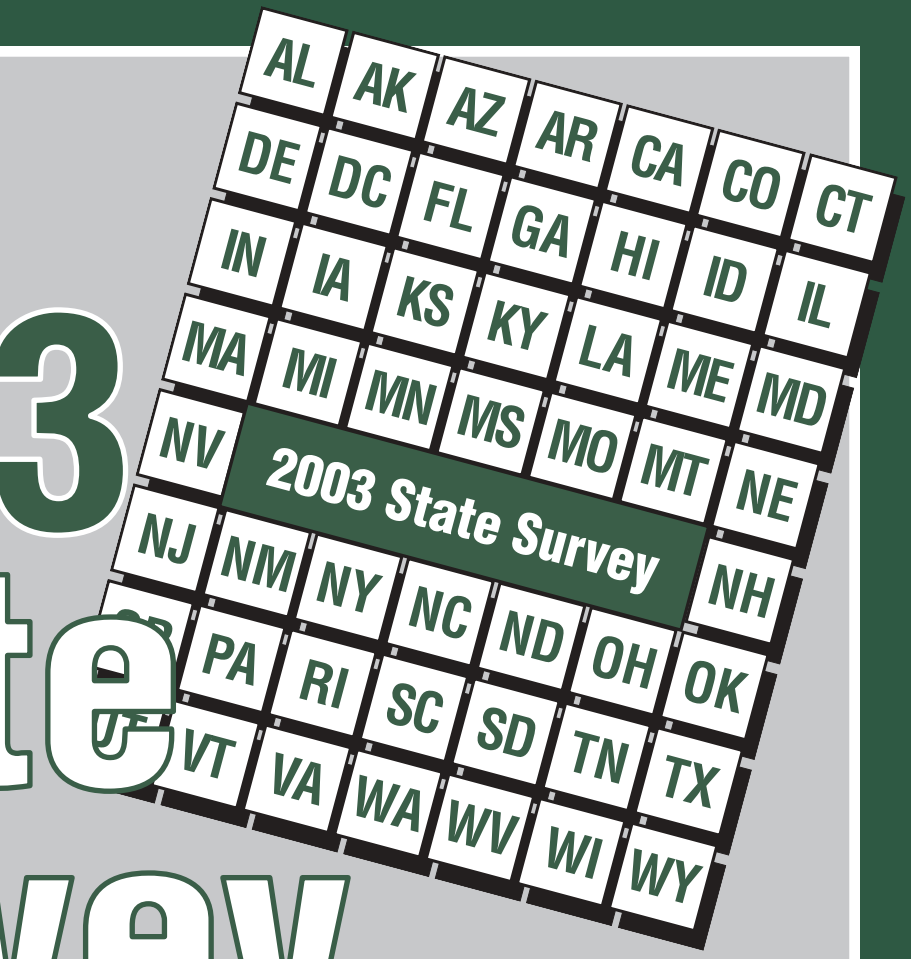
2003 State Survey



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

HCRTP Health Care Reform Tracking Project

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

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Department of Child and Family Studies
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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

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Featuring

Child Welfare Special Analysis

Prepared by Jan McCarthy

February 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

Acknowledgments

The **2003 State Survey** is the fourth and last such all-state survey conducted over the life of the **Health Care Reform Tracking Project** (**HCRTP**). Over the course of this project, the support and participation of many individuals and organizations has been invaluable in assisting the study team to accomplish its goals. As we conclude the series of state surveys, we would like to acknowledge and express appreciation to all who have facilitated this work.

First, we wish to thank the federal agencies that have funded this project, recognizing the importance of improving behavioral health care for children and adolescents in the context of managed care systems — the National Institute on Disability and Rehabilitation Research (NIDRR) of the U.S. Department of Education and the Child, Adolescent and Family Branch of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. In particular, we are grateful to our Project Officers, Rosanne Rafferty of NIDRR, and Diane Sondheimer of CMHS for their ongoing support and guidance throughout this project.

Our gratitude also goes to the agencies and organizations that have contributed supplemental funding to the Tracking Project to enable the incorporation of a special focus and special analyses related to the child welfare population. Such funding has been contributed by the Administration on Children, Youth, and Families of the Administration for Children and Families, U.S. Department of Health and Human Services; the David and Lucile Packard Foundation; and the Center for Health Care Strategies, Inc. In addition, the Child Welfare League of America Managed Care Institute has been a valued partner in our work, coordinating their survey work with ours to collaboratively explore behavioral health managed care and child welfare managed care that impacts children and families in the child welfare system. Jan McCarthy, of the National Technical Assistance Center for Children's Mental Health at Georgetown University, has ably led and coordinated all of these efforts related to the child welfare population, and we gratefully acknowledge her contribution and expertise in this area.

Throughout the Tracking Project, family members have played a vital role as members of the study team and have participated in all aspects of the study, including survey design, data collection and analysis, report preparation, and dissemination activities. Ginny Wood of Family Support Systems, Inc. has led these efforts since the project's inception and has ensured that the insights, concerns, and perspectives of families have guided this work. We thank her for her outstanding leadership and her contribution to this survey, as well as all of the Tracking Project's activities.

Many staff members from the Louis de la Parte Florida Mental Health Institute have supported this state survey, as well as the previous surveys, managing survey distribution, response tracking, follow-up activities, data cleaning, data entry, data analysis, and report preparation. Special thanks go to the staff who assisted with the 2003 survey — Jill Jones, Rebecca Whitlock, Jeana Matos, Flora Kilpatrick, Camille Leachman, and Bill Leader. We wish to thank the staff who have worked with the study team in the past, in particular Kristina Chambers and Mary Ann Kershaw. The study team dedicates this 2003 State Survey report to the memory of Amy Quinlan, who provided exceptional support to the 2000 State Survey.

The entire Tracking Project has been conducted through a collaboration among three entities — The Louis de la Parte Florida Mental Health Institute (FMHI) of the University of South Florida, the National Technical Assistance Center for Children's Mental Health of the Georgetown University Center for Child and Human Development, and the Human Service Collaborative of Washington, DC. This productive effort has benefited from the resources, organizational support, staff, and collective expertise of these partners. We wish to express our appreciation to Bob Friedman, Chair, Department of Child and Family Studies at the Louis de la Parte Florida Mental Health Institute; Phyllis Magrab, Director of the Georgetown University Center for Child and Human Development; Gary Macbeth, Director of the National Technical Assistance Center for Children's Mental Health; and Sybil Goldman, former Director of the National Technical Assistance Center and currently at SAMHSA; and the partners of the Human Service Collaborative for supporting and facilitating this partnership.

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It is our hope that the findings of the 2003 State Survey, in combination with other Tracking Project products, will provide guidance to states and communities seeking to refine their managed care systems to better serve children with emotional disorders and their families.

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

Table of Contents

Page

Table of Contents continued

Page

Table of Contents continued

Page

Table of Contents continued

Page

Index of Tables and Matricies

Page

II. General Information about State Managed Care Systems

III. Populations Covered by Managed Care Systems

IV. Managed Care Entities

Index of Tables and Matricies continued

Page

V. Service Coverage and Capacity

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

Index of Tables and Matricies continued

Page

VII. Financing and Risk

Index of Tables and Matricies continued

Page

Index of Tables and Matricies continued

Page

X. Service Coordination

XI. Early Identification and Intervention

XII. Cultural Competence

XIII. Family Involvement

Index of Tables and Matricies continued

Page

XIV. Providers

XV. Accountability

XVI. General Update

Index of Tables and Matricies continued

Page

Child Welfare Special Analysis

HCRTP 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

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

Executive Summary

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 in the U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration on Children, Youth, 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 to develop recommendations for future policy, practice, and research related to children's behavioral health services in 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 within a managed care system, 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 executive summary briefly reviews the results of the 2003 all-state survey.

General Information about State Managed Care Systems

Extent of Managed Care Activity

- Only five states over the past decade have never implemented a managed care system.
- Out of 46 states that have implemented managed care over the past decade, 38 (86%) are still involved in managed care.
- Since the 2000 survey, there has been a slight retrenchment, with only one state starting a new managed care initiative, two terminating existing systems, and two terminating planning for managed care implementation. However, these are fewer terminations than between 1997/98 and 2000, when there were seven terminations, suggesting a certain settling in the managed care landscape.

2003 State Sample

- The 2003 State Survey sample includes 39 managed care systems in 37 states, 22 carve outs and 17 integrated physical health/behavioral health managed care systems
- The primary focus of most systems (61%) is Medicaid managed care, followed by a joint focus on Medicaid and public behavioral health systems (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 one system in the sample was limited to 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 reforms 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% (two systems) indicated they were in early stages of implementation; no systems were in the planning stage.

Inclusion of Substance Abuse Services

- 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 services are *not* included, they remain fee-for-service in 78% of the systems; in the remaining, substance abuse treatment is provided either through a separate carve out or is included in a physical health managed care system that does not include mental health.

Parity Between Physical Health and Behavioral Health Services

- In about two-thirds of managed care systems (68%), reportedly there 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 of Managed Care Systems

- 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.

Responsible Agency

- The state Medicaid agency is the lead player in most systems (65%), followed by the state mental health agency with lead responsibility for 35% of systems — all carve outs. Mental health plays a larger role with respect to carve outs, as one would expect.

Involvement of Key Stakeholders

- State child mental health staff and providers are the two key stakeholder groups most likely to have significant involvement in the planning, implementation, and refinement of managed care systems (in 63% and 56% of managed care systems, respectively).
- Families reportedly have significant involvement in only about one-third of managed care systems, although they reportedly have some involvement in another 56%
- Other child-serving systems have significant involvement in one-third of the systems or less. (State substance abuse staff are significantly involved in 33%; state juvenile justice staff in 29%; state child welfare staff in 21%; state education staff in 15%).
- Carve outs are significantly more likely to involve all stakeholder groups than are integrated systems, except for state education staff, whose involvement reportedly is low in both types of systems.
- There are reported declines in significant involvement in managed care systems by all stakeholder groups since 2000, which may be because managed care is no longer “new”, stakeholder interest has waned, or managed care systems have settled into a “business as usual” mode.

Planning for Special Populations

- Most managed care systems (74%) reportedly engage in a discrete planning process for children with serious emotional disorders, although only about one-third (35%) have a similar process for adolescents with substance abuse disorders or for youth in the juvenile justice system.
- Fewer than half of the systems (47%) have a discrete planning process for children involved in the child welfare system, a 25% decline since 2000. However, there is a reported increase in the percentage of reforms (now 47%) that discretely plan for culturally diverse children and adolescents.
- Carve outs are significantly more likely to have a discrete planning process for all special populations than are integrated managed care systems.

Education and Training in Managed Care for Stakeholders

- Most managed care systems provide education and training to key stakeholder groups about the goals and operation of the system, although there has been a moderate decline since 2000 in the percentage of systems doing so, which may be attributable to the fact that systems are in later stages of development and/or to waning stakeholder engagement.
- Carve outs are significantly more likely than integrated systems to provide education and training across all stakeholder group categories.
- Providers are the group most likely to receive education and training (89% of the systems).

Populations Covered by Managed Care Systems

- Nearly 11% fewer managed care systems are covering the total Medicaid population than in 2000; fewer than half (39%) cover the Medicaid 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 approximately three-quarters (74%) cover children in the child welfare population who are eligible for Medicaid. 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.

Managed Care Entities

Types of MCOs Used

- Both integrated systems and carve outs rely heavily on for-profit managed care entities, with carve outs more likely to used specialized Behavioral Health Organizations (BHOs), reportedly used by 59% of the carve outs, and integrated systems more likely to use Managed Care Organizations (MCOs) that manage both physical and behavioral health care (75% of the integrated systems.)
- Over a third of carve outs (36%) utilize government entities as MCOs, making them nearly twice as likely to do so than integrated systems.
- Private, nonprofit agencies consistently have been the least likely type of entity to be used as MCOs by either carve outs or integrated systems.
- Few states reportedly have changed the type of entity they are using as MCO since 2000.

Use of Multiple Versus Single MCO

- Integrated systems tend to utilize multiple MCOs statewide or within regions (79% do so). Carve outs are more likely to use a single MCO statewide or within regions (68% do so).

Education and Training for MCOs About Special Populations

- The 2003 data show a moderate increase in the percentage of managed care systems that are providing education and training to MCOs about special populations, home and community-based services, and system of care values and principles.
- Nearly three-quarters of managed care systems (71%) reportedly provide training and education to MCOs about children and adolescents with serious emotional disorders. However, fewer than half (43%) do so regarding adolescents with substance abuse disorders or about youngsters with co-occurring disorders (46%).
- About half provide training and education to MCOs about children in the child welfare and juvenile justice systems.
- About half (57%) provide training and education to MCOs about home and community-based services, and reportedly 63% educate MCOs about system of care values and principles. However, carve outs are twice as likely to do so than are integrated systems, even though a greater percentage of integrated systems in 2003 reportedly are doing this type of education for MCOs than was the case in 2000.
- Carve outs are more likely to provide education and training regarding all special populations than are integrated systems, and carve outs are twice as likely to provide training about home and community-based services and about systems of care.

Service Coverage and Capacity

Inclusion of Acute and Extended Care

- The majority of managed care systems include both acute and extended care services (95%), a 7% increase from 2000. All carve outs include acute and extended care; only a small percentage of the integrated systems (12%) still limit coverage to acute care services only.
- In most managed care systems, other agencies retain responsibility and resources for behavioral health extended care services in addition to coverage within the managed care systems. In only 8% of the managed care system do no other systems have responsibility or resources for behavioral health extended care.
- Child mental health (81% of systems) and child welfare (83%) are the most likely to have extended care responsibility and resources outside of the managed care system, followed by juvenile justice (72%), substance abuse (72%), and education (58%).

Service Coverage

- Consistent with previous findings, carve outs are more likely to cover a broader service array. In 2003, half of the carve outs (50%) but only 18% of the integrated systems covered 80 – 100% of the mental health services included on the list in the survey. Nearly half of the carve outs (48%) and 27% of the integrated systems cover most or all of the substance abuse service array listed.
- Focusing on only the mental health services that were included on previous surveys yields a similar pattern of greater coverage by carve outs, but a 16% decline in coverage of most or all services since 2000 across all systems.
- The services most likely to be covered by the managed care system include: assessment and diagnostic evaluation, outpatient psychotherapy, medical management, inpatient services, day treatment/partial hospitalization, crisis services, case management, and home-based services.
- The services least likely to be covered include: therapeutic nursery/preschool, therapeutic group homes, respite services, behavioral aide services, and crisis residential services.
- Many of the services, both those covered and not covered by the managed care system, are covered by another source outside the system. Few instances of services not covered by any source were found. Uncovered services were most likely to be: therapeutic nursery/preschool, behavioral aide services, mental health consultation, school-based services, and crisis residential services.

Coverage and Availability of Home and Community-Based Services

- Reflecting little change from previous surveys, most carve outs have expanded coverage of home and community-based services in comparison with pre-managed care (73%), whereas few integrated systems reported expansion in home and community-based service coverage (31%).
- The range of services added includes respite care, family support, therapeutic foster care, intensive home-based services, day treatment, after school programs, crisis services, multisystemic therapy (MST), therapeutic group homes, behavioral aides, case management, home-based services, and others.
- Despite increased coverage, availability of home and community-based services is a separate issue. Carve outs are more likely to report expanded availability of home and community-based services (81% report some or significant expansion); 36% of the carve outs but none of the integrated systems reported significant expansion. In nearly half of the integrated systems (44%), there has been no expansion at all.
- No system rated the adequacy of home and community-based service capacity in the state as highly adequate, and only 19% of all systems rated capacity as mostly adequate. Mean ratings of adequacy fall squarely in the "moderately" adequate category, with carve outs much more likely to report more highly developed capacity in the state than integrated systems.
- Fewer than one-third of the systems require reinvestment of savings back in the system to develop service capacity (32%) — all carve outs. However, 57% of all systems reported that they do not have savings to reinvest.
- About half of the systems (53%) reported state investment in service capacity development (apart from managed care system), but state investment declined from 2000 in both carve outs and integrated systems (26% of all systems), most likely due to the current economic climate.

Individualized Service Provision

- Similar to 2000 findings, nearly all carve outs (91%), but only half of the integrated systems (53%) reported that managed care has made it easier to provide flexible/ individualized services.

Services to Young Children and Their Families

- The majority of systems (74%) reportedly provide few services to young children and their families. Only 23% reported providing many services to this population, a 21% decline since 2000.
- When services are provided to young children, they most frequently are family therapy and family support services.

Evidence-Based Practices

- Most carve outs (77%), but fewer than half of the integrated systems (44%) reportedly are encouraging or providing incentives for providers to use evidence-based practices.
- The most commonly used strategies to promote evidence-based practices include providing training and/or consultation (75% of systems), developing practice guidelines (50%), or monitoring through quality improvement protocols (50%). The least used strategy (25%) is developing special rates.
- The types of evidence-based practices being promoted include: wraparound, functional family therapy, cognitive-behavioral therapy, and MST.

Serving Youth with Serious and Complex Behavioral Health Needs

Provisions for Children with Serious and Complex Behavioral Health Needs

- Most systems (81%) reportedly have special provisions for children with serious emotional disorders, as compared with only 44% in 1995 (a 37% increase).
- About two-thirds (63%) reportedly have special provisions for children in the child welfare system and about half (50%) have provisions for children in the juvenile justice system. Overall, carve outs are more likely to the various types of special provisions for each of the three populations.
- The most common types of special provisions for children with serious emotional disorders are intensive case management, wraparound services/process, interagency treatment and service planning, and an expanded service array. A particular increase since 2000 was reported in the use of wraparound (50% of systems with special provisions also reported having flexible service dollars for this population).
- The least common strategy used is higher capitation or case rates to support services to these high-need populations (used in less than a third, 31%, of the systems with provisions), suggesting that resources to provide these additional services to high-need children may be lacking.

