and child welfare initiatives.

The following finance and contracting findings draw upon data and analysis contained in the CWLA 2000–2001 survey report; the activities of the HCRTP, including its most recent survey report and the Promising Approaches Series; the recently completed GWU contracting study, and findings of other national studies, particularly a recent report by the Children's Rights Organization.

Salient Findings Related to Child Welfare and Medicaid Managed Care Financing and Contracting Practices

Medicaid managed care reforms and new risk-based child welfare initiatives continue to present both opportunities and challenges for children's services.

- One of the more promising findings from the 2000 CWLA survey was the number of multi-system risk-based initiatives that were based on system of care principles. Many of these reforms were also reported to the HCRTP, indicating that both child welfare and mental health agencies view the reform as "theirs."
- Risk-based contracting arrangements are commonplace in both child welfare and Medicaid managed care reforms, but with new twists that more directly link payment schedules or amounts to performance. The 2000 CWLA survey revealed that over

90% of the child welfare initiatives included changes in contracting practices to create incentives for performance. There is an increased focus on purchasing results that relate to child welfare legal mandates.

- Many child welfare initiatives include more than one mechanism to align payment with desired results but the CWLA surveys have consistently found the most common risk-based financing model in child welfare is a case rate. Similar to the child welfare findings, most Medicaid managed care reforms (88%) also use some type of risk-based financing, with the HCRTP finding that 62% are using capitation and 26% are using case rates. Performance incentives related to children's behavioral health are being used in 27% of Medicaid managed care reforms, with carve out plans more likely to do so than integrated reforms. Carve outs were also more likely to use non risk-based financing and case rates.

- In many instances, fiscal goals in both child welfare and managed care reforms are balanced with goals that stress improved child and family outcomes. When incentives are included, they are often tied to system performance areas that would reflect a more child and family friendly service system. In general, child welfare initiatives appear to have more in common with carve outs than with integrated managed care reforms in terms of selecting fiscal goals and financing options.

- Child welfare initiatives are far more likely than Medicaid managed care reforms to introduce mechanisms to limit a contractor's risk. 85.7% of the child welfare initiatives include some mechanisms to limit risks. In contrast, the HCRTP found that only one-fifth of Medicaid managed care reforms reported any risk-adjustment mechanisms and less than 15% used risk corridors or stop-loss. Less than a third of reforms use risk adjusted rates for high need populations of children, such as children in the child welfare system.

- In child welfare contracts, initial rates have often been developed with inadequate data or risk modeling tools. It appears when rates change under new child welfare finance arrangements, the change is more likely to result in increased rates for lead agencies and/or individual providers. This finding is partially consistent with findings of the HCRTP in which most Medicaid managed care reforms that had changed rates to MCOs reported that rates had gone up (80%).

- Risk arrangements in child welfare initiatives may change during the contract term or during re-bids as both public agencies and contractors gain experience. There are some indications that the level of risk may be reduced when changes are made. This finding is consistent with the HCRTP finding that some Medicaid managed care reforms, especially carve outs, are moving away from capitation as they enroll more populations with serious and complex needs.

- There does not appear to be a one-to-one relationship between fiscal assumptions and performance. Some child welfare initiatives were not designed explicitly or intended to save money, but they have, whereas others were intended to be cost neutral and have in fact cost more. Only 3 states expected the initiative to cost more than the previous system, but fiscal performance data indicate that 10 initiatives cost more. In a similar finding, the HCRTP found increases in the total cost of children's behavioral health services in about 24% of reforms, decreases in 19% of reforms, and a constant level of costs in 16% of reforms. A striking finding is that 41% of respondents reported that they did not know the impact of the Medicaid managed care reform on the total cost of child behavioral health services.

- There are also significant differences in the types of agencies that bear risk and in the way risk-based contracts are structured. In the vast majority of child welfare initiatives, the public agency has partnered with nonprofit agencies, functioning as "lead agencies" (similar to managed care organizations in Medicaid reforms). Less than 10% of the child welfare initiatives share financial risk with for-profit entities. This is in stark contrast to the HCRTP finding that for-profit entities retain a significant role in most reforms. The entity least likely to function as an MCO in Medicaid managed care reforms is a community-based, private, nonprofit agency, exactly the type of entity that is most likely to play the lead role in child welfare.

Judith Cook
University of Illinois at Chicago
Department of Psychiatry

Effects of Managed Behavioral Healthcare Arrangements

Study Description

Although Medicaid-funded managed care arrangements are commonly used in the delivery of mental health and substance abuse services to low-income children and youth, little is known about the effectiveness of such efforts. This study explored the effects of managed behavioral healthcare arrangements on Medicaid-funded children with mental health and substance abuse difficulties. Two major research questions guided the analysis. First, do children with SED who receive services in MC versus fee-for-service (FFS) settings differ in regard to their mental health and functional impairment statuses? Second, does utilization of behavioral health services vary according to whether the child receives services in a MC versus FFS setting?