Effect on Case Management/Care Coordination for Children with Serious Behavioral Health Disorders

- Most carve outs (82%) reported that managed care has increased case management in comparison with pre-managed care, whereas increased case management has resulted in only 21% of the integrated systems (decreased from 2000). Decreased care management was reported in 7% of the integrated systems in comparison with pre-managed care, but in none of the carve outs.

Facilitation and Support for Systems of Care

- The majority of carve outs (90%) but less than half of the integrated systems (44%) 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 (81 – 95% for the various principles of broad service array, family involvement, individualized services, care management, and cultural competence). The only principle that approaches this level in integrated systems is "broad array of services," included in 92%. Slight declines in the reported incorporation of system of care principles, with the exception of a broad array of services, were found since 1997/98.

Financing and Risk

Agency Financing Sources for Managed Care Systems

- The state Medicaid agency is the primary contributor of funds to managed care systems, contributing to 100% of the systems in the 2003 sample.
- The state mental health authority contributes to most carve outs (86%) but to none of the integrated systems in the sample. Since 2000, there has been a 10% decline in the percentage of carve outs to which mental health contributes funds and a 13% decrease in integrated systems to which mental health contributes, a 26% decline overall.
- While the 2003 data show increases since 2000 in the percentage of managed care systems in which other child-serving agencies (i.e., non-Medicaid and non-mental health) are contributing funds, these other agencies still contribute in relatively few cases. Child welfare and state substance abuse agencies contribute funds in about one-third of the systems. Other agencies (e.g., juvenile justice, health, education) contribute to fewer than 17% of the systems.
- Overall, since 2000, there has been a 16% increase in the percentage of systems in which only Medicaid contributes funds, a 22% decline in systems to which both Medicaid and mental health contribute, and a 5% increase in systems to which other child-serving agencies contribute dollars. Other child-serving agencies across the board are more likely to contribute to carve outs than to integrated reforms.

Types of Revenue Used To Finance Managed Care Systems

- Consistent with the agency source of funds, Medicaid revenue is the type of financing used in most systems (97%), followed by: state general revenue (55% of systems); SCHIP (45% of systems); block grant (29% of systems, all carve outs); child welfare (16% of systems); and, TANF (16% of systems).
- Integrated systems are more likely to use SCHIP and TANF dollars, in addition to Medicaid; carve outs are more likely to use state general revenue, block grant, and child welfare dollars, in addition to Medicaid.
- As has consistently been reported since 1997/98, carve outs are significantly more likely than integrated systems to utilize multiple types of funding contributed by multiple agencies.

Use of Medicaid Dollars Outside of Managed Care Systems

- Over the past decade, states consistently have reported that some Medicaid dollars for children's behavioral health services are left outside of the managed care system in fee-for-service arrangements. This was reported for 100% of the managed care systems in the 2003 sample.
- The following child-serving agencies were reported to be using Medicaid dollars outside of the managed care system for children's behavioral health services: child welfare (in 72% of the systems); mental health, education, and mental retardation/ developmental disabilities (in 67% each); substance abuse (58%); juvenile justice (56%); and, health (44%).

Cost Shifting

- In half of managed care systems in 2003, cost shifting reportedly is *not* occurring, an improvement compared to reports of cost shifting in 2000. In 2000, cost shifting reportedly was occurring in two-thirds of the managed care systems, as compared with reports of cost shifting in only half of the systems in 2003. Carve outs are less likely to have reported cost shifting than are integrated systems. The decline in reported cost shifting may be due to the later stages of development of managed care systems, and possible progress that has been made on resolving boundary issues.
- More cost shifting is reported from the managed care system to other child-serving agencies for integrated systems than for carve outs. Reports of cost shifting remain anecdotal since few systems (11%) actually track and monitor cost shifting.
- Most systems (69%) reportedly do include strategies to clarify responsibilities for providing and paying for services across child-serving agencies. Carve outs are more likely to incorporate these strategies than are integrated systems.

Use of Risk-Based Financing

- Since 2000, there has been a 16% increase reported in the percentage of managed care systems using capitation, a 7% decline in the percentage using case rates, and a 5% decline in the percentage using neither. In other words, some systems seem to have moved toward more use of full-blown risk models since 2000. This may reflect an increasing sophistication with managed care on the part of state purchasers and/ or an outgrowth of state budget problems.
- Both carve outs and integrated systems reportedly have increased use of capitation. Carve outs remain less likely to use capitation than integrated systems (68% of carve outs versus 93% of integrated systems), but the gap seems to be narrowing.

Changes in Rates

- Most managed care systems reportedly have changed rates paid to MCOs since 2000, with over half (57%) reportedly increasing rates, and the remainder (43%) decreasing rates. The percentage of systems increasing rates has fallen since 2000, however, when 80% of systems that changed rates reportedly increased them and 20% decreased rates.
- Two-thirds of managed care systems reportedly assess on some systematic basis the sufficiency of rates paid to MCOs, with most then making adjustments in rates based on this assessment.

Required Allocation of a Percentage of the Rate to Behavioral Health

- No integrated managed care systems specify that a percentage of the rate paid to MCOs be allocated for behavioral health services; this has been a consistent finding over the past decade.

Use of Risk Adjusted Rates and Other Risk Adjustment Mechanisms

- Only about a third of managed care systems (31%) reportedly use risk adjusted rates specifically for high-need child populations.
- Thirteen percent of managed care systems (5 states) incorporate risk adjusted rates for children with serious emotional disorders (a 57% decrease since 2000), with carve outs more likely to do so. Ten percent of systems (4 states) incorporate risk adjusted rates for children in the child welfare system (a 30% decrease since 2000), with integrated systems more likely to do so. Eight percent of systems (3 states) incorporate risk adjusted rates for youth involved in the juvenile justice system (a 12% decline since 2000), with integrated systems more likely to do so.
- Few managed care systems use other types of risk adjustment mechanisms for children with serious behavioral health disorders, such as: stop-loss arrangements (used by 13% of systems, mainly in integrated systems); risk corridors (used by 13% of systems, mainly in carve outs); reinsurance (used by 10% of systems, mainly in integrated systems); and risk pools (used in 3%, representing two carve outs, a 14% decline in use of risk pools by carve outs since 2000). In general, use of risk adjustment mechanisms reportedly has declined slightly since 2000.

Risk Sharing

- In about half of managed care systems (46%), MCOs reportedly have all of the benefit and all of the risk, representing little change from 2000. States reportedly have all the benefit and all the risk in only 17% of systems. In a little over a quarter (29%), MCOs and states share benefit and risk.
- In a marked change from 2000, in roughly half (53%) of managed care systems, providers do not share risk, with little reported differences between carve outs and integrated systems, whereas in 2000, providers had no risk in only 25% of systems.

- Most of the change since 2000 in risk-sharing arrangements with providers seems to be driven by carve outs. In 2000, providers had no risk in only 18% of carve outs, compared with no risk for providers in 55% of carve outs in 2003.
- In the 47% of managed care systems that do share risk with providers, risk sharing arrangements include subcapitation and bonuses/penalties tied to performance (used by 56% each in systems that share risk), and case rates (used by 44%).
- About one-fifth of managed care systems utilize bonuses/penalties tied to performance, with carve outs being more likely to do so, but there has been a slight decline reported since 2000 in use of performance-based bonuses/penalties overall.

Limits on Administrative Costs and Profits

- Nearly 61% of managed care systems reportedly place a limit on MCO administrative costs, with carve outs being far more likely to do so (71% of carve outs versus 42% of integrated systems).
- Fewer than half of managed care systems (42%) limit MCO profits; again, carve outs are far more likely to do so (57% of carve outs versus 17% of integrated systems).
- In general, there has been a moderate decline since 2000 in the percentage of systems that limit MCO profits and a slight increase in the percentage that limit administrative costs.

Clinical Decision Making and Management Mechanisms

- The majority of managed care systems (89%) now have medical necessity criteria that allow consideration of psychosocial and environmental factors. Reportedly these criteria are interpreted broadly by MCOs in most managed care systems (73%).
- There has been a steady increase in the percent of managed care systems that use child-specific clinical decision making criteria. In 2003, reportedly almost all managed care systems (97%) use level of care criteria for children's mental health, and about two-thirds (65%) use patient placement criteria for adolescent substance abuse.
- Half of managed care systems continue to report that clinical decision making criteria are standardized across the state. Almost all managed care systems report improved consistency in clinical decision making as a result of using child-specific criteria (94%, up from 62% in 2000.).
- Most systems continue to report using various management mechanisms. The most frequently used mechanism is prior authorization (used by 97% of the systems), although most systems now allow certain services without prior authorization. Other widely used mechanisms are concurrent and retrospective reviews.

Access

Initial Access and Access to Extended Care

- Initial access to behavioral health services in comparison to pre-managed care reportedly is better in the majority of managed care systems (85%), 15% more systems than in 2000. The improved initial access is found at equally high levels in both carve outs and integrated systems.
- Access to extended care in comparison with pre-managed care, however, has improved in most carve outs (71%) but in less than half of the integrated systems (46%). Overall, reports of better access to extended care were found in 62% of the systems, 26% more in 2003 than in 2000. Only 8% reported worse access to extended care.
- Consistent with findings on access, wait lists reportedly were slightly less of a problem in 2003 than previously. Half (50%) of the systems reported shorter wait lists as compared with pre-managed care; only 9% reported longer wait lists.

Access to Inpatient Services

- Initial access to inpatient services reportedly is easier in nearly two-thirds of the systems (63%); it was reported to be more difficult to enter an inpatient setting in only 11% of the systems. However, average lengths of stay in inpatient setting are shorter in most systems (80%) — up 17% since 2000. No systems reported longer average inpatient lengths of stay.
- A number of problems associated with curtailed lengths of stays have been reported, such as placement in community services without the clinical capacity to serve them, premature discharge before stabilization, and increased use of residential treatment services as an alternative.
- Some reductions in these problems were noted in 2003, such as an 11% decline in systems reporting children discharged without needed services and a 15% decline in inappropriate use of child welfare emergency shelters.
- There has been an increase (11%) in systems reporting development of treatment alternatives to hospitalization, found in 73% of systems. The alternatives cited include crisis respite, crisis stabilization units, mobile crisis response, partial hospitalization, wraparound, home-based services, therapeutic foster care, intensive outpatient, intensive case management, and others.

Service Coordination

- In comparison with pre-managed care, improved physical health/behavioral health coordination was reported for 67% of the systems, reflecting a small increase (7%) from the 2000 survey findings. In 30% of the systems, managed care reportedly has had no effect on service coordination.
- Reports of improved coordination between mental health and substance abuse services increased from 52% of systems in the 2000 survey to 63% in 2003. Improved coordination is more evident in carve outs (73%) than in integrated systems (46%). In 2003, no system reported that coordination was worse than pre-managed care.

- About two-thirds of the systems reported improved interagency coordination in general among child-serving agencies in both 2000 and 2003.
- Improved coordination between mental health and child welfare was reported for 61% of the systems; managed care reportedly has had no effect on mental health/ child welfare coordination in 39%.
- Improved interagency coordination of all types was more likely to be reported for carve outs than for integrated systems.

Early Identification and Intervention

- The majority of systems (76%) conduct EPSDT screens within managed care, a 32% increase from 2000.
- In both 2000 and 2003, over 90% of the EPSDT screens used in managed care systems include a behavioral health component.
- More than half of the systems (58%) reportedly include incentives or strategies to encourage primary care practitioners to conduct EPSDT screens and make appropriate referrals for behavioral health services, such as monitoring and training.

Cultural Competence

- Most managed care systems include specific strategies related to cultural competence. Nearly all 86%) include translation and interpreter services. 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, outreach to culturally diverse populations, training of MCOs and providers on cultural competence, including culturally diverse providers in networks, and including specialized services needed by culturally diverse populations.
- Managed care planning includes a specific focus on culturally diverse groups in slightly more than half of the systems (56%), as compared with one-third of managed care systems in 2000.
- Cultural competence requirements under managed care are reportedly stronger than pre-managed care in 78% of the systems, a 14% increase from 2000.

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 do not incorporate any of these strategies for family involvement.
- More than half (54%) of systems include requirements for family involvement at the service delivery level, but less than half of the managed care systems (41%) include requirements for system-level family involvement. Family involvement requirements

reportedly are stronger in about two-thirds of the systems (63%, mainly in carve outs), in comparison with pre-managed care.

- In both 2000 and 2003, about half of the managed care systems reported funding a family organization to play a role in managed care (71% of carve outs and 19% of integrated systems in 2003).
- In most systems (65%), the focus of service delivery reportedly is on the family in addition to the identified child (79% of carve outs and half of the integrated systems). About half (49%) cover family support services and pay for services to family members if only the child is covered, with carve outs more likely to do both.
- Over 80% of the systems reported that managed care has had no impact (either 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 (74% of the systems) and participation in focus groups (53%). More significant involvement through such mechanisms as involvement in the design and monitoring of quality processes reportedly occurs in 39% of managed care systems, virtually all carve outs.

Providers

- With respect to the inclusion of specialty providers within provider networks, approximately two-thirds of managed care systems (62%) include school-based behavioral health providers, certified addictions counselors, and culturally diverse and indigenous providers. Half (54%) include child welfare providers, less than half reportedly include paraprofessionals, and only one-quarter include family members as providers. Inclusion of these types of providers occurs far more frequently in carve outs than in integrated systems.
- About two-thirds of managed care systems (66%) report that credentialing requirements do not impede the inclusion of various types of providers in provider networks.
- There have been complaints about increased administrative burden for providers identified through the Tracking Project, but a decrease in reports of higher administrative burden were found in the 2003 survey (61% of systems in 2000, 23% in 2003.)
- Higher provider reimbursement rates under managed care in comparison with pre-managed care were reported by about two-thirds of the systems (66%), a 43% increase from the 2000 findings, and reports of provider financial hardship or closure have decreased from 27% in 2000 to 14% in 2003.
- About three-quarters of managed care systems in both 2000 and 2003 reported that front-line practitioners have the skills, knowledge and attitudes to function effectively in a managed care system, with carve outs somewhat more likely to report adequate provider capacity.

Accountability

- The availability of adequate data for behavioral health decision making in managed care has increased since 2000, from 59% to 70% of systems. However, in 2003 about one-third of systems (30%) still do not have adequate data to guide decision making. The most frequent reasons for lack of data are inadequate MIS systems and a lack of encounter data.
- In both 2000 and 2003 findings, the types of system performance information most likely to be tracked by managed care systems are child behavioral health service utilization (92% in 2003), child behavioral health penetration rates (71%), and total aggregate cost of child behavioral health services (66%). The type of information used most frequently for system planning is service utilization rates.
- Most managed care systems (82%) include child-specific behavioral health quality measures. There has been a steady increase in the measurement of child clinical and functional outcomes in managed care systems, up from 51% in 1995 to 86% of the systems in 2003, although nearly half of the outcome measurement systems (44%) still are characterized as being in early stages of development and do not as yet have results.
- Most managed care systems (82%) measure parent satisfaction, but only 55% of the systems reported assessing youth satisfaction in both 2000 and 2003; carve outs are more likely to measure both parent and youth satisfaction.
- Many respondents continue to report that they do not know the impact of managed care on system performance. Over half of the systems do not know the total cost of children's behavioral health services or overall clinical and functional outcomes; about half do not know the impact on quality; over one-third do not know the impact on penetration rates or family satisfaction. Where effects are known, they reportedly are positive: 63% report an increase in child behavioral health service utilization, family satisfaction is reportedly higher in 58% of the systems, and 42% report an increase in child behavioral health penetration rates.

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 28 systems experiencing detrimental effects, 45% have reduced services to non-Medicaid eligible children; over a third (34%) have eliminated specific populations from eligibility for the managed care system; 29% have reduced or eliminated coverage of certain services; 28% have incorporated or raised co-pays; and 20 to 25% have decreased capitation rates paid to MCOs, implemented more stringent management mechanisms, changed drug formularies, lowered the federal poverty level eligibility cut-off, or lowered provider reimbursement rates.

- Integrated systems reportedly were most likely to incorporate or raise co-pays in response to the fiscal climate, while carve outs were most likely to reduce services to non-Medicaid eligible children, populations that integrated systems do not tend to cover in any event.
- 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 reforms 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
  - Declines in investment in service capacity development

Perceptions of Success of Managed Care in Achieving Desired Goals

- Perceptions of respondents are that managed care systems have been, on balance, moderately to mostly successful in achieving their goals (containing costs, increasing access, expanding service array, improving quality, and improving accountability), with about a third of the systems falling into each of these categories overall. Carve outs reportedly have had greater success in goal achievement; 73% fall into the moderately or mostly successful categories combined, as compared with 56% of the integrated systems.

Future Plans for Managed Behavioral Health Care

- The 2003 State Survey found that managed care for behavioral health care is highly likely to continue in the future. Not one respondent indicated plans to phase out managed care in their state; in 89% of the systems, the state reportedly plans to continue to use managed care technologies to manage behavioral health service delivery.
- Of those indicating potential changes, one state indicated plans to move to a non-risk based system, and four indicated plans to increase the use of ASO (Administrative Service Organization) arrangements.
- The Tracking Project results indicate that managed care will continue into the foreseeable future, underscoring the need to implement the refinements and revisions that will ensure that these systems are successful in meeting the needs of children and adolescents with behavioral health disorders and their families.

Child Welfare Special Analysis

Inclusion of Children in the Child Welfare System in Managed Care

- There has been a decline in managed care systems covering children in the child welfare system, down from 91% in 2000 to 74% in 2003.
- Children in state custody continue to be included in the majority of the managed care systems (66%).
- When children in state custody are included in managed care systems, enrollment typically is mandatory (in 90% of the systems).

Losing Eligibility for Managed Care System Based on Placement Type

- As in 2000, the 2003 survey found that in most systems (79%), children in child welfare and in juvenile justice may lose eligibility for the managed care system based on their placement type. The placements that primarily make children ineligible for the managed care system are detention, incarceration, and placement in state operated facilities. Four systems also mentioned placement in residential facilities.

Involvement in Planning, Refining, Implementing

- Child welfare system stakeholders are not significantly involved in system planning and refinement to the extent that they had been in the past; 21% of the systems reported *significant* involvement in 2003, as compared with 46% in 2000. However, in 50% of the systems child welfare stakeholders have at least some involvement. This decline was reported for other stakeholder groups as well, and may be related to the fact that most systems have been operational for several years.

Discrete Planning Process

- Fewer than half of the systems (47%) reported a discrete planning process for children in the child welfare system, down from the 72% reporting discrete planning for this population in 2000.

Special Provisions

- Although the percentage has dropped (from 87% in 2000 to 63% in 2003), the majority of systems continue to include special provisions of some type for children in the child welfare system.
- Special provisions most frequently included are interagency treatment and service planning, intensive case management, an expanded service array, and wraparound services/process. Only 33% of the systems reportedly offer family support services for families involved with the child welfare system, and only 15% of the systems incorporate higher capitation or case rates for children in child welfare.
- Special provisions are slightly more likely to be offered for children in the juvenile justice system than they are for those in the child welfare system.

Responsibility for Screening Children who Enter State Custody

- Almost half of the managed care systems (42%) reported that they are responsible for screening children who enter state custody to identify mental health problems and treatment needs.
- Of those systems responsible for this screening, 77% reportedly screen most children.

Service Coverage

- Consistent with 2000 findings, the services least likely to be covered by managed care systems are critical services for children and adolescents in the child welfare system — therapeutic group homes (covered by only 38% of the systems), behavioral aide services (41%), respite services (36%), crisis residential services (44%). Therapeutic foster care is covered by 59% of the systems.

Responsibility for Providing Behavioral Health Extended Care Services

- A good sign for the child welfare system is that almost all systems (95%) are providing both acute and extended care, up from 88% in 2000.
- The child welfare system also continues to have funds and responsibility for extended behavioral health services (94% in 2000, 83% in 2003). By a small margin child welfare continues to be the system most likely to have funds and responsibility for extended care in addition to the managed care systems.

Impact of Managed Care on Use of Behavioral Health Inpatient Services

- When systems reported problems associated with access to inpatient care and reduced lengths of stay, the negative impacts on the child welfare system reportedly have decreased since 2000. For example, children being discharged without needed services was reported by 33% of the systems in 2000, but only 13% in 2003; inappropriate use of child welfare emergency shelters by 21% in 2000 down to 6% in 2003; and discharge without safe placement for children in child welfare by 8% in 2000 and only 3% of systems in 2003.

Training For Child Welfare Stakeholders on the Goals and Operation of Managed Care System

- Training on managed care system goals and operation has decreased from 72% in 2000 to 61% in 2003. However, this is consistent with decreased training for other groups as well, and may be due to the relative maturity of managed care systems.

Training for MCOs About the Needs of Children in the Child Welfare System

- Training for MCOs related to the child welfare population increased slightly (52% of systems included training in 2000, 57% in 2003). This is consistent with a slight increase in training for MCOs regarding other populations served. However, training for MCOs on other populations has increased more significantly; for example, training on children with serious emotional disorders increased by 16%, and training on the juvenile justice population increased by 15% to 51% in 2003.

Inclusion of Child Welfare Providers in Managed Care Systems

- Approximately half of the managed care systems continue to include child welfare providers (providers who traditionally provide mental health services to the child welfare population) in their provider networks (53% in 2000, 54% in 2003). The lack of inclusion of these providers in the remaining systems has both fiscal and clinical implications for meeting the specialized treatment needs of this population.

Inclusion of Child Welfare Funds in the Managed Care System

- The child welfare system contributes funds in 29% of the systems, up from 21% in 2000. Child welfare continues to contribute funds in a greater proportion of the managed care systems than the education (11%), juvenile justice (11%), mental retardation/developmental disabilities (13%), or health (16%) systems.

Access to Medicaid Funds Outside of the Managed Care System

- In most managed care systems, child welfare continues to have access to Medicaid outside of managed care (72% in both 2000 and 2003). Child welfare accesses outside Medicaid funds in more systems than do the other child-serving systems.

Impact of Managed Care on Interagency Coordination

- About two-thirds of the systems reported improved interagency coordination among all child-serving systems in 2000 and in 2003 (67%).
- Nearly two-thirds (61%) of the systems noted that coordination between mental health and child welfare has improved; the remaining systems reported that managed care has had no effect on coordination between the two systems.

Impact of Managed Care on Families Having to Relinquish Custody of their Children to Access Services

- Managed care continues to have very little impact on the practice of custody relinquishment in order to obtain behavioral health care (81% report no effect in 2003, 83% in 2000). Only 2% indicate that managed care has made this practice worse, and 16% of the systems reported that the practice has improved under managed care.

Utilization of Behavioral Health Services by Children in Child Welfare

- Tracking behavioral health service use by children in the child welfare system has decreased slightly since 2000 (74% in 2000 and 63% in 2003 reported tracking service use by children in child welfare). It is interesting to note that while most managed care systems now track utilization, fewer systems use this information for system planning (42% in 2003).

HCRTP 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

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

I. Introduction and Methodology

Health Care Reform Tracking Project

The **Health Care Reform Tracking Project** (**HCRTP**) was initiated in 1995 to track and analyze state and local managed care initiatives as they affect children and adolescents with behavioral health disorders and their families. It is co-funded by two federal agencies — the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services and the National Institute on Disability and Rehabilitation Research in the Department of Education. Supplemental funding has been provided by the Administration on Children, Youth, and Families of the Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies to support a special focus on children involved with the child welfare system and special analyses of the effects of managed care initiatives on this population. The Tracking Project is conducted jointly by the Research and Training Center for Children's Mental Health at the Louis de la Parte Florida Mental Health Institute (FMHI), 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 Tracking Project has been undertaken during a period of rapid change in public sector health and human service systems. States, and, increasingly, local governments have been applying managed care technologies to the delivery of mental health and substance abuse services (together referred to as "behavioral health services" in this study) for children and adolescents and their families in Medicaid, mental health, substance abuse, and child welfare programs. These public sector managed care reforms are the focus of the Health Care Reform Tracking Project. The Tracking Project is the only national study focusing specifically on the impact of these public sector managed care systems on children and adolescents with behavioral health disorders and their families.

The Tracking Project focuses on children, adolescents, and families who rely on public sector agencies for behavioral health services. These include Medicaid-eligible, poor, and uninsured children and their families; children and adolescents who have serious behavioral health disorders whose families exhaust their private health coverage; and families who turn to

the public sector to access particular types of services that are not available through their private coverage. Often, these youth are involved with multiple state and local systems, including mental health, substance abuse, health, child welfare, juvenile justice, and education systems.

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

Since its inception, the Tracking Project has been exploring whether and how different kinds of managed care approaches and characteristics have differing effects on this population of children and adolescents and their families and on the systems of care that serve them. It is examining the impact of managed care across a broad range of areas associated with effective behavioral health service delivery for children, including: access to and availability of services, services for children with serious and complex disorders, family involvement, service coordination, provider capacity, cultural competence, financing approaches, quality, outcomes, and cost.

Throughout all of its activities, the Tracking Project has been comparing the characteristics and effects of managed care systems with two basic types of designs:

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

The Tracking Project is intended to be useful to public officials, families, managed care entities, providers, advocates, and other key stakeholders involved in and affected by public sector managed care.

Methodology of the Tracking Project

The methodology of the Tracking Project has involved four major components: 1) conducting periodic surveys of all states, 2) conducting impact analyses through in-depth site visits to a select sample of states, 3) identifying and studying promising approaches and features of managed care systems for children and adolescents with behavioral health treatment needs, and 4) organizing a consensus conference to develop recommendations for behavioral health managed care policy, practice, and research.

State Surveys

The Tracking Project has completed four state surveys — the 1995, 1997/98, 2000, and 2003 State Surveys. These surveys were designed to identify and describe public sector managed care activity occurring in all 50 states and the District of Columbia that affects children and adolescents with behavioral health disorders and their families. The 1995 State Survey provided a baseline description of state managed care activity, which the

1997/98, 2000, and 2003 State Surveys updated by examining changes over time. The 2003 State Survey is the last all-state survey conducted as part of the Tracking Project. This report documents the results of the 2003 State Survey, building on the previous work of the Tracking Project.

Impact Analyses

Two impact analyses were conducted as a component of the Tracking Project, one in 1997 and a second in 1999. The impact analyses examined the impact of managed care activity as perceived by multiple key stakeholders interviewed during site visits and as documented quantitatively to the extent that data were available. For the 1997 Impact Analysis, site visits were conducted to a sample of 10 states (Arizona, Connecticut, Delaware, Iowa, Massachusetts, North Carolina, Oregon, Rhode Island, Utah, and Washington) and for the 1999 Impact Analysis, the Tracking Project conducted site visits to a sample of eight new states (Colorado, Indiana, Maryland, Nebraska, New Mexico, Oklahoma, Pennsylvania, and Vermont). Site visits were conducted by teams comprised of four to five trained interviewers, knowledgeable in the areas of children's mental health, child welfare, adolescent substance abuse, and managed care; each site visit team included a family member with expertise in these areas. Another component of the 1999 Impact Analysis involved examining changes that occurred in the first sample of 10 states since the 1997 analysis through a series of telephone interviews with key stakeholders (referred to as the "maturational analysis").

Study of Promising Approaches

Another component of the Tracking Project has focused on identifying and describing promising strategies, approaches, and features within publicly financed managed care systems for providing behavioral health services to children and adolescents and their families. The impact analyses and state surveys were used as vehicles to identify promising approaches. More detailed information was gathered about these approaches and features through site visits and telephone interviews. The products comprise a series of papers, each describing promising approaches focusing on a specific aspect of managed care systems. The series is intended to offer guidance to states and communities attempting to refine their managed care systems to better meet the needs of youth with behavioral health disorders and their families.

Consensus Conference

A consensus conference, planned and organized by the Tracking Project, was held in September 2003. The overall goal of the conference was to develop a set of agreed-upon recommendations for policy, practice, and research, based on research results, related to publicly financed managed care for children and adolescents with behavioral health disorders and their families. The consensus conference was attended by researchers who have conducted research related to managed care for children's behavioral health services, as well as key stakeholders representing the policy making, advocacy, family, and managed care communities. The process involved identifying key learnings across research projects; identifying implications for policy, practice, and research; identifying essential elements of managed care for children's behavioral health; and developing recommendations for policy, practice, and research. The product will be a report outlining

the agreed-upon essential elements for managed care systems serving children and adolescents with behavioral health disorders and their families and the recommendations. This will be disseminated strategically to key stakeholders to provide assistance in improving behavioral health care to children and adolescents within the context of managed care.

Methodology of the 2003 State Survey

The approach to conducting the 2003 State Survey involved three distinct phases: survey development, survey distribution and collection, and data analysis and report development. Each phase is briefly described below.

Survey Development

The 2003 State Survey, included as **Appendix A**, was designed to build on previous activities and findings of the Tracking Project. The primary goals in developing the survey instrument included:

- Retaining key items from the 1995, 1997/98, and 2000 State Surveys in order to be able to track continuing development, changes, and trends in managed care systems affecting children and adolescents with behavioral health needs over time.
- Incorporating additional items to address issues that were identified during previous Tracking Project activities to clarify findings and examine key questions across all states.
- Incorporating a "general update" section to determine the impact of the current fiscal crises facing most states on their managed care systems, perceived success of managed care systems in achieving their goals, and future plans regarding managed care for behavioral health services.

With these objectives as a guide, the 2000 State Survey instrument was revised and refined to create the 2003 survey instrument. The survey captures information within the following domains:

- General information about managed care systems
- Populations included in managed care systems
- Managed care entities
- Service coverage and capacity
- Special provisions for youth with serious and complex behavioral health needs
- Financing and risk
- Clinical decision making and management mechanisms
- Access
- Service coordination
- Early identification
- Family involvement
- Cultural competence
- Providers
- Accountability
- General update

Survey Distribution and Follow-Up

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

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

Survey Analysis and Report Development

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

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

This report presents the results of the 2003 State Survey. Where possible, findings are compared with survey results obtained in 1995, 1997/98, and 2000 to identify changes and trends; findings from the two impact analyses also are cited where relevant and appropriate to elucidate issues or survey results.

II. General Information about State Managed Care Systems

Extent of Managed Care Activity

All 50 states, plus the District of Columbia, responded to the survey, with 38 states reporting that they are involved in implementing one or more managed care systems affecting behavioral health service delivery for children and their families.

Only five states over the past decade have never implemented managed care technologies affecting behavioral health services for children and their families. This includes three states that planned but never implemented managed care affecting behavioral health services (Kentucky, Maine, and New Hampshire), and two states (Kansas and Wyoming) that never planned or implemented managed behavioral health care.[1]

As **Table 1** shows, of the 46 states (including the District of Columbia) 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 only a slight retrenchment, with just four states terminating an existing or planned managed care system — two terminated existing systems and two terminated planning for managed care implementation. These are fewer terminations than between 1997/98 and 2000, when there were seven terminations. Since 2000, one state (New Jersey) reported starting a managed care system affecting behavioral health services for children. Thus, the 2003 state survey data suggest a certain settling in the managed care landscape.

Table 1
Status of Managed Care Systems Affecting Behavioral Health Services for Children and Adolescents in States in 2003

Number of states that started a managed care system since 2000			1
Total number of states that terminated a managed care system	Terminated Pre 2000	7	9
	Terminated Post 2000	2	
Number of states that continued to operate a managed care system			37
Number of states that have never planned nor implemented a managed care system			2
Number of states that have planned for managed care system but did not implement			5

Matrix 1 describes managed care activity by state.

[1] The Tracking Project use a broad definition of managed care, which 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.

Notes:

1 Using managed care system technologies

2 Substance abuse only

3 Multiple managed care sytems described in detail

Matrix 1: Status of Managed Care Systems Affecting Behavioral Health Services for Children and Adolescents in States in 2003

		Started a Managed Care System Since 2000	Terminated a Managed Care Reform		Continued to Operate a Managed Care System	Never Planned nor Implemented a Managed Care System	Planned for Managed Care System but Did Not Implement
			Pre 2000	Post 2000			
Alabama	AL		●				
Alaska	AK		●				
Arizona	AZ				●		
Arkansas	AR		●				
California	CA				●		
Colorado	CO				●		
Connecticut	CT				●		
Delaware	DE				●		
District of Columbia	DC				●		●
Florida	FL				●		
Georgia	GA				● 1		
Hawaii	HI				●		
Idaho	ID				● 2		
Illinois	IL				●		
Indiana	IN				●		
Iowa	IA				●		
Kansas	KS					●	
Kentucky	KY						●
Louisiana	LA		●				
Maine	ME						●
Maryland	MD				●		
Massachusetts	MA				●		
Michigan	MI				●		
Minnesota	MN				●		
Mississippi	MS			●			
Missouri	MO				●		
Montana	MT		●				
Nebraska	NE				●		
Nevada	NV				●		
New Hampshire	NH						●
New Jersey	NJ	●					
New Mexico	NM				●		
New York	NY		●		●		
North Carolina	NC		● 1				
North Dakota	ND				● 3		●
Ohio	OH				●		
Oklahoma	OK				●		
Oregon	OR				●		
Pennsylvania	PA				●		
Rhode Island	RI				●		
South Carolina	SC			●			
South Dakota	SD				●		
Tennessee	TN				●		
Texas	TX				●		
Utah	UT				●		
Vermont	VT				●		
Virginia	VA				●		
Washington	WA				●		
West Virginia	WV				●		
Wisconsin	WI				● 3		
Wyoming	WY					●	
Total		**1**	**9**		**37**	**2**	**5**

2003 State Sample

While 2003 survey respondents reported a total of 40 managed care systems underway in 38 states, they provided detailed descriptive data on a total of 39 systems in 37 states (**Table 2**). The analysis that follows pertains to these 39 managed care systems operating in 37 states.

Table 3 provides a brief narrative description of the 39 systems that are analyzed for the 2003 state survey report.