Data came from the Substance Abuse and Mental Health Services Administration-funded Managed Behavioral Health Care in the Public Sector Study. Principal Investigators (PIs) from five sites (Pennsylvania, New York, Ohio, Oregon, and Tennessee/Mississippi), a PI from the University of Illinois at Chicago (UIC) data Coordinating Center, and a consumer representative from the Federation for Families comprised the study's Steering Committee (SC). The SC was charged with developing, administering, and overseeing the analysis of a common protocol (CP) of research instruments. At each site, Medicaid-eligible children with SED were enrolled in MC or FFS behavioral health plans. Interviews with the children's caregivers elicited information about services used by these children in the six months prior to study enrollment and during the period between enrollment (baseline) and six-month follow-up, as well as the caregivers' ratings of the child's mental health status at baseline and follow-up. Interviews with children with SED age 11 years and older elicited information regarding substance use, perceptions of their own mental health, and their opinions about their behavioral health care plan. Sites varied according to the specifics of the MC and FFS arrangements at each location, the types of children with SED that were studied, the nature of caregivers who were interviewed, the ways services were funded, and the political and social climate at each location.

Major Findings

A major finding of this study is that the child's enrollment in state- or county-wide MC programs did not have a major effect on the child's functioning and psychiatric status. Study findings suggest that children with SED enrolled in Medicaid-financed MC versus FFS behavioral health care plans do not differ significantly in levels of functional impairment or psychiatric symptomatology at the time of follow-up. Instead, it appears that the child's initial mental health and functional status at Time 1 had a much stronger effect on the child's psychiatric and functional status at follow-up than did any other variable.

Another major finding of this study is that the MC study condition was significantly and consistently predictive of lower utilization of most services, even controlling for child need, household, and site variations. In the models predicting children's mental health service

utilization, the likelihood of service use at follow-up was greater for children in FFS (versus MC) plans when the service studied was inpatient/residential treatment, psychiatric medications, and nontraditional services. These study condition effects were significant even when controlling for need variables, such as baseline levels of functional impairment, total mental health symptoms, and use of drugs and alcohol. In addition, study condition effects were not influenced by controlling for study site, except that the statistical significance of the lower likelihood of psychiatric medication use diminished slightly. Thus, study condition was a noteworthy predictor of all but outpatient services utilization, with the children in the MC condition being less likely to have used most types of services examined.

An exception to these findings was the likelihood of use of traditional outpatient services, defined as visiting a mental health professional in a community mental health center or other office setting. This service was equally likely to be used by children enrolled in MC and FFS plans, suggesting that this comparatively lower cost service may be more equitably available to children who need it, regardless of type of behavioral health plan membership.

Doreen Cavanaugh
Institute for Health Care Research & Policy
Georgetown University

Massachusetts Adolescent Substance Abuse Treatment Study: A Component of the SAMHSA—Sponsored 21 Site Study on Managed Behavioral Health Care and the Public Sector

Methods

Three main research methods:

- Semi-structured interviews
- Focus group
- Document review

Preliminary Findings

- DPH funds adolescent substance abuse prevention and youth intervention
- Acute adolescent substance abuse treatment for low-income youth funded by MassHealth
- Responsibility for adolescent substance abuse continuing care unclear

Access/barriers to adolescent substance abuse treatment

- Lack of knowledge on how to find substance abuse services
- Inadequate amount of substance abuse services across all levels of care
- Substance abuse treatment program characteristics
- Discrepancies in payment for services
- Difficulties associated with adolescents with multiple problems including adolescents "stuck" in acute hospital care

Substance Abuse Program Treatment Characteristics

- Too many rigid rules
- Family dynamics
- Culturally and ethnically appropriate services
- Voluntary admissions

Interagency Coordination

- There is no single agency and no single point of entry for adolescents needing substance abuse services.
- Currently there is confusion about agency roles and responsibilities.
- Existing coordination mechanisms are informal and vary by region.

Summary of Key Issues

- Quality of adolescent substance abuse treatment
- Definition of adolescent substance abuse treatment
- Research needs
- Clinical aspects of treatment
- Clinical assessments
- Readiness for treatment
- Engaging youth in treatment
- Mandated treatment
- Financing drives the range of services offered
- Extensive network of substance abuse prevention services
- Possible emphasis on primary prevention may be in part due to SAPTBG language
- MCO's substance abuse treatment benefit dependent on:
- State's choice of federal Medicaid optional services
- Contracting language
- Continuum of acute services in MA has expanded but still not enough services
- Continuity of care, service availability differs by region
- Many adolescents receive services from more than one agency
- No parallel state agency structure
- Differing perceptions of agency responsibility causes confusion
- DPH in process of reviewing role and responsibility
- DPH relationship with DMA greatly improved
- DPH providers may absorb the stress