Table 2
Managed Care System Described Through 2003 Survey

	2000 Survey	2003 Survey
Number of states that continued to operate or started a managed care system	42	38
Total number of managed care systems identified by states	43	40
Total number of managed care systems described in detail included in 2003 survey analysis	35	39

Table 3
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Arizona AZ	Arizona has had an 1115 waiver since the beginning of its Medicaid program. The waiver allows for the enrollment of Medicaid eligible persons in a statewide system of health plans which operate similar to HMOs. In October of 1990, the state incorporated mental health services into its managed care system through a contract from the State Medicaid agency to the AZ Department of Health, Division of Behavioral Health, to operate a behavioral health carve out for mental health and substance abuse services. Medicaid eligible populations were phased in under capitated behavioral health contracts with Regional Behavioral Health Authorities (RBHAs) as the managed care entities. RBHAs offer a continuum of behavioral health services within each geographic service area of the state. Initially, children and adolescents were covered, later adults with serious mental illness were added, and later adults with substance abuse problems and general mental health clients were added to covered populations. As of October 2001, the managed care system has incorporated significant changes. For example, the services covered under the managed care system were expanded to include 9 domains of covered services (treatment, rehab, support, medical, crisis, inpatient, prevention, residential, and day programs) in order to increase flexibility and service capacity, and provider types were expanded to deliver covered services (e.g., paraprofessionals). Under support, services are now included such as therapeutic foster care, respite, family support, peer support, personal assistance, housing support, etc.	Statewide	1115	Carve Out	1990

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
California CA	California's Medi-Cal Mental Health Managed Care Program began implementation in March 1995 with the consolidation of Medi-Cal Psychiatric Hospital Inpatient services at the county level. Phase two consolidated Medi-Cal professional specialty mental health services at the county level in November of 1997. These were based on approval of a 1915(b) Freedom of Choice waiver that allowed the county mental health programs (MHPs) to contract with specific providers. The county MHPs negotiate rates, authorize services, and provide payment for services rendered by specialty mental health providers.	Statewide	1915(b)	Carve Out	1995
Colorado CO	Mental health services to Medicaid clients are provided through a capitated managed care program. Eight contractors, known as Mental Health Assessment and Services Agencies (MHASAs) operate the program in eight separate geographic areas of the state. Enrollment is mandatory based on aid category and county of Medicaid eligibility, and is completed through an automated system operated by the state.	Statewide	1915(b)	Carve Out	1995
Connecticut CT	Husky A & B The Husky managed care program enrolls recipients into health plans providing physical and acute care behavioral health services. Health plans typically subcontract behaviorh health services to BHOs.	Statewide	1915(b)	Integrated	1995 (A) 1998 (B)

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Delaware DE	The state of Delaware received a Medicaid 1115 waiver to implement managed care in Delaware (mandatory). The "Diamond State Health Plan" began in 1996. Under the waiver, a public/private partnership for children's behavioral healthcare was created. Contracted Managed Care Organizations (MCOs) provide the Medicaid managed care basic benefit, which includes 30 hours of outpatient behavioral (mental health and/or substance abuse) services for children. Delaware's Medicaid Office selected the Delaware Division of Child Mental Health Services to provide all extended care for Medicaid clients. When child MA clients need a more intensive/restrictive level of care than outpatient or if they exhaust their 30 hours of outpatient services, they are referred by the MCO (or its treatment provider on its behalf) to DCMHS for extended services. DCMHS is a JCAHO-accredited managed behavioral healthcare organization and provides mental health and substance abuse treatment for children statewide who are Medicaid clients or are without insurance. DCMHS provides treatment to more than 2,220 children and their families each year. Its service array includes outpatient, intensive outpatient (in-home/frequent outpatient), behavioral health aides, statewide mobile crisis intervention service, day treatment, individual residential treatment, mental health/substance abuse residential treatment (facility based) and psychiatric hospital. There are no benefit limits per se–the only limitation is the clinical necessity determination. Services are provided as long as they are clinically necessary for the child. DCMHS is part of a Cabinet-level, integrated Children's Department in Delaware, with sister divisions for child welfare, juvenile justice, and support. An electronic management information system (Family and Child Tracking System–FACTS) includes children served by all of the department's divisions. It is available state-wide, 24/7 to care coordinators for children's services, including by remote access.	Statewide	1115	Integrated with Partial Carve Out	1996

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
District of Columbia DC	The DC Medicaid agency oversees a Medicaid managed care system that enrolls recipients into health plans providing physical and acute care behavioral health services. Health plans typically subcontract behavioral health services.	Statewide	NA	Integrated	NA
Florida FL	Medicaid beneficiaries in Areas Six and One (nine counties total) in certain eligibility categories and who are not also enrolled in Medicare, have a choice of enrollment in a Medicaid HMO or MediPass/PMHP. Medicaid beneficiaries who are enrolled in MediPass in the designated areas are also assigned to the Prepaid Mental Health Plan for their mental health benefits. PMHP contractors are capitated for inpatient psychiatric, emergency mental health, community mental health and mental health targeted case management services. All other benefits for these beneficiaries remain fee-for-service through the Medicaid system.Medicaid beneficiaries who enroll in a Medicaid HMO in their designated areas receive both physical and mental health services through the HMO provider network. HMOs in these areas are capitated for almost all health care with the exception of dental and transportation. Florida has two different Prepaid Mental Health Plans currently operating. One is a partnership between the MCO and community mental health centers and they share risk. In the other arrangement the MCO assumes all risk and subcontracts with three providers on a subcapitated basis and one provider on a fee-for-service basis.	2 Areas, Phasing in Statewide	1915(b)	Carve Out	1996, Area Six 2001, Area One
Georgia GA	Currently there is not a full managed care system in GA that affects behavioral health services for children and adolescents/families who receive public mental health services. GA does have an extended review organization (ERO) called American Psych Systems (APS), which contracts with the state to perform utilization management/ utilization review for Medicaid rehabilitation option services. The contract is not an at-risk contract, but a fee-for-service contract using managed care technologies.	Statewide		Carve Out	
Hawaii HI	The Hawaii Child and Adolescent Mental Health Division (CAMHD) manages a carve out in the state's managed care system, Hawaii Quest. CAMHD provides a comprehensive array of mental health services to children and youth eligible for services in accordance with the definition of the eligible population. CAMHD receives capitation payments to provide services through case management and a full array of services.	Statewide	1115b	Carve Out	1999

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Illinois IL	Illinois operates an integrated, voluntary Medicaid managed care program (Voluntary Managed Care) that includes some mental health and substance abuse services. The Illinois Department of Public Aid contracts with four health maintenance organizations and one Managed Care Community Network (MCCN) to provide services in Cook, St. Clair and Madison counties. MCCNs are similar to HMOs except that they are provider-based and regulated by the Illinois Department of Public Aid, whereas HMOs are regulated by the Illinois Department of Insurance. The program is financed with Title XIX, Title XXI and state GRF funds and serves Temporary Assistance for Needy Families, Family Health Plans, and KidCare (State Children's Health Insurance Program) populations.	3 Counties Including Chicago	NA	Integrated	1998
Indiana IN	The Hoosier Assurance Plan (HAP) is a risk sharing managed care system for non-Medicaid public behavioral health services, operated by the State Division of Mental Health, which acts as a purchasing agent, contracting with qualified managed care providers offering an array of individualized mental health and addiction care. HAP creates a priority for individuals with greatest need, and incorporates separate case rates for children with serious emotional disorders and for adolescents with substance abuse problems.	Statewide	NA	Carve Out	1995
Iowa IA	The Iowa Plan combined the two original managed care contracts for Mental Health (initiated on March 1, 1995) and for Substance Abuse (initiated on September 1, 1995) into one combined contract. The Iowa Plan contract includes: a full risk Medicaid carve out for most of Iowa's Medicaid population and the Substance Abuse Block Grant funds for non-Medicaid persons below 300% of poverty.	Statewide	1915(b)	Carve Out	1999
Maryland MD	Mental Health services are provided through a carve out administered by the state Mental Hygiene Administration in conjunction with local Core Service agencies and a contracted BHO that provides ASO functions.	Statewide	1115	Carve Out	1997
Massachusetts MA	The waiver includes both the Primary Care Clinician (PCC) Plan and its behavioral health carve out, as well as the traditional HMOs and MCOs, some of which have mental health subcontracts and some of which do not.	Statewide	1115	Carve Out	1992

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Michigan MI	As of October 1, 2002 the Department has a new relationship with the Community Mental Health Services Programs (CMHSPs) as the 48 CMHSPs will be covered by 18 Prepaid Health Plans (PHPs), responsible for Medicaid mental health and substance abuse services implementation. A comprehensive Application for Participation (AFP) was utilized to determine whether CMHSPs were able to provide the services required under Medicaid Managed Care while still meeting State Mental Health Code and Department of Community Health requirements. In order to be eligible to submit an AFP, a CMHSP had to have a minimum of 20,000 Medicaid covered persons within their geographic service area. Thus, in response to the AFP, CMHSPs submitted lengthy applications that were reviewed and then followed up with on-site reviews by Department staff. Many CMHSPs used a "hub and spoke" model and formed legal affiliations in which one CMHSP is the recipient of the funds (the hub) with the other CMHSPs being affiliates (spokes). This is intended to reduce administrative costs and the duplication of services that occurred when each agency functioned as its own entity. Six of the larger CMHSPs have applied to be independent PHPs with no affiliates, however they have had to make significant changes to comply with the AFP. Additionally, many mechanisms are in place to protect consumers and limit administrative costs to 10%. The 18 Prepaid Health Plan (PHPs) are the recipients of the Medicaid funds to use to provide services for the persons served.	Statewide	1915(b) & (c)	Carve Out	1998 (from 2000 survey)
Minnesota MN	Integrated reform includes health and mental health. In some plans, also includes substance abuse. Has been implemented incrementally. Most of the counties (and Medicaid populations) are now covered. Number of plans varies regionally.	Most Counties Covered, Phasing in Statewide	1115	Integrated	1985

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Missouri MO	MC+ managed care provides health care services for MC+ beneficiaries through a managed care system. All MC+ beneficiaries are required to enroll in MC+ managed care except individuals who are in the MC+ managed care program either because they receive SSI disability payments, they meet the SSI disability definition as determined by the Department of Social Services, or they receive adoption subsidy benefits. These individuals have the option of choosing to receive health care services on a fee-for-service basis or through the MC+ managed care program. The option is entirely up to the individual, parent, or guardian. Those individuals not residing in a MC+ managed care county receive their health care services on a fee-for-service basis. MC+ managed care is currently operating in 37 counties in the eastern, central, and western regions of the state. Missouri expanded Medicaid coverage to low-income, uninsured children under the age of 19 under an 1115 waiver in September, 1998. Effective February 1, 1999, the expansion began providing health insurance for some uninsured parents.	37 Counties in Eastern Central & Western Regions	1915(b) & 1115	Integrated	1995
Nebraska NE	There was a capitated contract with Value Options until January 2002, as the statewide BHO for its Medicaid behavorial health carve out. The system changed to a contract for an ASO with Value Options until July 2002. In July 2002 this changed to an ASO with Magellan Behavioral Health through current date September 2003.	Statewide	NA	Integrated	1995
Nevada NV	In 1999, Nevada began operating a capitated, risk based, non-waiver Medicaid Managed Care Program that includes behavioral health services. The integrated program operates strictly in Clark and Washoe counties. It provides mental health and substance abuse services to the Temporary Assistance for Needy Families population. Medicaid contracts directly with four HMOs, three of which subcontract with behavioral health managed care organizations to provide services on a fully capitated basis.	Most Populated 2 Counties	NA	Integrated	2001

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
New Jersey NJ	NJ's Partnership For Children: The Managed Care System is changing how care is organized, managed and coordinated for children with emotional and behavioral problems to support community living and ensure children receive the same level and quality of services regardless of where they live in NJ. Since January 2001 and over the next 3 years the system has and will continue to pool resources and maximize federal funding to expand the array of services. Residential treatment, group homes, mobile response, intensive in-home/ in-community services, behavioral assistance, care management, and administrative portion of Family Support are now eligible for Federal Medicaid. System assures family involvement at all levels through Family Support Organizations (FSO) that provide family support and advocacy and assure family partnership in all policy and service provision decision making. There is one Contracted System Administrator (CSA) statewide which provides families/caregivers with 24 hour access through a single statewide toll-free line. The CSA triages crises, tracks and authorizes services, coordinates care and assists DHS to monitor and improve the quality of care. The CSA in NJ is a non-risk based model. CSA also provides the MIS and continuous quality improvement tracking. Care coordination for children with the most serious emotional and behavioral problems and their families is assured through Care Management Organizations (CMOs) on the local level. CMOs organize Child and Family Teams to plan for and ensure the delivery of individualized and intensive community-based services. They have access to flex funds and clinical services for developing wraparound plans for the youth and their families.	Statewide	NA	Carve Out	2001
New Mexico NM	Integrated model. In July of 2001, the human services department medical assistance division (Medicaid) issued new contracts. These contracts were to three MCOs which are required to manage the behavioral health benefit. They are not allowed to sub-contract to BHO's or regional networks for administrational services.	Statewide	1915(b)	Integrated	1997

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
New York NY	Effective July 1997, the Federal government approved a waiver pursuant to Section 1115 of the Social Security Act authorizing New York State to implement a mandatory Medicaid managed care program, referred to as "The Partnership Plan." The Partnership Plan provides managed health care and behavioral health care through Medicaid managed care organizations and HIV/AIDS special needs plans. The New York State Department of Health, which is both the single state agency responsible for the Medicaid program and the State Health agency, administers the Partnership Plan. Mandatory Medicaid managed care is being implemented on a phase-in basis. To date, twenty-two counties, and the five boroughs of NYC participate in the program. Certain other counties are exempt from mandatory participation due to lack of plan/provider capacity. The counties and New York City contract with Managed Care Organizations qualified by New York State Department of Health (NYSDOH) to provide Medicaid managed care benefits to the enrolled population. All of the OMH certified services designed for children and adolescents with SED are excluded from the managed care benefit. Children and adolescents enrolled in Medicaid managed care receive these services through Medicaid participating providers who are paid through the Medicaid fee-for-service program. This includes New York's Home and Community Based waiver program for children with SED. With the exception of medically managed inpatient detoxification and medically supervised inpatient and outpatient withdrawal services, the managed care benefit for the SSI population is a health only benefit with all behavioral health services available from Medicaid participating providers who are paid through the Medicaid fee-for-service program.	22 Counties, Including New York City	1115	Integrated	1997
North Dakota ND	1. Fully capitated MCO program in one county in the state.	One county	NA	Integrated	1997
	2. Statewide fee-for-services Primary Care Case Management; administered by the state	Statewide	NA	Integrated	1994
Ohio OH	Currently operating in 15 counties as a mix of voluntary, mandatory, and "preferred option" enrollment in the counties. Medicaid-serving MCOs are responsible for providing behavioral health services. This may be accomplished via their own provider panels or more commonly through enrollees' ability to self direct without the need for a referral to publicly funded community providers administered by a local board.	15 Counties	1915(b)	Integrated	2002

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Oklahoma OK	SoonerCare Plus is the Medicaid managed care reform for the urban areas of the state including the surrounding counties of Lawton, Oklahoma City, and Tulsa. Behavioral health care was left out of SoonerCare Plus in the first year; it became part of the HMO system in the second year. The first population to be brought into managed care was AFDC/TANF. The Aged, Blind and Disabled population was added to SoonerCare Plus in July 1998. Children who are in the custody of the Department of Human Services or the Office of Juvenile Affairs are not enrolled in managed care. For the rural areas of the state, a partially capitated program (SoonerCare CHOICE) is provided, using a primary care provider/case manager model for medical needs. Under SoonerCare CHOICE, individuals may self refer for behavioral health care and payment is made through Medicaid fee-for-service.	25 Counties, 3 of 6 Zones	1115	Integrated	1995
Oregon OR	The Oregon Health Plan is a statewide managed care system using capitation financing. A mental health package was implemented statewide in 1997.	Statewide	1115	Carve Out	1997

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Pennsylvania PA	HealthChoices is implemented by zone. Thus far, PA has procurred three out of six zones which represent a total of 25 counties.The HealthChoices Medicaid Mandatory Managed Care Program operates under a Federal 1915(b) waiver to provide medical, psychiatric and substance abuse services to Medical Assistance recipients, and consists of physical and behavioral health components which are implemented through separate procurements. The goals of the Health Choices physical and behavioral health care programs are to improve accessibility, continuity, and quality of services for Pennsylvania's Medical Assistance populations, while controlling the program's rate of cost increases. The Federal 1915(b) waiver allows Pennsylvania counties First Right of Opportunity to self-manage HealthChoices behavioral health services or subcontract to a Behavioral Health Managed Care Organization (BH-MCO) to manage the services with county oversight. The Department of Public Welfare is interested in contracting with entities that will: 1.) Facilitate efficient coordination, continuity and integration in the provision of behavioral health services; 2.) Coordinate the provision of behavioral health services with the Physical Health Services component of the HealthChoices Program; and 3.) Coordinate behavioral health services with the broader array of publicly funded human service agencies, as well as the informal, community support systems of members. HealthChoices innovations include, but are not limited to: County First Right of Opportunity, Behavioral Health Carve Out, County Consortiums, County Formed 501 C3, Readiness Review Process prior to implementation through Letters of Agreement, Consumer/Family/ Persons in Recovery Involvement, In-Plan Service Benefits, Supplemental Services, Access Standards, Medical Necessity Criteria, Quality Improvement Plans, Restrospective and Annual Reviews, and Consumer/Family Satisfaction Assessment.	25 Counties	1915(b)	Carve Out	SE-1997, SW-1999, Lehigh/ Capitol-2001
Rhode Island RI	Rhode Island has been implementing RiteCare, an integrated Medicaid managed care system since 1994. RiteCare expanded Medicaid eligibility and increased access to physical health services and behavioral health services.	Statewide	1115	Integrated	1994

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Table 3 (continued)
Description of Managed Care Reforms

State		Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
South Dakota	SD	The South Dakota Managed Care Program is a Medicaid managed health care system for primary care services. This program creates a "partnership" between the Primary Care Provider (PCP) and the Medicaid Managed Care eligible recipient. The Medicaid Managed Care Program was incrementally implemented by groups of counties and became a statewide program December 1, 1995. This program emphasized recipient responsibility and communication between Primary Care Providers and recipients. South Dakota operates one statewide Medicaid managed care program, the Provider and Recipient in Medicaid Efficiency (PRIME) program. PRIME is a primary care case management program that requires referrals for inpatient and outpatient services (including physical and behavioral health) for most Medicaid and SCHIP beneficiaries.	Statewide	NA	Integrated	1993
Tennessee	TN	TennCare Partners is a 1115 waiver program covering Medicaid eligibles as well as uninsured/ uninsureables statewide. Tennessee contracts with two Behavioral Health Organizations to provide services previously covered by Medicaid. The BHOs are paid a capitated rate on a per member/per month basis.	Statewide	1115	Carve Out	1996
Texas	TX	NorthSTAR is a fully capitated managed care "carve out" providing behavioral health services for persons residing in North Texas, specifically Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties. NorthSTAR provides services to both Medicaid and non-Medicaid (medically indigent) individuals using state, local and federal funds to provide an integrated and less fragmented system of care for eligible individuals.	7 Counties	1915(b)	Carve Out	1999
Utah	UT	The Medicaid agency contracts with nine community mental health centers to provide all inpatient and outpatient mental health care to Medicaid recipients residing in their catchment areas. Enrollment is automatic. The nine community mental health centers cover 27 of Utah's 29 countries. The only populations excluded from enrollment in this managed care program are residents at the Utah State Hospital and the Development Center. Also, children in state custody are enrolled only for inpatient psychiatric care. Their oupatient care is excluded from the managed care system.	27 out of 29 Counties	1915(b)	Carve Out	1991
Vermont	VT	Vermont implemented a Medicaid managed care system with two basic goals: to expand eligibility to cover low income people, and to institute managed care for Medicaid only (as opposed to dual eligible) recipients.	Statewide	1115	Integrated	1996

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Table 3 (continued)
Description of Managed Care Reforms

State	Description of Managed Care Reform	Extent of Managed Care System	Type of Waiver	Type of Design	Implementation Date
Virginia VA	Medallion II is an integrated Medicaid managed care system utilizing HMOs. The system covers clinic option services only (e.g., outpatient, inpatient, and emergency) for mental health. State plan option service (e.g., rehab services) remain fee-for-service.	42 of 124 Areas, Phasing in Statewide	NA	Integrated	1995
Washington WA	The system started with a capitated system for outpatient mental health only in 1993. In 1996, it was amended to include community psychiatric inpatient services. Outside the waiver are state psychiatric hospital and residential treatment facilities for children and youth. The system includes mandatory enrollment of all Medicaid enrollees into a single PHP for their service area, 14 in total operated by county governments.	Statewide	1915(b)	Carve Out	1993
West Virginia WV	An ASO, APS Healthcare, Inc., provides prior authorization, continued stay (concurrent review), and retrospective review of Medicaid clinic, rehabilitation and targeted case management services; prior authorization of out-of-state child welfare placements (non-Medicaid added 04-03); review of PRTF certifications; basic eligibility; determination for non-Medicaid Mental Health and Substance Aubse Services funded by the Mental Health Authority.	Statewide	NA	Carve Out	1996
Wisconsin WI	1. Medicaid Health Care HMO for TANF and SCHIP populations (13 HMOs statewide)	Statewide	1115	Integrated	1984
— end of Table 3	2. Children Come First/Wraparound Milwaukee; County contracted behavioral health carve out for children under 18 with Severe Emotional Disturbance.	2 Most Populated Counties	NA	Carve Out	1997

Focus and Design of Managed Care Activity

As **Table 4** shows, the primary focus of most managed care systems in the 2003 sample (61% of the systems) is Medicaid managed care reform, followed by a joint focus on Medicaid and public behavioral health system reform (33%). As was the case in 2000, few systems (3%) are focused on interagency reform across children's systems, and few (3%) are focused only on public behavioral health system reform.

Table 4
Primary Focus of Managed Care Systems

	2000		2003		Percent of Change 2000–2003
	Number of Systems	Percent of Systems	Number of Systems	Percent of Systems	
Medicaid managed care system	15	43%	24	61%	18%
Public sector behavioral health managed care system	2	6%	1	3%	-3%
Medicaid and public behavioral health managed care system	16	46%	13	33%	-12%
Children's interagency managed care system	2	6%	1	3%	-3%
Other	0	0%	0	0%	0%

The 2003 sample of 39 systems includes 22 behavioral health carve outs and 17 integrated physical/behavioral health designs[2] (**Table 5**). The 2003 sample includes a larger percentage (21% more) of integrated physical/behavioral health managed care designs than the 2000 sample, which reflects an effort on the part of the HCRTP to increase the percentage of systems with integrated designs responding to the survey rather than an actual increase in the number of integrated systems in operation in the states.

Table 5
Number and Percent of Managed Care Systems by Type of Design

	1997–1998		2000		2003		Percent of Change 1997/98–2003	Percent of Change 2000–2003
	Number of Systems	Percent of Systems	Number of Systems	Percent of Systems	Number of Systems	Percent of Systems		
Integrated	15	35%	8	23%	17	44%	9%	21%
Carve Out	28	65%	27	77%	22	56%	-9%	-21%

[2] The HCRTP defines an integrated design as one in which the financing and administration of physical and behavioral health services are integrated (even if behavioral health services are subcontracted), and defines a behavioral health carve out as one in which behavioral health services are financed and administered separately from physical health care within a managed care system.

Table 6 lists the 37 states in the 2003 sample by type of managed care design. (Note that North Dakota and Wisconsin reported on two systems, bringing the number of managed care systems in the 2003 sample to 39.)

Most of these managed care systems (62%) are statewide, and an additional third (36%) affect multiple areas within states, typically, the most populated areas. Only one system in the sample was limited to a single area within the state. This reflects an expansion of managed care within states over the past decade as, increasingly, systems have moved to statewide implementation.

Use of Waivers

As **Table 7** shows, most managed care systems (71%) involve the use of a Medicaid waiver, although there has been a moderate decline in the percentage of systems with waivers over time, down 15% since the 1997/98 state survey. This may be due to the Balanced Budget Act of 1997, which allowed for the implementation of managed care without a Medicaid waiver.

Table 6

Type of Design of Managed Care Systems in Sample by State

2003			
Carve Out Design		**Integrated Design**	
Arizona	AZ	Connecticut	CT
California	CA	District of Columbia	DC
Colorado	CO	Illinois	IL
Delaware	DE	Minnesota	MN
Florida	FL	Missouri	MO
Georgia	GA	Nevada	NV
Hawaii	HI	New Mexico	NM
Indiana	IN	New York	NY
Iowa	IA	North Dakota –1	ND
Maryland	MD	North Dakota –2	ND
Massachusetts	MA	Ohio	OH
Michigan	MI	Oklahoma	OK
Nebraska	NE	Rhode Island	RI
New Jersey	NJ	South Dakota	SD
Oregon	OR	Vermont	VT
Pennsylvania	PA	Virginia	VA
Tennessee	TN	Wisconsin	WI
Texas	TX		
Utah	UT		
Washington	WA		
West Virginia	WV		
Wisconsin	WI		

Table 7

Percent of Managed Care Systems Involving Any Medicaid Waiver

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Any Waiver	84%	86%	71%	77%	63%	71%	-13%	-15%	0%

Table 8 Percent of Managed Care Systems Involving Any Medicaid Waiver									
	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
1115	37%	87%	17%	47%	64%	54%	17%	-33%	37%
1915(b)	44%	49%	37%	53%	36%	46%	2%	-3%	9%

Table 8 shows, consistent with findings over the course of the Tracking Project, that integrated systems are more likely to use 1115 waivers, and behavioral health carve outs are more likely to use 1915(b) waivers. (The 2003 survey sample shows an increase in the percentage of systems with 1115 waivers because of the larger percentage of integrated designs in the sample than was the case in 2000.)

Stage of Implementation

Most managed care systems (90%) are in late stages of implementation, defined as more than three years, with integrated systems somewhat 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) were reported to be in the early stages of implementation in the 2003 sample; none reportedly were in the planning stage (**Table 9**).

Table 9 Implementation Stage of Managed Care Systems									
	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Planned, Not Yet Implemented	58%	21%	9%	0%	0%	0%	-58%	-21%	-9%
Early Implementation (Less than 1 year)	21%	23%	11%	5%	6%	5%	-16%	-18%	-6%
Mid Implementation (1–3 years)	12%	33%	9%	9%	0%	5%	-7%	-28%	-4%
Late Implementation (More than 3 years)	9%	19%	71%	86%	94%	90%	81%	71%	19%

Inclusion of Substance Abuse Services

As **Table 10** shows, most managed care systems in the 2003 sample (77%) include substance abuse services, with integrated systems being more likely to do so (88% of integrated systems versus 68% of carve outs). The Tracking Project consistently has found that integrated systems are more likely to include substance abuse than are carve outs. This is an interesting finding, given the known co-morbidity of mental health and substance abuse disorders. However, it is not necessarily surprising given the historical separation of the two systems. The 2003 data do suggest, however, that both carve outs and integrated systems have increased slightly their inclusion of substance abuse since 2000.

Table 10
Percent of Managed Care Systems Including Substance Abuse Services

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Managed care systems include substance abuse services	75%	79%	68%	68%	88%	77%	2%	-2%	9%

When substance abuse treatment is not included in the behavioral health managed care system, 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 (**Table 11**).

Table 11
Percent of Managed Care Systems by Type of Arrangements for Substance Abuse Services When Substance Abuse is Not Included in the Reported Managed Care System

	2000 Survey	2003 Survey
Separate substance abuse managed care system carve out	18%	11%
Substance abuse is Integrated with physical health managed care system that does not include mental health	9%	11%
Substance abuse remains fee-for-service	73%	78%

Parity Between Physical Health and Behavioral Health Services

Table 12 indicates that in two-thirds of the managed care systems in the 2003 sample (68%), reportedly there 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 in which there is reported parity. The decline in parity may be associated with state budget deficits, or with the greater percentage of integrated designs in the 2003 sample, or some other factor. Throughout the Tracking Project, stakeholders interviewed for the impact analyses have reported that, even in states with parity laws, the duration or types of mental health services provided in managed care systems often are curtailed by the imposition of restrictive medical necessity or level of care criteria. This consistently has been associated more often with integrated designs than with carve outs. In the systems in the 2003 sample that did not report parity, the types of limitations on behavioral health services included day and visit limits on behavioral health care that are not imposed on physical health care, as well as lifetime limits on behavioral health services (**Table 13**).

Table 12

Percent of Managed Care Systems with Parity Between Behavioral Health and Physical Health Services

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Managed Care Systems with Parity	71%	60%	83%	44%	81%	68%	-3%	8%	-15%
Behavioral health more limited	29%	40%	17%	56%	19%	32%	3%	-8%	15%

Table 13

Percent of Managed Care Systems by Type of Limitation for Behavioral Health in Managed Care Systems Without Parity

	2003		
	Carve Out	Integrated	Total
Behavioral health services subject to higher co-payments and deductibles	20%	0%	13%
Lifetime limits on behavioral health services	40%	67%	50%
Day and/or visit limits on behavioral health services	40%	67%	50%
Other	100%	0%	63%

Goals of Managed Care Systems

Table 14 depicts the types of goals that managed care systems are trying to achieve. 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, up from 79% in 2000 to 97% in 2003. 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 to improve quality. State budget deficits may be contributing to this apparent shift in focus.

Table 14
Percent of Managed Care Systems by Types of Stated Goals

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Contain costs	93%	79%	95%	100%	97%	4%	18%
Increase access	93%	91%	86%	94%	90%	-3%	-1%
Expand service array	63%	67%	59%	29%	46%	-17%	-21%
Improve quality	91%	97%	86%	82%	85%	-6%	-12%
Improve accountability	65%	79%	86%	65%	77%	12%	-2%
Other	16%	21%	14%	12%	13%	-3%	-8%

Lead Agency Responsibility

As has been found consistently by the Tracking Project, state Medicaid agencies are most likely to be the lead agency responsible for managed care systems, with this being the case in nearly two thirds (65%) of the 2003 sample (**Table 15**). State mental health agencies are the next most likely agency to have lead responsibility, with this being the case in about a third of the 2003 sample (35%), all carve outs. State mental health agencies are far more likely to play the lead role in carve out arrangements, as one would expect, and state Medicaid agencies in integrated systems.

Table 15
Percent of Managed Care Systems by Lead Agency Responsibility

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Governor's office	3%	0%	0%	0%	-3%
State health agency	6%	0%	6%	3%	-3%
State Medicaid agency	55%	40%	94%	65%	10%
State mental health agency	24%	65%	0%	35%	11%
State substance abuse agency	Not Asked	5%	0%	3%	NA
Other	12%	20%	6%	14%	2%
NA=Not Applicable					

Involvement of Key Stakeholders

Since its inception, the Tracking Project has been looking at the issue of key stakeholder involvement in planning, implementing, and refining managed care systems. Key stakeholders as defined by the Tracking Project include: families; providers; and the major state child-serving systems, including children's mental health, substance abuse, child welfare, juvenile justice, and education systems. Nationally, the federal government has encouraged attention to the importance of partnering with families and consumers in the design and implementation of behavioral health delivery systems. This emphasis was most recently incorporated in the report of the President's New Freedom Commission on Mental Health. Additionally, there is recognition that, because children with behavioral health problems often are involved in multiple systems, a cross-agency perspective is critical to the design and operation of managed care systems. Since 1995, the Tracking Project has been examining the extent to which these key constituencies are involved in managed care systems.

From 1995 to 2000, the Tracking Project found a gradual trend toward increased stakeholder involvement, although, even with this trend, most key stakeholders lacked *significant* involvement in most systems. As **Table 16** shows, between 2000 and 2003, all stakeholder groups, except juvenile justice systems, reportedly lost ground in terms of being significantly involved in managed care systems. This may be because managed care is no longer "new," stakeholder interest has waned, or managed care systems have settled into a "business as usual" mode. The fact that significant involvement of juvenile justice systems actually increased slightly over 2000 may be due to the later enrollment and attention paid to this population within managed care systems relative to other populations, although it should be noted that significant involvement of juvenile justice stakeholders reportedly occurs in less than a third of managed care systems, even with the increase since 2000.

Table 16

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

	1997–98 Total	2000 Total	2003									Percent of Change	
			Carve Out			Integrated			Total			1997/98–2003	2000-2003
	Significant Involvement	Significant Involvement	Not Involved	Some Involvement	Significant Involvement	Not Involved	Some Involvement	Significant Involvement	Not Involved	Some Involvement	Significant Involvement	Significant Involvement	Significant Involvement
Families	38%	48%	0%	50%	50%	25%	67%	8%	9%	56%	35%	-3%	-13%
State child mental health staff	54%	74%	0%	23%	77%	15%	46%	39%	6%	31%	63%	9%	-11%
State substance abuse staff	23%	35%	14%	48%	38%	17%	58%	25%	15%	52%	33%	10%	-2%
State juvenile justice staff	21%	23%	0%	59%	41%	46%	46%	8%	17%	54%	29%	8%	6%
State child welfare staff	37%	46%	14%	59%	27%	58%	34%	8%	29%	50%	21%	-16%	-25%
State education staff	21%	19%	36%	50%	14%	58%	25%	17%	44%	41%	15%	-6%	-4%
Providers	Not Asked	60%	5%	14%	81%	21%	65%	14%	11%	33%	56%	NA	-4%

NA=Not Applicable

State child mental health staff and providers were reported to be the two stakeholder groups most likely to have significant involvement in planning, implementing, and refining managed care systems in 2003 (in 63% and 56% of managed care systems, respectively). Families reportedly have significant involvement in only about one-third of managed care systems, a decline of 13% since 2000. Other child-serving systems have significant involvement in one-third of the systems or less. State substance abuse staff is significantly involved in 33%; state juvenile justice staff in 29%; state child welfare staff in 21%; state education staff in 15%. State education staff consistently has been the stakeholder group with the least involvement. Given that schools are a major provider and referral source for behavioral health services for children, both through regular and special education, their lack of involvement in managed care systems is disconcerting.

As has been found consistently by the Tracking Project, carve outs are significantly more likely to involve all stakeholder groups than are integrated systems, except for state education staff, whose involvement reportedly is low in both types of systems. Carve outs are especially more active in involving families, with half reportedly involving families significantly compared to only 8% of integrated systems. However, most integrated systems and half of the carve outs do not involve families in significant ways in managed care systems, in spite of increased national attention to the importance of the consumer and family role.

Planning for Special Populations

The Tracking Project has tracked over time whether states engage in discrete planning processes for certain special populations in managed care systems, including adolescents with substance abuse disorders, children and adolescents with serious emotional disorders, children and adolescents involved in the child welfare system, and culturally diverse children. The Tracking Project found increases in planning for these special populations between 1997/98 and 2000. However, as **Table 17** shows, there is more of a mixed picture in 2003.

Table 17
Percent of Managed Care Systems with Discrete Planning for Special Populations

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Adolescents with substance abuse disorders	24%	34%	38%	31%	35%	11%	1%
Children and adolescents with serious emotional disorders	57%	83%	81%	62%	74%	17%	-9%
Children and adolescents involved with the child welfare system	48%	72%	67%	15%	47%	-1%	-25%
Children and adolescents involved with the juvenile justice system	Not Asked	Not Asked	52%	8%	35%	NA	NA
Culturally diverse children and adolescents	19%	31%	52%	38%	47%	28%	16%
No discrete planning for special populations	Not Asked	Not Asked	5%	38%	NA	NA	NA

NA=Not Applicable

Between 2000 and 2003, there was a reported 16% increase in the percentage of systems engaged in discrete planning for culturally diverse children and a very slight increase of 1% for adolescents with substance abuse disorders. Discrete planning for children with serious emotional disorders and children involved in child welfare systems appears to have declined since 2000.