Dissemination Ideas

- Identify where fairly large conferences are being held by federal agencies or divisions that should have this information as use as vehicles for disseminating the recommendations (e.g., CMS conferences for systems change grants March 2–3 in Baltimore, managed care organization conferences, Behavioral Health Tomorrow conference)
- Use strategic mailing lists to disseminate recommendations (e.g., state agencies, MCOs, BHOs)
- Use technology and long-distance learning strategies (e.g., Georgetown's telephone conferences)
- Disseminate to key associations including NASMHPD, NAPCWA, NASADAD, State Medicaid Directors, American Psychological and Psychiatric Associations, Academy of Child and Adolescent Psychiatry, AMBHA, National Council of Community Behavioral Health , Rural Health Roundtable, Home and Community-Based ListServ, NASW
- Provide brief documents in user-friendly terms
- Disseminate information in public health, social work, business administration and other graduate schools that have public sector programs

- When a draft of the consensus conference report is sent to group, include a form to solicit ideas and contact information for dissemination opportunities
- Disseminate information to Work Group at SAMHSA that is developing implementation plan for President's Commission on Mental Health
- Link dissemination activities with NCQA

Appendix D

Participants of Consensus Conference

Kamala Allen
Mary Armstrong
Marilyn Benoit
Mary Bruce Webb
Jeffrey Buck
Rebecca Carman
Doreen Cavanaugh
Peggy Clark
Julie Collins
Judith Cook
Christina Corps
Terry Cross (contact info unavailable)
Richard Dougherty
Holly Echo-Hawk
Michael Faenza
Cynthia Fontanella
Mike Foster
Robert Friedman
Lewis Gallant
Vijay K. Ganju
Sophia Gatowski
Bill Goldman
Sybil Goldman
Tim Goldsmith
Bonnie Gracer
Katherine E. Grimes
Darcy Guattadero
Craig Ann Heflinger
Regina Hicks
Pat Hunt (contact info unavailable)
Sarah Hurley
Carolyn Ingram
Neva Kay
Chris Koyanagi
John Landsverk
Cindy Lederman
Meredith Lee
Nancy Lucas
Gary Macbeth
Ken Martinez
Richard Mauery
Jan McCarthy
Patrick McCarthy
Charlotte McCullough
Kathy McHugh
Candice Nardini
Mary Nelson
Russ Newman (contact info unavailable)
Trina Osher
Sheila Pires
Kathy Pottick
Charles Ray
Rolando Santiago
Dorn Schuffman
Diane Sondheimer
Colleen Sonosky
Glenn Stanton
Beth Stroul
Rita Vandervort-Warren
Ginny M. Wood

Kamala Allen, M.H.S.
Program Director
Civic Center for Health Care
Strategies
P.O. Box 3469
Princeton, NJ 08543
Phone: 609-895-8101
kallen@chcs.com

Mary Armstrong, Ph.D.
Associate Director of Research
Director
Division of State & Local Support
Department of Child & Family
Studies
Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612
Phone: 813-974-4601
armstron@fmhi.usf.edu

Marilyn Benoit, M.D.
President
AACAP
3615 Wisconsin Ave. NW
Washington, D.C. 20016
Phone: 202-607-3032
Fax: 202-363-4621
bartolom@aol.com

Mary Bruce Webb, Ph.D.
Senior Research Analyst
ACF Child Outcomes Research
Evaluation OPRE
370 L'Enfant Promenade
Washington, D.C. 20447
Phone: 202-205-5628
mbwebb@acf.hhs.gov

Jeffrey Buck, Ph.D.
Associate Director
CMHS/SAMHSA
5600 Fishers LN, 15–87
Rockville, MD 20857
Phone: 301-443-3138
Fax: 301-480-8296
jbuck@samhsa.gov

Rebecca Carman
Research Associate
Georgetown University Center for
Child and Human Development
3307 M Street NW, Suite 401
Washington, D.C. 20007
Phone: 202-687-8510
rac39@georgetown.edu

Doreen Cavanaugh
Assistant Professor
Georgetown Institute for
Health Care Research & Policy
Georgetown University
1 Davol Square, Suite 5
Providence, RI 02903
Phone: 401-454-0881
Fax: 401-331-2745
DC address:
2233 Wisconsin Avenue
Washington, DC 20007
Phone: 202-687-0880
dac48@georgetown.edu

Peggy Clark, M.S.W., M.P.A.
Technical Director
Disabled & Elderly Health Program
Center for Medicaid & Medicare
Services
State Group Operations
7500 Security Blvd.
Mailstop S2-14-26
Baltimore, MD 21244
Phone: 410-786-5321
Fax: 410-786-3262
pclark@cms.hhs.gov