Even with the decline reported since 2000, most managed care systems (74%) engage in a discrete planning process for children with serious emotional disorders, and even with the slight reported increase, only about one-third (35%) have a similar process for adolescents with substance abuse disorders or for youth in the juvenile justice system. Fewer than half of the systems (47%) have a discrete planning process for children involved in the child welfare system, a 25% decline since 2000, and fewer than half (47%) engage in discrete planning for culturally diverse children, even with the reported increase since 2000.

Carve outs are significantly more likely to have a discrete planning process for all special populations than are integrated managed care systems. Only 5% of carve outs reportedly engage in no discrete planning for these special populations, compared to 38% of the integrated systems.

Education and Training in Managed Care for Stakeholders

Between 1997/98 and 2000, the Tracking Project found a trend toward more education and training of key stakeholders on the goals and operations of managed care systems. However, as **Table 18** shows, less education and training seems to be occurring since 2000 with respect to all stakeholder groups, except providers where there has been little change. The reported percentage of systems providing no training to any stakeholder group increased by 12% since 2000 to 18% of all systems in 2003 providing no training. Again, this may be due to a certain settling in the managed care landscape, the fact that managed care in most states is no longer a new phenomenon, and waning stakeholder advocacy.

Table 18

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

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
No training	15%	6%	10%	29%	18%	3%	12%
Families	59%	75%	86%	29%	61%	2%	-14%
Providers	79%	88%	100%	76%	89%	10%	1%
Child welfare system	67%	72%	81%	35%	61%	-6%	-11%
Juvenile justice system	Not Asked*	63%	81%	29%	58%	NA	-5%
Other child-serving system	64%	72%	62%	24%	45%	-19%	-27%
Other	10%	34%	19%	18%	18%	8%	-16%

* Included in "Other child-serving system" category in 1997/98
NA=Not Applicable

Providers reportedly are most likely to receive education and training (in 89% of systems). Families and child welfare system stakeholders reportedly receive education and training in 61% of systems and juvenile justice system stakeholders in 58% of systems. However, there are significant differences between carve outs and integrated systems. Carve outs are significantly more likely than integrated systems to provide education and training across all stakeholder group categories. For example, 86% of carve outs reportedly provide education and training to families, compared to only 29% of integrated systems. Eighty-one percent of carve outs educate and train child welfare system stakeholders, compared to only 35% of the integrated systems. It should also be noted, however, as discussed in the following section, that carve outs are also more likely to include the child welfare population than are integrated systems.

III. Populations Covered by Managed Care Systems

Between 1997/98 and 2000, the Tracking Project found little change in the extent to which managed care systems covered the total Medicaid population or only a portion of the Medicaid population. However, as **Table 19** shows, 11% fewer managed care systems in 2003 reportedly are covering the total Medicaid population than in 2000. Fewer than half of managed care systems in 2003 (39%) reportedly cover the total Medicaid population, compared to 50% in 2000. As has been found consistently by the Tracking Project, 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 in 2003 reportedly are covering the population eligible for the State Children's Health Insurance Program (SCHIP) than in 2000. Fewer than half (45%) cover the SCHIP population, with carve outs being more likely to cover the SCHIP population (50% versus 38%). This represents a change from 2000 in which there was little difference in the extent to which carve outs and integrated systems covered this population.

As was also the case in 2000, only carve outs (45% of them) are reported in 2003 to cover non-Medicaid and non-SCHIP populations, and there has been a 15% decline in coverage of these populations since 2000. The non-Medicaid populations covered by carve outs most often include children with serious behavioral health disorders who depend on the public system, including uninsured children and children whose families exhaust private insurance coverage due to the severity of their children's disorders.

The decline in coverage of total Medicaid populations, SCHIP and non-Medicaid populations may be associated with state budget deficits. As states grapple with budget problems, one policy decision they are making, as discussed in a later section of this report, is to eliminate certain populations from eligibility for managed care systems.

Table 19
Percent of Managed Care Systems Covering Population Types

	1995	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Total Medicaid population	59%	49%	50%	55%	19%	39%	-20%	-10%	-11%
Portion of Medicaid population	Not Asked	47%	47%	45%	81%	61%	NA	14%	14%
SCHIP population	Not Asked	Not Asked	53%	50%	38%	45%	NA	NA	-8%
Non-Medicaid, non-SCHIP population	Not Asked	Not Asked	41%	45%	0%	26%	NA	NA	-15%
Other	Not Asked	Not Asked	Not Asked	14%	0%	8%	NA	NA	NA

NA=Not Applicable

Between 1997/98 and 2000, the Tracking Project noted a trend of states covering more types of Medicaid populations, including those that would be expected to use more and costlier services, such as those eligible for Supplemental Security Income (SSI) and children involved in child welfare and juvenile justice systems. As **Table 20** shows, however, this trend seems to have reversed course to a certain extent since 2000.

Table 20
Percent of Managed Care Systems Covering Medicaid Subpopulations

	1995 Total	1997–98 Total	2000			2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total	Carve Out	Integrated	Total			
TANF population	44%	96%	85%	100%	88%	70%	100%	87%	43%	-9%	-1%
Poverty related population	24%	88%	85%	100%	88%	80%	85%	83%	59%	-5%	-5%
SSI population	20%	56%	81%	75%	79%	90%	46%	65%	45%	9%	-14%
Pregnant women and children	34%	84%	77%	100%	82%	70%	100%	87%	53%	3%	5%
Children and adolescents in child welfare system	37%	60%	88%	63%	82%	80%	38%	57%	20%	-3%	-25%
Children and adolescents in juvenile justice system	Not Asked	40%	88%	63%	82%	80%	15%	43%	NA	3%	-39%
Other	15%	12%	15%	13%	15%	40%	23%	30%	15%	18%	15%

NA=Not Applicable

Since 2000, there has been a reported decline in inclusion within managed care systems of Medicaid populations that can be expected to use more and costlier services, including children involved in child welfare and juvenile justice systems and children eligible for SSI. This decline, however, is driven largely by decreases in inclusion of these populations by integrated systems. Carve outs actually increased coverage of children eligible for SSI since 2000 and only slightly reduced coverage of children involved in child welfare and juvenile justice systems. In contrast, integrated systems reduced coverage of these populations significantly between 2000 and 2003. For example, 90% of carve outs reportedly cover the SSI population, a 9% increase over 2000, compared to only 46% of integrated systems, a 29% decline since 2000. Eighty percent of carve outs are reported to cover children involved in child welfare and juvenile justice systems, a decline of only 8% with respect to both populations since 2000. This compares to 38% of integrated systems that cover the child welfare population in 2003, a 25% decrease since 2000, and 15% of integrated systems that cover youth involved in juvenile justice systems, a 48% decrease since 2000.

Inclusion of high-need populations requires adaptation of traditional managed care approaches and inclusion of appropriate financing and risk adjustment mechanisms. As discussed throughout this and other Tracking Project reports, results suggest that carve outs are more likely to incorporate the special features and financing required by high-need populations and thus seem to be continuing to cover them in their managed care arrangements

in comparison to integrated systems, which appear to be decreasing coverage of certain high-need child populations. On the other hand, as the Tracking Project also has found consistently, integrated systems are more likely than carve outs to cover pregnant women and their children, those eligible for Temporary Assistance to Needy Families (TANF), and poverty-related populations. These populations are considered to have primarily acute care needs, which is the principal focus of integrated systems.

IV. Managed Care Entities

Types of Managed Care Organizations (MCOs) Used

As **Table 21** indicates, both integrated systems and carve outs rely heavily on for-profit managed care entities. One difference, however, is that carve outs reportedly use for-profit behavioral health organizations (BHOs), which specialize in managing behavioral health services; 59% do so. In contrast, most integrated systems (75%) reported using for-profit managed care organizations (MCOs) that manage both physical health and behavioral health services, i.e., health maintenance organizations (HMOs).

The Tracking Project noted an increase between 1997/98 and 2000 of more states using government entities in the MCO role, particularly states with carve out arrangements. However, in 2003, there was a reported 15% decline in use of government entities as MCOs, driven solely by a decline in use of government entity MCOs by carve outs; integrated systems actually increased their use of government entities as MCOs (**Table 21**). As state mental health authorities have become more comfortable with the use of managed care technologies, they also may be more comfortable utilizing commercial managed care companies, particularly BHOs. In spite of the decline since 2000 in carve outs using government entities as MCO, and the increased use of government entities in integrated systems, carve outs remain twice as likely as integrated systems to use government entities in the MCO role. These are often, although not solely, county mental health authorities or quasi-public mental health boards. A number of states also use hybrid MCO structures in which these public entities partner with commercial managed care companies. Private, nonprofit agencies consistently have been the least likely type of entity to be used as MCOs by either carve outs or integrated systems. As **Table 22** shows, 20% of integrated systems and 14% of carve outs changed the type of managed care entity they were using between 2000 and 2003.

Table 21
Percent of Managed Care Systems by Type of Managed Care Organizations (MCOs) Used

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
No training	15%	6%	10%	29%	18%	3%	12%
For-profit managed health care organizations	47%	29%	5%	75%	34%	-13%	5%
Nonprofit managed health care organizations	29%	21%	18%	44%	29%	0%	8%
For-profit behavioral health MCO	34%	41%	59%	13%	39%	5%	-2%
Nonprofit behavioral health MCO	24%	24%	14%	19%	16%	-8%	-8%
Private, nonprofit agencies	13%	15%	18%	13%	16%	3%	1%
Government entities	29%	44%	36%	19%	29%	0%	-15%
Other	0%	3%	9%	13%	11%	11%	8%

Table 22 Percent of Managed Care Systems with a Change in Type of Entities Used as MCOs for Behavioral Health Services Since 2000			
	2003		
	Carve Out	Integrated	Total
Systems with a change in type of entities used as MCOs since 2000	14%	20%	16%

Use of Multiple Managed Care Organizations

The Tracking Project consistently has found that when states use multiple MCOs, as opposed to a single MCO statewide or within a single region, significant challenges are created for providers, families, and for state agencies as well. Each MCO has in place different procedures for every aspect of system operations — billing and reimbursement, credentialing, utilization management, service authorization, reporting, and others. According to stakeholders interviewed for the impact analyses, many problems result, including increased administrative burden for providers, difficulty for consumers in understanding and navigating systems, and monitoring challenges for state purchasers. The use of multiple MCOs creates particular challenges for families involved in the child welfare system, such as foster families, who may have children enrolled in different MCOs. Although state officials reported that the use of multiple MCOs was intended to create consumer choice and competition, consumers interviewed for the impact analyses emphasized that choice of providers was more important to them than choice of MCO.

As **Table 23** shows, integrated systems utilize multiple MCOs statewide or within regions to a far greater extent than carve outs (79% versus 32%). Carve outs are more likely to use a single MCO statewide or within regions; 68% do so compared to 21% of integrated systems. The 2003 data indicate a slight increase (9%) in the use of multiple MCOs statewide or within a single region.

Table 23 Percent of Managed Care Systems Using Single Versus Multiple Managed Care Organizations							
	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
One MCO statewide	27%	25%	32%	14%	25%	-2%	0%
One MCO per region	23%	34%	36%	7%	25%	2%	-9%
Multiple MCOs statewide or within region	50%	41%	32%	79%	50%	0%	9%

Training and Education for Managed Care Organizations

The Tracking Project has found consistently that stakeholders believe commercial managed care organizations lack sufficient familiarity with children with behavioral health disorders and their families, and that training and education for MCOs are critical needs. Stakeholders from the child welfare and juvenile justice systems in most states, regardless of the type of MCO used, reported that MCOs lacked sufficient knowledge about these systems and the populations they serve and that greater priority on training was needed. Stakeholders also reported that training was needed on newer types of home and community-based services and on system of care values and principles.

The 2003 data, as shown on **Table 24**, indicate some gains since 2000 in the percentage of managed care systems that are providing education and training to MCOs about special populations, home and community-based services, and system of care values and principles.

Table 24

Percent of Managed Care Systems Providing Training or Education to Managed Care Organizations

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
No Training	16%	18%	9%	23%	14%	-2%	-4%
Children and adolescents with serious emotional disorders	57%	55%	86%	46%	71%	14%	16%
Adolescents with substance abuse disorders	27%	27%	45%	38%	43%	16%	16%
Children and adolescents with co-occurring mental health and substance abuse disorders	Not Asked	Not Asked	64%	15%	46%	NA	NA
Children and adolescents in the child welfare system	49%	52%	73%	31%	57%	8%	5%
Children and adolescents in the juvenile justice system	Not Asked	36%	64%	31%	51%	NA	15%
The Medicaid population in general	68%	39%	59%	46%	54%	-14%	15%
Home and community-based service approaches	Not Asked	48%	68%	38%	57%	NA	9%
System of care values and principles	Not Asked	52%	77%	38%	63%	NA	11%
Coordination between physical health and behavioral health services	Not Asked	Not Asked	45%	46%	46%	NA	NA
Other	Not Asked	Not Asked	5%	8%	6%	NA	NA

NA=Not Applicable

Nearly three-quarters of managed care systems (71%) reportedly provide training and education to MCOs about children and adolescents with serious emotional disorders, a 16% increase since 2000. However, fewer than half (43%) provide training regarding adolescents with substance abuse disorders, even though this, too, represents a 16% increase since 2000. Fewer than half provide training to MCOs about youngsters with co-occurring disorders (46%), and about half provide training and education to MCOs about children in the child welfare and juvenile justice systems. As the Tracking Project consistently has found, carve outs are more likely to provide education and training regarding all special populations than are integrated systems.

About half of managed care systems (57%) reportedly provide training and education to MCOs about home and community-based services, and 63% reportedly educate MCOs about system of care values and principles. However, carve outs are twice as likely to do so than are integrated systems, even though a greater percentage of integrated systems in 2003 reportedly are doing this type of education for MCOs than was the case in 2000.

The 2003 survey asked a new question regarding education and training of MCOs on the importance of coordinating physical and behavioral health care for children with behavioral health disorders. Reportedly, slightly less than half (46%) of managed care systems provide this education and training to MCOs, with little difference between carve outs and integrated systems.

V. Service Coverage and Capacity

Coverage of Acute and Extended Care Services

For purposes of the Tracking Project, acute care is defined as brief short-term treatment with, in some cases, limited intermediate care also provided, and extended care is defined as care extending beyond the acute care stabilization phase, i.e., care required by children with more serious disorders and their families. A recommendation emerging from the impact analyses was to include both acute and extended care in managed care systems, based on the assertion that inclusion of both types of services creates the potential to integrate care for the total eligible population and reduces the potential for cost shifting and fragmentation at the service delivery level. Early findings of the Tracking Project found many managed care systems limiting coverage to acute care, particularly systems with integrated designs. However, over time, findings indicated that states were moving in the direction of including coverage for extended care in managed care systems.

Table 25
Percent of Managed Care Systems Including Acute and Extended Care Services

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Acute care only	26%	9%	0%	12%	5%	-21%	-4%
Acute care and extended care	74%	88%	100%	88%	95%	21%	7%
Extended care only	0%	3%	0%	0%	0%	0%	-3%

As shown on **Table 25**, the 2003 State Survey found that this trend is continuing. A 7% increase in managed care systems including both acute and extended care was found since 2000 (a 21% increase since 1997/98), with 95% of all managed care systems now covering both acute and extended care services — all of the carve outs and the majority of integrated systems.

Over time, a significant increase in the inclusion of extended care services within integrated systems has been noted. Less than half (44%) of the integrated systems covered extended care in 1997/98, but the majority (88%) reported covering both acute and extended care in both 2000 and 2003. As of 2003, only a small percentage (12%) of integrated managed care systems reportedly limit coverage to acute care only.

Other Systems with Resources and Responsibility for Extended Care

Although managed care systems increasingly are covering extended care services, stakeholders interviewed in the impact analyses noted that the actual provision of extended care services may be hampered by factors such as strict interpretation of medical necessity criteria to limit duration of care, MCOs creating arbitrary limits on certain types of services, and lack of capacity to provide extended care services. A significant barrier noted by stakeholders was that large amounts of extended care funding streams remain outside of managed care systems for a variety of reasons.

Table 26

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Child mental health	76%	68%	100%	81%	5%
Child welfare	94%	86%	79%	83%	-11%
Juvenile justice	76%	68%	79%	72%	-4%
Education	61%	50%	71%	58%	-3%
Substance abuse	45%	68%	79%	72%	27%
No other systems have extended care behavioral health dollars	Not Asked	5%	14%	8%	NA
Other	21%	5%	29%	14%	-7%

NA=Not Applicable

Table 26 shows that, even though most systems reportedly cover both acute and extended care, other child-serving systems still retain both responsibility and resources for extended care behavioral health services as well. In fact, 92% of the managed care systems reported that other systems also retain resources and responsibility for extended care services.

The child welfare and children's mental health systems are most likely to have resources and responsibility for extended care services, in addition to the managed care system, reported in 83% and 81% of the systems respectively. These are followed by the juvenile justice and substance abuse systems (both reported in 72% of the systems). The education system was cited as having resources and responsibility for extended care behavioral health services less frequently, in only 58% of the systems.

This finding suggests that although an increased percentage of managed care systems reported that they include coverage for extended care, the extended care actually provided within some managed care systems may be limited, resulting in reliance on these other child-serving systems for longer-term services. The continued fragmentation of resources and responsibility for extended care across managed care systems and other child-serving systems perpetuates the potential for boundary issues, creation of parallel systems, duplication of services across systems, and resource disputes across systems. In addition, this may contribute to incentives for managed care systems to underserve extended care populations, especially when responsibility can be shifted to another child-serving system that has resources for these services.

Coverage of Behavioral Health Services in Managed Care Systems

Since 1997/98, the state surveys have presented respondents with a list of services and asked respondents to identify which mental health services were covered under their managed care systems. In 2003, 41% of the managed care systems reportedly cover most or all of the services, with "most or all" defined as covering 80 to 100% of the services on the list presented in the survey. This represents a 16% decline from 2000 to 2003, effectively reversing an 18% increase found from 1997/98 to 2000. Survey findings related to the effects of the current fiscal climate suggest that elimination of coverage for specific services may be resulting from cost containment measures.

Consistent with previous findings, carve outs are more likely to cover a broader service array. In 2003, more than half of the carve outs (55%) but only about a quarter (24%) of the integrated systems reported covering most or all of the services on the list presented in the survey (**Table 27**).

Table 27

Percent of Managed Care Systems Covering Most or All (80 – 100%) of the First 16 Services in the Service Array

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care systems cover 80 – 100% (13 or more of 16) of the first 16 mental health services listed (through and including wraparound)	39%	57%	55%	24%	41%	2%	-16%

For the 2000 State Survey, three additional services were added to the list originally presented in 1997/98, family support/education, transportation, and mental health consultation; in 2003 therapeutic nursery/preschool was added to the list as well. When considering the expanded list of services, comparable results were obtained. Overall, 50% of the carve outs compared with only 18% of the integrated systems reportedly cover most or all (80 to 100%) of the expanded service list (**Table 28**).

Table 28

Percent of Managed Care Systems Covering Most or All (80 – 100%) of the Service Array

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care systems cover 80 – 100% (16 or more of 20) of the mental health services listed	Not Asked	Not Asked	50%	18%	36%	NA	NA

NA=Not Applicable

Matrix 2 shows, state by state, the mental health services that respondents to the 2003 State Survey reported are currently covered by their managed care systems.

Matrix 2: Mental Health Services Covered by Managed Care System

● = Covered under managed care system
○ = Covered by another funding source
⊗ = Not Covered by the State through any source

States Alpha List		Assessment and Diagnostic Evaluation	Outpatient Psychotherapy	Medical Management	Home-Based Services	Day Tx/Partial Hospitalization	Crisis Services	Behavioral Aide Services	Therapeutic Foster Care	Therapeutic Group Homes	Residential Treatment Centers	Crisis Residential Services	Inpatient Hospital Services	Case Management Services	School-Based Services	Respite Services	Wraparound Services/Process	Family Support/Education	Transportation	Mental Health Consultation	Therapeutic Nursery/Preschool	Other
Arizona	AZ	●○	●○	●	●○	●	●	●○	●○	●○	●○	●	●○	●○	●	●○	●	●	●○	●	●	
California	CA	●○	●	●○	●	●○	●○	●○	●○	●	●	●	●○	●○	●	●	●	●	⊗	●	●	
Connecticut	CT	●	●	●	○	●○	○	○	○	○	●○	○	●	○	●○	○	○	○	●	⊗	○	
Colorado	CO	●	●	○	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	●	
Delaware	DE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	⊗	●○	●	⊗	●
District of Columbia	DC	●○	●○	●○	○	●○	●○	○	○	○	●○	●○	●○	●○	○	○	○	○	○	○	●○	
Florida	FL	●○	●	●	●	●	●	●	●	○	○	○	●	●	●	○	●	●○	○	●	○	
Georgia	GA	●○	●○	●○	●○	●○	●○	●○	●○	●○	○	●○	○	●○	●○	○	●○	●○	○	○	○	
Hawaii	HI	○	○	○	●	●○	●○	○	●	●	●	●	○	●	●○	●	●	●	●	●	○	
Illionois	IL	●○	●○	●○	○	●○	●○	⊗	⊗	⊗	○	⊗	●○	●○	○	○	○	●○	●○	●○	○	●○
Indiana	IN	●○	●○	●○	●	●○	●○	⊗	●○	○	○	○	●○	●○	⊗	●○	●	●	○	⊗	⊗	
Iowa	IA	●	●	●	●○	●	●	⊗	○	○	○	○	●	⊗	●⊗	○	●	●	●	●	○	
Maryland	MD	●	●	●	●	●	○	●	○	○	●	○	●	●	●	●	○	○	○	○	○	
Massachusetts	MA	●	●	●	●○	●○	●	○	○	○	○	●○	●○	●○	●○	○	○	●○	●○	●○	○	
Michigan	MI	●	●	●	●	●	●	●	○	○	○	●	●	●	○	●	●	●	●	●	⊗	
Minnesota	MN	●	●	●	●○	●○	●○	○	●○	○	●○	○	●	○	●○	○	○	●○	●○	○	●	
Missouri	MO	●○	●○	●○	●○	●○	●○	○	○	○	○	●	●	●○	●○	○	○			●○	⊗	
Nebraska	NE	●○	●○	●	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	○	○	●○	○	●○	●○	●	
Nevada	NV	●○	●○	●○	●○	●○	○	⊗	●○	●○	●○	●○	●○	●○	○	○	●○	○	●○	●○	○	
New Jersey	NJ	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	●	●	●	○	○	
New Mexico	NM	●○	●○	●	●○	●○	●○	●○	●○	●○	●○	⊗	●	●○	●○	●○	●○	○	●	○	○	
New York	NY	○	○	○	●○	○	○	○	○	○	○	○	●	○	○	○	○	○	●○	○	○	●○
North Dakota 1	ND	●	●	●	●	●	●	●	●	●	●	⊗	●	●	⊗	●	●	●	●	⊗	⊗	
North Dakota 2	ND	●	●	●	●	●	●	●	●	●	●	⊗	●	●	⊗	●	●	●	●	⊗	⊗	
Ohio	OH	●○	●○		⊗	○	●○	○	○	○	○	○	●○	●○	○	○	○	○	○	○	⊗	
Oklahoma	OK	●○	●○	●○	●○	○	●○	○	●○	○	●○	●○	●○	●○	●○	○	○	○	●○		⊗	
Oregon	OR	●	●	●	●	○	●○		○	○	○	○	●	○	●○			●		●	●	
Pennsylvania	PA	●	●	●	●	●	●	●	●○	○	●	○	●	●	●	○	●	●	●	●	●	
Rhode Island	RI	●○	●○	●○	●○	●○	●○	○	○	○	●○	○	●○	●○	●○	○	○	●○	●○	●○	○	●○
South Dakota	SD	●	●	●	●	●					●		●	●	●				○	●		
Tennessee	TN	●	●	●	●	●	●	○	●	⊗	●	●	●	●	●	●	○	○	●	●	●	
Texas	TX	●	●	●	●	●	●	⊗	●	⊗	●	●	●	●	●	●	●	●	●○	●	⊗	●
Utah	UT	●	●	●	●	●	●	○	●	●	●○	○	●	●	●	○	●	○	●	○	●	●
Vermont	VT	●○	●○	●○	○		●○	○	○	○	○	○	●○	○	●○	○	○	○	○	○	○	
Virginia	VA	●○	●○	●○	○	○	○	○	○	○	○	○	●○	○	●○	○	○	○	●○	○	○	
Washington	WA	●	●	●	●	●	●	●	●○	○	○	○	●	●	●	○	●	●	○	●	○	
West Virginia	WV	●	●	●○	●	●○	●	⊗	●○	●○	●○	○	●	●	○	○	●○	○	○	●	⊗	
Wisconsin 1	WI	●	●	●	●	●	●	○	○	○	○	○	●	○	○	○	○	○	●○	⊗	⊗	
Wisconsin 2	WI	●	●	○	●	●	●	●	●	●	●	●	●○	●	○	●	●	●	●	●	⊗	
N=Covered Under Managed Care System		37	37	34	33	33	33	16	23	15	24	17	37	31	25	14	22	21	25	23	10	7
N=Covered by Another Funding Source		18	15	16	16	19	17	20	25	26	26	23	16	21	23	26	20	20	26	17	17	3
N=Not Covered by the State through any Source		0	0	0	1	0	0	6	1	3	0	4	0	1	4	0	0	1	1	5	12	0

Derived from the matrix, the mental services most likely to be covered by managed care systems, according to the 2003 State Survey, include:

- Assessment and diagnostic evaluation
- Outpatient psychotherapy
- Inpatient services
- Medical management
- Day treatment/partial hospitalization
- Crisis services
- Home-based services
- Case management

A change from 2000 is the addition in 2003 of both home-based services and case management to the group of services most likely to be covered by managed care systems.

The services least likely to be covered by managed care systems in 2003 include:

- Therapeutic nursery/preschool
- Respite services
- Therapeutic group care
- Behavioral aide services
- Crisis residential services

Consistent with previous survey results, coverage in systems with integrated designs is most likely to include the traditional mental health services typically included in commercial insurance plans, such as assessment, outpatient services, medical management, and inpatient services; about 90 to 100% of the integrated systems cover these services. In addition to covering these services, however, carve outs are more likely to include coverage for additional home and community-based services such as home-based services, day treatment/partial hospitalization, crisis services, behavioral aides, therapeutic foster care, case management, school-based services, wraparound services/process, family support/education, and mental health consultation. From 77 to 100% of the carve outs cover these services; integrated systems cover these services much less frequently. The only services covered to a greater extent by integrated systems are transportation and inpatient hospital services.

When services are not covered under the managed care system, in most cases respondents reported that they are covered by another funding source in the state. In few cases were services reported not to be covered by any source whatsoever, although more services reportedly are not covered by any source in 2003 than in 2000. The services reported to be without any coverage most frequently were: therapeutic nursery/preschool (not covered by 12 states), behavioral aide services (not covered by 6 states), mental health consultation (not covered by 5 states), school-based services and crisis residential services (each not covered by 4 states), and therapeutic group homes (not covered by 3 states). In all other cases, the absence of any coverage for any particular service was reported by only one state.

Matrix 2 also shows the services that are covered by another source, either instead of or in addition to coverage under the managed care system. The services most likely to be covered by another source in 2003 (and fairly consistent with previous survey results) include therapeutic group care, residential treatment, therapeutic foster care, respite services, transportation, school-based services, and crisis residential services. Although it is encouraging to note that most children's behavioral health services and supports reportedly are covered to some extent by some funding source in states, the multiple funding sources and systems used to provide these services continues the historic pattern of fragmentation in behavioral health service delivery for children and adolescents and their families, resulting in discontinuity, potential duplication, cost shifting, and confusion for providers and families.

The 2003 State Survey included a list of substance abuse services in addition to the children's mental health service array. Similar to the results for mental health services, 39% of the managed care systems reportedly cover most or all of the substance abuse service array

(defined as 80 to 100% of the list included in the survey), with carve outs more likely to cover a broader array of services. Nearly half of the carve outs (48%) as compared with about a quarter (27%) of the integrated systems cover most or all of the services listed (**Table 29**).

Table 29

Percent of Managed Care System Covering Most or All (80 – 100%) of the Substance Abuse

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care systems cover 80 – 100% (13 or more of 17) of the substance abuse services listed	Not Asked	Not Asked	48%	27%	39%	NA	NA

NA=Not Applicable

Matrix 3 displays the substance abuse services reportedly covered by managed care systems in each state.

Based on this matrix, the substance abuse services most likely to be covered by managed care systems include:

- Assessment and diagnostic evaluation
- Intensive outpatient services
- Outpatient individual counseling
- Inpatient detoxification
- Outpatient group counseling
- Outpatient family counseling

The substance abuse services least likely to be covered are:

- School-based services
- Methadone maintenance
- Relapse prevention
- Day treatment
- Ambulatory detoxification
- Residential detoxification

Similar to mental health services, when services are not covered through the managed care system, they are likely to be covered by another funding source. There were, however, some services which reportedly are not covered in four or more states: school-based substance abuse services and relapse prevention (not covered in 7 states), day treatment (not covered in 6 states), partial hospitalization (not covered in 5 states), methadone maintenance (not covered in 5 states), ambulatory and residential detoxification and case management (each not covered in 4 states).

The substance abuse services most likely to be covered by another source, in addition to or instead of the managed care system, include case management, residential treatment, assessment and diagnostic evaluation, day treatment, school-based services, and outpatient counseling (individual, group, and family).

Matrix 3: Substance Abuse Services Covered by Managed Care System

● = Covered under Managed Care System
○ = Covered by another funding source
⊗ = Not Covered by the State through any source

States Alpha List		Assessment and Diagnostic Evaluation	Intensive Outpatient Services	Outpatient Individual Counseling	Outpatient Group Counseling	Outpatient Family Counseling	School-Based Services	Day Treatment	Ambulatory Detoxification	Residential Detoxification	Inpatient Detoxification	Residential Treatment	Inpatient Hospital Services	Partial Hospitalization	Methadone Maintenance	Relapse Prevention	Case Management	Other
Arizona	AZ	●○	●○	●○	●○	●○	●	●○	●	●	●	●○	●	●○	●	●	●	
California	CA	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
Connecticut	CT	●	●	●	●	●	●	●	●	●	●	○	●	●	●	⊗	○	
Colorado	CO	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
Delaware	DE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	⊗
District of Columbia	DC																	
Florida	FL	○	○	○	○	○	○	○	⊗	○	○	○	○	○	○	○	○	
Georgia	GA	●○	●○	●○	●○	●○	●○	●○	●○	●○	⊗	●○		⊗	●○	●○	●○	
Hawaii	HI	●○	○	○	○	○	○	○	○	●	○	○	○	○	○	○	● ○	
Illionois	IL	●○	●○	●○	○	○	⊗	⊗	●○	○	●○	○	●○	●⊗	⊗	●○	●○	
Indiana	IN	●	●	●	●	●	●○	●	●	●	●	●○	○	●○	●	●○	●	
Iowa	IA	●	●	●	●	●		●	●	●	●	●	●	●	○	●	⊗	
Maryland	MD																	
Massachusetts	MA	●	●	●	●	●	●	●	○	●○	●○	●	●	●	●	●	●○	
Michigan	MI	●	●	●	●	●	⊗	⊗	⊗	●	○	○	⊗	●	●	⊗	⊗	
Minnesota	MN	●○	●	●	●	●○	○	●○	○	●○	●	●○	●	●	●	●	●○	
Missouri	MO	●○	●○	●○	●○	●○	●○	●○	●○	○	●○	○	○	○	○	○	●○	
Nebraska	NE	●○	●○	●○	●○	●○	⊗	●○	⊗	⊗	●○	●○	●○	●○		●○	●○	
Nevada	NV	●○	●○	●○	●○	●○	●○	○	○	○	○	○	○	●○	○	●○	●○	●○
New Jersey	NJ	○	○	○	○	○	⊗	○	●	⊗	●	●	●	○	●	○	⊗	
New Mexico	NM	●○	●○	●○	●○	●○	●○	●○	⊗	●	●	●○	●	●○	⊗	⊗	●○	
New York	NY	●	○	○	○	●○	○	○	○	○	●	○	●	○	○	⊗	○	
North Dakota 1	ND	●	●		●	⊗	⊗	⊗	●	⊗	●	●	●	●	⊗	⊗	●	
North Dakota 2	ND	●	●	●	●	⊗	⊗	⊗	●	⊗	●	●	●	●	⊗	⊗	●	
Ohio	OH	●○	●○	●○	●○	●○	○	○	○	○	●○	○	○	⊗	○	⊗		
Oklahoma	OK	●○	●○	●○	●○	●○	●○	○	○	○	●○	●○	●○	○	○	○	●○	
Oregon	OR	●	●	●	●	●	●	○⊗		●	●	●	●	●	●	●	●	
Pennsylvania	PA	●○	●○	●○	●○	○	○	○	○	●○	●○	●○	●○	●○	●○	●○	●○	
Rhode Island	RI	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	
South Dakota	SD																	
Tennessee	TN	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●	●	○	●	
Texas	TX	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	⊗	
Utah	UT	○	○	○	○	○	○	○	○	○	○	○	○	○	○	●	○	○
Vermont	VT	●	●	●					●○	●○	●	●	●	●	●	●	●	
Virginia	VA	○	●	●○	●○	⊗	⊗	⊗	○	○	○	○	○	⊗	○	○	○	
Washington	WA	○	○	○	○	○	○	○	○	○	○	○	○	○	⊗	○	○	
West Virginia	WV	●	●	●	●	●	○	●	●	●	●	●	●	⊗	○	○	●	
Wisconsin 1	WI	●○	●	●	●	●	○	●	●	○	●	○	●	●	○	○	○	
Wisconsin 2	WI	●	●	●	●	●	○	●	●	●	●	●	●	●	●	●	●	
N=Covered Under MC System		29	28	28	26	23	13	17	18	19	26	21	24	21	15	16	22	2
N=Covered by Another Funding Source		22	20	20	21	20	20	21	19	19	18	24	17	17	17	20	25	2
N=Not Covered by the State through any Source		0	0	0	0	3	7	6	4	4	1	0	1	5	5	7	4	0

Note: District of Columbia, Maryland and South Dakota did not answer this question.

Coverage of Home and Community-Based Services

The surveys have explored whether managed care systems have expanded the array of home and community-based services covered for children and adolescents. The 2003 findings were similar to previous findings — 55% of the systems reported that coverage of home and community-based services has been expanded in comparison with pre-managed care (**Table 30**).

However, consistent with the results reported above as well as with previous findings, a sharp contrast was found between the expansion of coverage of home and community-based services in carve outs and in integrated systems. Nearly three-quarters of the carve outs (73%) expanded coverage of home and community-based services through their managed care systems, compared with less than one-third (31%) of the integrated systems. Both impact analyses also found that managed care systems were credited with expanding the range of mental health services covered in systems with carve out designs but much less so in integrated systems.