Julie Collins, M.S.W., L.C.S.W.
Mental Health Coordinator
Behavioral Health Division, CWLA
50 F Street NW 6th Floor
Washington, D.C. 20001
Phone: 202-639-4932
Fax: 202-737-3687
jcollins@cwla.org

Judith Cook, Ph.D.
  Professor/Psychiatry
  University of Chicago
  104 S Michigan Ave., Suite 900
  Chicago, IL 60603
  Phone: 312-422-8180 ext. 19
  Fax: 312-422-0740
  cook@ripco.com

Christina Corps, PA
  Director
  Delaware County Parents
  Involved Network
  135 Long Lane
  Upper Darby, PA 19082-3116
  Phone: 610-713-9401 Ext. 101
  Fax: 610-713-9405

Richard Dougherty, Ph.D.
  President
  Dougherty Management
  Association, Inc.
  9 Meriam Street, Suite 4
  Lexington, MA 02420
  Phone: 781-863-8003
  Fax: 781-863-1519
  dickd@doughertymanagement.com

Holly Echo-Hawk, M.S.
  Senior Mental Health Consultant
  NICWA
  16715 Leapen Road
  Vancouver, WA
  Phone: 360-571-3203
  Fax: 360-571-3183
  echohawk@pacifier.com

Michael Faenza
  National Mental health Association
  2001 Beauregard St.
  Alexandria, VA 22311
  Phone: 703-838-7500
  Fax: 703-683-9061
  mfaenza@nmha.org

Cynthia Fontanella, Ph.D.
  4705 Creekside Circle, 201
  Owings Mills, MD 21117
  Phone: 410-902-0664
  cfontanella@msn.com

Michael Foster, Ph.D.
  Associate Professor, Health Policy
  & Administration
  Pennsylvania State University
  116 Henderson Building
  University Park, PA 16802
  Phone: 814-865-1923
  Fax: 814-863-2905
  emf10@psu.edu

Robert Friedman, Ph.D.
  Chair
  Department of Child &
  Family Studies
  Louis de la Parte
  Florida Mental Health Institute
  13301 Bruce B. Downs Blvd.
  Tampa, FL 33612
  Phone: 813-974-4640
  Fax: 813-974-4406
  friedman@fmhi.usf.edu

Lewis Gallant, Ph.D.
  Executive Director, NASADAD
  808 17th Street, NW, Suite 410
  Washington, D.C. 20006
  Phone: 202-293-0090 ext. 109
  Fax: 202-293-1250/3210
  lgallant@nasadad.org

Vijay Ganju, Ph.D.
  Director
  Center for Mental Health Quality
  and Accountability
  NASMHPD Research Institute
  66 Canal Center Plaza, Suite 302
  Alexandria, VA 22314
  Phone: 703-739-9333 ext. 132
  Fax: 703-548-9517
  vijay.ganju@nri-inc.org

Sophia Gatowski, Ph.D.
  Assistant Director
  Permanency Planning for
  Children Department
  National Council of Juvenile &
  Family Court Judges
  University of Nevada
  P.O. Box 8970
  Reno, NV 89507
  Phone: 775-327-5305
  Fax: 775-784-7530
  sgatowski@ncjfcj.org

Bill Goldman, M.D.
  Clinical Professor of Psychiatry
  University of California
  Consultant United Behavioral
  Health
  13 Channing Way
  Sausalito, CA 94965
  Phone: 415-331-5045
  Fax: 415-331-7350
  wkgoldman@yahoo.com

Sybil Goldman, M.S.W.
  Director of Evaluation
  SAMHSA
  5600 Fishers Lane 13 C26
  Rockville, MD 20857
  Phone: 301-443-7023
  Fax: 301-480-1554
  sgoldman@samhsa.gov

Tim Goldsmith
  Clinical Director
  Youth Villages
  5515 Shelby Oaks
  Memphis, TN 38144
  Phone: 901-252-7672
  Fax: 901-252-7620
  tim.goldsmith@youthvillages.org

Bonnie Gracer, M.A., M.S.W.
  U.S. Department of Education
  Office of Special Education and
  Rehabilitative Services
  National Institute on Disability and
  Rehabilitation Research
  400 Maryland Avenue, SW (MES
  3033-B)
  Washington, DC 20202
  Phone: 202-205-5449
  Fax: 202-205-8515
  TTY: 202-260-8859

Katherine Grimes, M.D.
  Medical Director MHSPY Program
  253 Sumner Street
  Boston, MA 02210
  Phone: 617-204-1409
  Fax: 617-255-5515
  katherine_grimes@hms.harvard.edu
  katherine_grimes@nhp.org

Darcy Guattadero, J.D.
Director
Child & Adolescent Action Center
NAMI
210 F Wilson Blvd., Suite 300
Arlington, VA 22201
Phone: 703-516-7965
Fax: 703-524-9093
darcy@nami.org

Craig Ann Heflinger, Ph.D.
Associate Professor
Vanderbilt University
Peabody College #90
230 Appleton Pl
Nashville, TN 37203-5701
Phone: 615-322-8275
Fax: 615-343-2661
c.heflinger@vanderbilt.edu

Regina Hicks, Ph.D.
Project Director
American Institute For Research
Technical Assistance Partnership
1000 Thomas Jefferson St. NW
Washington, D.C. 20007
Phone: 202-944-5381
713-729-3827
Fax: 713-729-3839
rhicks@air.org

Sarah Hurley
Research and
Outcome Evaluation Manager
Youth Villages
5515 Shelby Oaks Drive
Memphis, TN 38134
Phone: 901-252-7678
Fax: 901-252-7620
sarah.hurley@youthvillages.org

Carolyn Ingram
Acting Director
Medical Assistance Division
Department of Human Services
P.O. Box 2348
Santa Fe, NM 87504-2348
Phone: 505-827-3106
Fax: 505-827-3185

Neva Kay
Program Director
National Academy of State Health
Policy
50 Monument Square, Suite 502
Portland, ME 04101
Phone: 207-874-6524
Fax: 207-874-6527
nkaye@nashp.org

Chris Koyanagi
Policy Director
Bazelon Center for MH Law
1101 15th Street NW, Suite 1212
Washington, D.C. 20005
Phone: 202-467-5730
Fax: 202-223-0409

John Landsverk, Ph.D.
Director
Child & Adolescent Services
Research Center
Children's Hospital
3020 Children's Way, MC 5033
San Diego, CA 92123
Phone: 858-966-7703 ext. 3755
Fax: 858-966-7704
jlandsverk@aol.com

Cindy Lederman, J.D.
Administrative Judge, Juvenile
Division
Eleventh Judicial Circuit Court of
Florida
Juvenile Justice Center
3300 NW 27th Avenue, Room 201
Miami, FL 33142
Phone: 305-638-6087
judgeled@juno.com

Meredith Lee, M.P.H.
Health Policy Analyst
APHSA
810 First Street NE, Suite 500
Washington, D.C. 20002
Phone: 202-682-0700
Fax: 202-289-6555
mlee@aphsa.org

Nancy Lucas
Chief Executive Officer (CEO)
Community Behavioral Health
714 Market Street
Philadelphia, PA 19118
Phone: 215-413-7102
Fax: 215-413-7111
nancy.lucas@phila.gov

Gary Macbeth, M.S.W., M.Ed.
Director
Georgetown University Center for
Child & Human Development
for Children's Mental Health
3307 M Street NW, Suite 401
Washington, D.C. 20007
Phone: 202-687-5052
Fax: 202-687-1954
gfm5@georgetown.edu

Ken Martinez, Psy.D.
Children's Behavioral Health
Director
New Mexico Children Youth &
Families Department
P.O. Box 5160
Santa Fe, NM 87502
Phone: 505-827-4667
Fax: 505-827-4053
kjmartinez@cyfd.state.nm.us

Richard Mauery, M.P.H.
George Washington University
Department of Health Policy/
CHSRP
2021 K Street NW, Suite 800
Washington, D.C. 20002
Phone: 202-530-2376
Fax: 202-246-0025
rmauery@gwu.edu

Jan McCarthy, M.S.W.
Director of Child Welfare Policy
Georgetown University Center for
Child & Human Development
3307 M Street NW, Suite 401
Washington, D.C. 20007-3935
Phone: 202-687-5062
Fax: 202-687-8899
jrm33@georgetown.edu

Patrick McCarthy, Ph.D,
Vice President System and
Service Reform
Casey Foundation
The Annie E. Casey Foundation
701 St. Paul St.
Baltimore, MD 21202
Phone: 410-547-6600
pmccarthy@aecf.org

Charlotte McCullough
McCullough Associates
3903 Leland Street
Chevy Chase, MD 20815
Phone: 301-652-2289
Fax 301-652-5719
mcculloughassociates@yahoo.com

Kathy McHugh
Director of Policy
Children's Bureau
Administration for Children and
Families
330 C Street SW Switzer Building
Room 2411
Washington, DC 20447
Phone: 202-401-5789
Fax: 202-260-9345
kmchugh@acf.hhs.gov

Candice Nardini, M.P.A.
Vice President
Public Sector Development
Value Options
3500 Caulder Avenue
Des Moines, IA 50321-1842
Phone: 515-287-5785
Fax: 515-287-5864
candice.nardini@valueoptions.com

Mary Nelson
Administrator
State Child Welfare Division of
Behavioral, Developmental and
Protective Services for Families,
Adults, and Children
Iowa Dept. of Human Services
Hoover State Office Building,
5th Floor
1305 East Walnut
Des Moines, IA 50319
Phone: 515-281-5521
Fax: 515-281-4597
mnelson1@dhs.state.ia.us

Trina Osher, M.A.
Coordinator of Policy & Research
Federation of Families for
Children's Mental Health
1101 King Street, Suite 420
Alexandria, VA 22314
Phone: 703-684-7710
Fax: 703-836-1040
tosher3@comcast.net

Sheila Pires, M.P.A.
Human Services Collaborative
1728 Wisconsin Ave. NW, Suite
224
Washington, D.C. 20007
Phone: 202-333-1892
Fax: 202-333-8217
sapires@aol.com

Kathy Pottick, Ph.D.
Institute for Health
Health Care Policy and Aging
Research
Professor, School of Social Work
Phone: 732-932-6582
pottick@rci.rutgers.edu

Charles Ray
President & Chief Executive Officer
(CEO)
National Council of Behavioral
Health Care Providers
12300 Twin Parkway, Suite 320
Rockville, MD 20852
charlesr@ncch.org

Rolando Santiago
Acting Deputy Chief
Child, Adolescent & Family Branch
Center for Mental Health Services
SAMHSA
5600 Fishers Lane, Room 11-C16
Rockville MD 20857
Phone: 301-443-1333
Fax: 301-443-1563
rsantiag@samhsa.gov

Dorn Schuffman
Director State Mental Health
Commissioner
Department of Mental Health
1706 East Elm Street
P.O. Box 687
Jefferson City, MO 65101
Phone: 573-751-3070
Fax: 573-526-7926

Diane Sondheimer, M.S., M.P.H.
Acting Branch Chief
Child, Adolescent, & Family
Branch Center for Mental Health
Services
SAMHSA
5600 Fishers Lane, Room 11C-16
Rockville MD 20857
Phone: 301-443-1333
Fax: 301-443-3693
dsondhei@samhsa.gov

Colleen Sonosky, J.D.
Senior Director of Programs &
Policy
Children's Defense Fund
25 E St., NW
Washington, D.C. 20001
Phone: 202-662-3547
Fax: 202-662-3560
csonosky@childrensdefense.org

Glenn Stanton
Acting Director, CMS
Disabled and Elderly
Health Programs Group
Centers for Medicare and
Medicaid Services
7500 Security Boulevard
Mail Stop S2-14-26
Baltimore, MD 21244
Phone: 410-786-6768
Fax: 410-786-9004
gstanton@cms.hhs.gov

Beth Stroul, M.Ed.
Management & Training
Innovations
6725 Curran Street
McLean, VA 22101
Phone: 703-790-0990
Fax: 703-790-1312
bethstroul@aol.com

Rita Vandervort-Warren, M.S.W.,
A.C.S.W.
Public Health Analyst
Organization & Financing Branch,
CSAT, SAMSHA
5600 Fishers Lane, Room 7-198
Rockwall II, Suite 740
Rockville, MD 20857
Phone: 301-443-0789
Fax: 301-443-3543
rvandivo@samhsa.gov

Ginny M. Wood, B.S.
President
Founder Family Support Systems
Inc. Consulting Firm
20487 N 94th Avenue
Peoria, AZ 85382
Phone: 623-825-1744
Fax: 623-825-7130
gmwood@worldnet.att.net

Publications of the HCRTP

Publications of the Health Care Reform Tracking Project (**HCRTP**) are available on-line as viewable/printable Adobe Acrobat PDF files:

> http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm   or
> http://pubs.fmhi.usf.edu click **Online Publications** (By Subject)

Reports of the Health Care Reform Tracking Project (HCRTP) are also available in print from the Research and Training Center for Children's Mental Health, at the Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL., (813) 974-6271:

HCRTP Consensus Conference

Stroul, B.A., Pires, S.A, & Armstrong, M.I. (2004). *Health care reform tracking project: Using research to move forward: A consensus conference on publicly funded managed care for children and adolescents with behavioral health disorders and their families — September 29–30, 2003.* 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 #215**)

HCRTP State Surveys

Stroul, B.A., Pires, S.A, & Armstrong, M.I. (2003). *Health care reform tracking project: Tracking state managed care systems as they affect children and adolescents with behavioral health disorders and their families — 2003 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 #212-4**)

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. (**New FMHI Publication #212-3**, formerly FMHI Publication #198)

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, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (**New FMHI Publication #212-2**, formerly FMHI Publication #175)

Pires, S.A., Stroul, B.A., Roebuck, L., Friedman, R.M., & 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, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (**New FMHI Publication #212-1**, formerly FMHI Publication #212) No PDF available, out of print.

HCRTP Impact Analyses

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, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (**New FMHI Publication #213-2**, formerly FMHI Publication #183)

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, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (**New FMHI Publication #213-1**, formerly FMHI Publication #167) No PDF available.

HCRTP Promising Approaches Series

Wood, G. M., (2004). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 6: Family involvement in managed care systems.* 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 #211-6**)

Stroul, B. A., (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 5: Serving youth with serious and complex behavioral health needs in managed care systems.* 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 #211-5**)

Armstrong, M. I., (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 4: Accountability and quality assurance in managed care systems.* 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 #211-4**)

Hepburn, K. & McCarthy, J. (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 3: Making interagency initiatives work for the children and families in the child welfare system.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (**Georgetown University Publication #211-3**)

McCarthy, J. & McCullough, C. (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 2: A view from the child welfare system.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (**Georgetown University Publication #211-2**)

Pires, S.A (2002). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 1: Managed care design & financing.* 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 #211-1**)

HCRTP Issue Briefs

The following Issue Briefs are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 3307 M Street, NW, Washington, DC 20007, (202) 687-5000:

Pires, S. A. (2002). *Issue Brief 4. Accountability for Children with Behavioral Health Disorders in Publicly Financed Managed Care Systems.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Pires, S. A. (2002). *Issue Brief 3. Financing and Risk.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Stroul, B. A. (2002). *Issue Brief 2. Special Provisions for Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Stroul, B. A. (2002). *Issue Brief 1. Service Coverage and Capacity in Managed Care Systems.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

HCRTP Special Analyses: Child Welfare

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 Center for Child and Human Development, 3307 M Street, NW, Washington, DC 20007, (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 behavioral health disorders and their families — Child Welfare Impact Analysis — 1999*. Washington, D.C.: 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 behavioral health disorders and their families — Special Analysis — Child Welfare Managed Care Reform Initiatives*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Featuring

- Background and Purpose of Consensus Conference
- Essential Elements of Publicly Financed Managed Care
- Recommendations for Policy, Practice and Research
- Appendix A: Essential Elements of Publicly Financed Managed Care
- Appendix B: Summary of Findings from the HCRTP 1995–2003
- Appendix C: Key Findings from Research on Managed Care for Children's Behavior Health
- Appendix D: Participants of Consensus
- Publications of the HCRTP
- HCRTP Publication Order Form

HCRTP Health Care Reform Tracking Project

Tracking State Managed Care Systems as They Affect Children and Adolescents with Behavioral Health Disorders and their Families

Consensus Conference

**Beth A. Stroul, M.Ed. • Sheila Pires, M.P.A.
Mary I. Armstrong, Ph.D.**

Research and Training Center for Children's Mental Health
Department of Child and Family Studies

FMHI *Louis de la Parte*
Florida Mental Health Institute
University of South Florida
Tampa, Florida

National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development
Washington, D.C.

Human Service Collaborative
Washington, D.C.

$10.00
While Supplies Last

80 Pages

Request FMHI Technical Document #215

Suggested APA Citation:

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (2004). *Health care reform tracking project: Using research to move forward: A consensus conference on publicly funded managed care for children and adolescents with behavioral health disorders and their families — September 29–30, 2003.* 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 #215**)

HCRTP Technical Publications in print and/or on-line as Acrobat PDF files:

http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm
http://pubs.fmhi.usf.edu click Online Publications (By Subject)

- **HCRTP Consensus Conference** – Doc. #215 (White Bk)
- **2003 State Survey** – Doc. #212-**4** (Olive Bk)
- **2000 State Survey** – Doc. #212-**3** old #198 (Purple Bk)
- **1997/98 State Survey** – Doc. #212-**2** old #175 (Blue Bk)
- **1999 Impact Analysis** – Doc. #213-**2** old #183 (Green Bk)
- **1997 Impact Analysis** – Doc. #213-**1** old #167 Print only (Red Bk)
- **Promising Approaches Series**
  - Family Involvement in MC Systems – Doc. #211-**6** (Aqua Bk)
  - Serving Youth w/Serious BH Needs – Doc. #211-**5** (Black Bk)
  - Accountability & Quality Assurance – Doc. #211-**4** (Purple Bk)
  - Interagency Initiatives – Doc. #211-**3** (Green Bk)
  - Child Welfare View – Doc. #211-**2** (Burgundy Bk)
  - Managed Care Design & Financing – #211-**1** (Blue Bk)

FMHI Library/Technical Publications

Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899

Phone: 813-974-4471
Fax: 813-974-7242

SunCom Phone: 574-4471
Sun Com Fax: 574-7242

Email: cone@fmhi.usf.edu

USF
UNIVERSITY OF SOUTH FLORIDA

FMHI *Louis de la Parte*
Florida Mental Health Institute

To Order, Mail or Fax this Form with Payment to:

FMHI *Louis de la Parte* **Florida Mental Health Institute**

FMHI Library/Technical Publications
Louis de la Parte Florida Mental Health Institute (FMHI)
The University of South Florida
13301 Bruce B. Downs Blvd. • Tampa, FL 33612-3899

Fax: 813-974-7242   **SunCom Fax:** 574-7242
Phone: 813-974-4471   **SunCom Phone:** 574-4471   **Email:** cone@fmhi.usf.edu

☐ **Please send ___ copies** of the *HCRTP: Using Research to Move Forward: A Consensus Conference — September 29–30, 2003*. FMHI Doc. **#215**. ($10 each copy–Including Shipping and Handling)

Payment accepted by Purchase Order, Check, or Money Order payable to: ***Louis de la Parte FMHI Auxiliary Fund***

Name   Title

Organization/Agency

Street Address   Suite

City   State   Zip

Country

( ) _____ Phone   ( ) _____ Fax

Email   Web Address

HCRTP: Order Form

Health Care Reform Tracking Project

HCRTP
Health Care Reform Tracking Project

Tracking State Managed Care Systems as They Affect Children and Adolescents with Behavioral Health Disorders and their Families

Consensus Conference
State Surveys
Impact Analyses
Promising Approaches

By:

Beth A. Stroul, M.Ed.
Sheila Pires, M.P.A.
Mary I. Armstrong, Ph.D.

Produced in Cooperation with:

Research and Training Center for Children's Mental Health
Department of Child and Family Studies

FMHI *Louis de la Parte* **Florida Mental Health Institute**

University of South Florida
Tampa, Florida

National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development
Washington, D.C.

Human Service Collaborative
Washington, D.C.

HCRPT Technical Publications in print and/or on-line as Acrobat PDF files:

http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm

http://pubs.fmhi.usf.edu click **Online Publications** (By Subject)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

FMHI Library/Technical Publications

Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899

Phone: 813-974-4471
Fax: 813-974-7242

SunCom Phone: 574-4471
Sun Com Fax: 574-7242

Email: cone@fmhi.usf.edu

FMHI *Louis de la Parte* **Florida Mental Health Institute**

USF UNIVERSITY OF SOUTH FLORIDA

HCRPT Technical Publications are also available at no cost, as Acrobat PDF files, on-line:

http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm
http://pubs.fmhi.usf.edu click **Online Publications** (By Subject)

To order HCRPT Publications in print:

- **Consensus Conference**
  - ☐ **Consensus Conference 2003** .... send # ___ copies @ $10 _____
    Doc. #215 (White Book)
- **State Surveys**
  - ☐ **2003 State Survey** .... send # ___ copies @ $12 _____
    Doc. #212-**4** (Olive Book)
  - ☐ **2000 State Survey** .... send ___ copies @ $12 _____
    Doc. #212-**3** old #198 (Purple Book)
  - ☐ **1997/98 State Survey** .... send #___ copies @ $10 _____
    Doc. #212-**2** old #175 (Blue Book)
- **Impact Analyses**
  - ☐ **1999 Impact Analysis** .... send #___ copies @ $15 _____
    Doc. #213-**2** old #183 (Green Book)
  - ☐ **1997 Impact Analysis** .... send #___ copies @ $8 _____
    Doc. #213-**1** old #167 Print only (Red Book)
- **Promising Approaches Series**
  - ☐ **PAS #6:** Family Involvement in MC Systems ... send #___ @ $6 _____
    Doc. #211-**6** (Aqua Book)
  - ☐ **PAS #5:** Serving Youth w/Serious BH Needs .... send #___ @ $6 _____
    Doc. #211-**5** (Black Book)
  - ☐ **PAS #4:** Accountability & Quality Assurance .... send #___ @ $6 _____
    Doc. #211-**4** (Purple Book)
  - ☐ **PAS #3:** Interagency Initiatives ... available Georgetown University
    Doc. #211-**3** (Green Book)
  - ☐ **PAS #2:** Child Welfare View .... available Georgetown University
    Doc. #211-**2** (Burgundy Book)
  - ☐ **PAS #1:** Managed Care Design & Financing .... send #___ @ $6 _____
    #211-**1** (Blue Book)

Total Due _____

To Order, Mail or Fax this Form with Payment to:

FMHI Library/Technical Publications
Louis de la Parte Florida Mental Health Institute (FMHI)
The University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899

Fax: 813-974-7242 **SunCom Fax:** 574-7242
Phone: 813-974-4471 **SunCom Phone:** 574-4471 **Email:** cone@fmhi.usf.edu

FMHI *Louis de la Parte* **Florida Mental Health Institute**

Payment accepted by Purchase Order, Check, or Money Order payable to: <u>Louis de la Parte FMHI Auxiliary Fund</u>

Name _____ Title _____

Organization/Agency _____

Street Address _____ Suite _____

City _____ State ___ Zip _____

Country _____

(___) _____ (___) _____
Phone   Fax

Email _____ Web Address _____