Table 30

Percent of Managed Care Systems Expanding Coverage of Home and Community-Based Services in Comparison with Pre-Managed Care System

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Yes	56%	57%	73%	31%	55%	-1%	-2%
No	44%	43%	27%	69%	45%	1%	2%

Where it occurred, expansion in the coverage of home and community-based services was attributed primarily to filling in the mid-range between outpatient and inpatient hospital services by adding an array of home and community-based service modalities. Respondents indicated that the following types of services were added to the service array in their managed care systems:

- Home-based services
- Case management
- Therapeutic foster care
- Respite services
- Behavioral aides
- Day treatment
- After-school programs
- Family support
- Crisis services, including mobile crisis response
- Multisystemic therapy (MST)
- Therapeutic group homes
- Intensive outpatient services
- Mentoring
- Non-hospital detoxification
- Substance abuse rehabilitation
- Substance abuse half-way houses

Home and Community-Based Service Capacity

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

A new area of exploration was incorporated into the 2000 and 2003 State Surveys to assess the issue of service capacity for home and community-based mental health services for children and their families. Consistent with findings from the impact analyses, significant expansion of the availability of home and community-based services was found in few managed care systems — only about one-third of the systems (32%) in 2000 and even fewer in 2003 (21%, an 11% decline). Another 42% of systems reported some expansion of service capacity for home and community-based services in 2003. However, 37% of the systems reported either very little expansion in the availability of services or no service capacity expansion at all (**Table 31**).

Table 31

Percent of Managed Care Systems Expanding the Availability of Home and Community-Based Services by Bringing About the Development of New Service Capacity

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Not at all	21%	5%	44%	21%	0%
Very little	21%	14%	18%	16%	-5%
Somewhat	26%	45%	38%	42%	16%
Significant	32%	36%	0%	21%	-11%

Again, the differences between carve outs and integrated systems are evident. Most integrated systems (62%) reportedly have had none or very little expansion in the availability of home and community-based services. In contrast, most carve outs (81%) have had some or significant expansion of home and community-based service capacity.

In addition to reporting on the expansion of home and community-based service capacity, the 2000 and 2003 State Surveys also asked respondents to rate on a scale of 1 to 5 the general level of development of home and community-based service capacity in the state, with 1 being highly adequate and 5 being not at all adequate. The mean ratings shown on **Table 32** suggest that the level of development of home and community-based services for children is judged to be higher in states with carve outs (mean rating of 2.8) as compared with states with integrated systems (mean rating 4.00) and further that ratings of service capacity have improved since 2000 in carve outs and deteriorated in integrated systems.

Table 32

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

	2000 Survey	2003 Survey
Carve Outs	3.15	2.8
Integrated	2.63	4.00
Total	3.03	3.20

Scale

1 = Highly Adequate
2 = Mostly Adequate
3 = Moderately Adequate
4 = Marginally Adequate
5 = Not At All Adequate

It is important to note that in neither carve outs nor integrated systems was service capacity for home and community-based services in the state characterized as highly adequate or even approaching this level. No systems rated the adequacy of home and community-based services as highly adequate in 2003, and only 19% overall rated capacity as mostly adequate. **Table 33** shows that few systems considered service capacity to be highly developed (1 or 2 on a five point scale) and that these are all carve outs. Nearly a third (30%) considered capacity to be poorly developed, a 9% increase since 2000, with integrated systems more likely to be in this category than carve outs.

Table 33

Percent of Managed Care Systems Rating Home and Community-Based Service Capacity as Highly and Poorly Developed

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Highly developed (1 and 2 on 5 point scale)	24%	32%	0%	19%	-5%
Poorly developed (4 and 5 on 5 point scale)	21%	23%	40%	30%	9%

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

To assess the extent of efforts to invest in service capacity development, the 2000 and 2003 State Surveys explored two areas — the reinvestment of savings from the managed care system back into the system to expand service capacity and state investment in service capacity with resources separate and apart from the managed care system.

Consistent with 2000 results, most systems (68%) do not require reinvestment of savings from managed care systems back into the system to expand service capacity for behavioral health services to children and their families (**Table 34**). In fact, there has been a 16% decline since the1997/98 State Survey in systems that do require reinvestment. Carve outs are more likely to require reinvestment; 57% do as compared with none of the integrated systems.

Table 34
Percent of Managed Care Systems Requiring Reinvestment of Savings

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Systems require reinvestment	48%	32%	57%	0%	32%	-16%	0%
Systems do not require reinvestment	52%	68%	43%	100%	68%	16%	0%

Although reinvestment of savings is required in some managed care systems, the requirement may be rendered meaningless if there are no savings to reinvest. The 2003 State Survey added an item to explore this issue, and found that in more than half of the systems (57%) there reportedly are no savings to reinvest. Carve outs are more likely to have savings for reinvestment — more than half reported savings (52%) as compared with less than one-third (29%) of the integrated systems (**Table 35**).

Table 35
Percent of Managed Care Systems with Savings to Reinvest

	2003		
	Carve Out	Integrated	Total
Systems have savings	52%	29%	43%
Systems do not have savings	48%	71%	57%

Where reinvestment of savings was reported, respondents indicated that such reinvestment was used to either expand the capacity to provide services (wraparound, community-based services, in-plan or covered services, and supplemental or “value-added” services were among those cited) or to expand eligibility.

Other than reinvestment of savings generated by the implementation of managed care, investment of state resources in the development of children’s behavioral health services has been a critical mechanism for building capacity. Both impact analyses found a broad consensus among stakeholders that they considered state investment in service capacity development for children’s behavioral health services to be inadequate. Tracking Project findings over time suggested that states were devoting increased attention to the need for investing in service capacity development. The 2000 State Survey, for example, found an 11% increase in systems reporting state investment in service capacity development from 68% in 1997/98 to 79% in 2000 (**Table 36**). The 2003 State Survey, however, found a substantial drop in reports of state investment in building service capacity, a 26% decline to only about half of the systems now

reporting state investment (53%). Responses to items related to the current fiscal climate indicate that the decline in state investment is likely related to the widespread budget deficits facing many state governments.

Table 36

Percent of Managed Care Systems with State Investing in Increasing Service Capacity for Behavioral Health Services for Children and Adolescents

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
State investment in service capacity development	68%	79%	59%	53%	53%	-15%	-26%
No state investment in service capacity development	32%	21%	41%	47%	47%	15%	26%

Again, states with carve outs are more likely to invest resources in service capacity development; 59% of the carve outs reported state investment as compared with only 41% of the integrated systems. Despite the reports of state investment by half of the systems, the impact analysis results suggested that stakeholders still considered any such investments to be insufficient in relation to the need.

Flexible/Individualized Care

The surveys have explored whether or not the managed care system has facilitated the provision of flexible/individualized services. Consistent with previous findings, the 2003 State Survey found that, for the majority of systems (76%), respondents indicated that managed care has indeed made it easier to provide flexible/individualized care. However, as shown on **Table 37**, it is reportedly easier to provide individualized care in nearly all of the carve outs (91%) but in only about half of the integrated systems (53%).

Table 37

Percent of Managed Care Systems Facilitating Flexible/Individualized Service Provision

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Easier to provide flexible/individualized services	81%	91%	53%	76%	-5%
Not easier to provide flexible/individualized services	19%	9%	47%	24%	5%

In previous surveys and impact analyses, respondents explained the greater flexibility and ability to individualize care, citing a number of contributing factors:

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

Where managed care has not supported flexible/individualized service delivery, stakeholders have pointed to factors including billing procedures and service codes that impede flexibility, reporting methods used to track encounter data that are disincentives to flexible service delivery, rigid authorization processes, the tendency of MCOs to focus on single episodes of discrete services, and lack of MCO and provider understanding of how to use flexible approaches.

Services to Young Children and Their Families

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

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

Given the issues raised through the impact analyses, the 2000 and 2003 State Surveys explored the extent to which services are being provided to young children and their families. Findings shown on **Table 38** indicate that only 23% of the systems reportedly provide "many" services to this population in 2003, down from 44% (a 21% decline) since 2000. About three-quarters (77%) of the carve outs and two-thirds of the integrated systems (69%) provide "few" services to young children and their families. Overall, most managed care systems (74%) are providing few services to this population, despite increased national attention to early childhood mental health issues and the need to intervene early, and despite reported increases in EPSDT screening for behavioral heath disorders.

Table 38

Percent of Managed Care Systems Providing Services to Young Children and their Families

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
None are provided	12%	5%	0%	3%	-9%
Few are provided	44%	77%	69%	74%	30%
Many are provided	44%	18%	31%	23%	-21%

Where services are provided to young children and their families, respondents indicated the services provided most frequently:

- Assessment
- Case management
- Family therapy
- Family support
- Respite services
- Mental health consultation
- Home-based services
- Parent training
- Behavior management
- Individual therapy
- Therapeutic preschool
- Day treatment

Evidence-Based Practices

Increasing priority has been given recently to the need to apply the knowledge gained from the rapidly growing research base for children's behavioral health services. Because of the importance of using evidence-based and promising practices in providing treatment and supports to children with behavioral health disorders and their families, items were incorporated into the 2003 State Survey to determine the extent to which managed care systems are addressing this issue. The survey explored whether managed care systems are encouraging and/or providing incentives for providers to use evidence-based practices and found that nearly two-thirds (63%) reportedly are taking some measures to encourage their use. Carve outs are far more likely to focus on evidence-based practices for children's behavioral health, with more than three-quarters (77%) promoting evidence-based practices in some way as compared with fewer than half (44%) of the integrated systems (**Table 39**).

Table 39

Percent of Managed Care Systems Encouraging or Providing Incentives for Providers to Use Evidence-Based Practices

	2003		
	Carve Out	Integrated	Total
Systems encouraging/providing incentives for evidence-based practices	77%	44%	63%
Systems not encouraging/providing incentives for evidence-based practices	23%	56%	37%

As shown on **Table 40**, the most commonly used strategies for promoting the use of evidence-based practices include providing training and consultation (reported in 75% of the systems that provide incentives), developing practice guidelines, and monitoring through quality improvement protocols (each reported in 50% of the systems that provide incentives).

Table 40

Strategies for Encouraging or Providing Incentives to Providers to Use Evidence-Based Practices

	2003		
	Carve Out	Integrated	Total
Developing practice guidelines	53%	43%	50%
Developing special rates	18%	43%	25%
Providing training and/or consultation	88%	43%	75%
Monitoring through quality improvement protocols	47%	57%	50%
Other	24%	43%	29%

Respondents specified the evidence-based practices that they are promoting. These included the wraparound process, multisystemic therapy (MST), functional family therapy, assertive community treatment, therapeutic foster care, cognitive-behavioral therapy, and others.

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

Incorporation of Special Provisions for High-Need Populations

An issue emphasized by stakeholders throughout the Tracking Project's activities is the need for managed care systems to incorporate special services, arrangements, or provisions for children and adolescents with serious and complex behavioral health needs and their families. High-need populations include children and adolescents with serious emotional disorders, children and adolescents involved with the child welfare system, and children and adolescents involved with the juvenile justice system. Many barriers to serving these high-need populations were identified through the impact analyses, including:

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

Previous state surveys explored whether special provisions were incorporated for the population of children and adolescents with serious emotional disorders. In 1995, only 44% of the systems reported doing so, increasing slightly in 1997/98 to 49% of the systems, perhaps reflecting the beginning of a trend to consider the special needs of these populations in managed care system planning and operation. The 2000 State Survey results confirmed this trend and showed a dramatic increase in the incorporation of special provisions for children and adolescents with serious emotional disorders, with a shift from less than half of the systems having any special provisions to the majority of systems (93%) indicating that did. The 2003 State Survey found a 12% decrease in the incorporation of special provisions. Still, the majority of managed care systems (81%) reportedly include special provisions of some type for this population, and the incorporation of such provisions has increased substantially since 1995 (a 37% increase from 1995 to 2003). This shift is likely the result of recognition of the special needs of children with serious emotional disorders over time, due to the many problems and challenges encountered in attempting to serve them within the context of managed care systems. The findings continue to reflect the previously established pattern of a greater likelihood of special provisions in managed care systems with carve out designs (86% of carve outs have special provisions for this population); however, a substantial proportion of integrated systems (70%) also reported having some special provisions for this group (**Table 41**).

Table 41

Percent of Managed Care Systems with Special Provisions for Children and Adolescents with Serious and Complex Behavioral Health Needs

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Children and adolescents with serious behavioral health disorders	44%	49%	93%	86%	70%	81%	37%	32%	-12%
Children and adolescents in the child welfare system	Not Asked	Not Asked	87%	77%	40%	63%	NA	NA	-25%
Children and adolescents in the juvenile justice system	Not Asked	Not Asked	60%	68%	30%	50%	NA	NA	-10%

NA=Not Applicable

Starting in 2000, the state surveys also assessed the incorporation of special provisions for children and adolescents in the child welfare and juvenile justice systems. As shown on **Table 41**, special provisions for these high-need populations are incorporated into managed care systems less frequently than for children with serious emotional disorders; 63% reportedly have special provisions for the child welfare population and 50% for the juvenile justice population. Consistent with the declines in reports of special provisions for children with serious emotional disorders, the incorporation of special provisions for these populations also has declined since 2000, a 25% decline in reports of special provisions for the child welfare population and a 10% decline in special provisions for the juvenile justice population. The decline in special provisions for high-need populations between 2000 and 2003 may be due to state fiscal problems. Again, special provisions for these populations are far more likely to be found in carve outs than in integrated systems.

Types of Special Provisions

Of the special provisions for children and adolescents with serious emotional disorders, as shown on **Table 42**, most take the form of intensive case management (found in 100% of the systems with special provisions), wraparound services/process (found in 92% of the systems with special provisions), interagency treatment and service planning (found in 88% of the systems with special provisions), an expanded service array (found in 85% of the systems with special provisions), or family support services (found in 77% of the systems with special provisions). Half of the systems with special provisions reportedly incorporate flexible service dollars to use in serving children with serious emotional disorders. However, only 31% of the systems with special provisions include a higher capitation or case rate for these youth, a finding consistent with the previous survey data and indicating a small decline (7%) in the use of financial incentives for this group from 1997/98 to 2003. This suggests that although special provisions such as intensive case management or an expanded service array are included, the resources to provide these additional services to this high-need population may not be sufficient.

Table 42

Type of Special Provisions Included by Managed Care Systems with Special Provisions for Children and Adolescents with Serious Behavioral Health Disorders

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Expanded service array	90%	79%	84%	86%	85%	-5%	6%
Intensive case management	86%	86%	100%	100%	100%	14%	14%
Interagency treatment and service planning	57%	86%	100%	57%	88%	31%	2%
Wraparound services/process	71%	57%	95%	86%	92%	21%	35%
Family support services	67%	79%	84%	57%	77%	10%	-2%
Higher capitation or case rates	38%	29%	21%	57%	31%	-7%	2%
Flexible service dollars	Not Asked	Not Asked	58%	29%	50%	NA	NA
Other	0%	21%	5%	14%	8%	8%	-13%

NA=Not Applicable

Of particular note is the reported increase in the use of two types of special provisions over time among systems using special provisions — wraparound services/process and interagency treatment and service planning. The use of the wraparound approach in managed care systems reportedly has increased 21% between 1997/98 and 2003, and the related use of interagency treatment and service planning reportedly has increased 31% over the same time period.

The special provisions incorporated for youth in the child welfare and juvenile justice systems are similar to those for the population of youngsters with serious emotional disorders (**Table 43**). For both populations, special provisions are most frequently in the form of interagency treatment and service planning, intensive case management, an expanded service array, and wraparound services/process.

Table 43

Types of Provisions Included by Managed Care Systems with Special Provisions for Children and Adolescents In the Child Welfare and Juvenile Justice Systems

	For Children Involved in the Child Welfare System					For Children Involved in the Juvenile Justice System				
	2000 Total	2003			Percent of Change 2000–2003	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total			Carve Out	Integrated	Total	
Expanded service array	73%	88%	75%	86%	13%	94%	87%	100%	89%	-5%
Intensive case management	62%	100%	75%	95%	33%	78%	87%	67%	83%	5%
Interagency treatment and service planning	77%	100%	75%	95%	18%	83%	100%	33%	89%	6%
Wraparound services/process	65%	88%	75%	86%	21%	67%	73%	67%	72%	5%
Family support services	50%	65%	50%	62%	12%	61%	60%	67%	61%	0%
Higher capitation or case rates	15%	12%	100%	29%	14%	17%	13%	100%	28%	11%
Flexible service dollars	Not Asked	53%	25%	48%	Not Asked	Not Asked	53%	33%	50%	Not Asked
Other	8%	6%	25%	10%	2%	11%	7%	33%	11%	0%

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

The impact analyses yielded conflicting results regarding the effect of managed care implementation on case management/care coordination for children with serious and complex behavioral heath needs. In some states, managed care reportedly expanded the provision of case management services, whereas in others case management services were reported to have been constricted as a result of managed care, ostensibly due to such factors as the need for authorization, greater emphasis on utilization management as opposed to accessing and coordinating care, and a perception that case management services are neither approved nor reimbursed as readily as under previous fee-for-service systems.

Given these conflicting results, the 2000 and 2003 State Surveys were used to clarify this area and to further assess the effects of managed care systems on case management/care coordination services. The surveys specifically investigated the effects of managed care on case management for children with serious and complex behavioral health needs, and both found that in most systems (58% in 2003) case management/care coordination services for this population reportedly have increased in comparison with pre-managed care. However, there are notable differences between systems with carve out and integrated designs with respect to case management. The majority of the carve outs (82%), but only 21% of the integrated

systems reported increased case management attributed to the managed care. Additionally, no carve outs reported decreased case management, compared with 7% of the integrated systems in which case management/care coordination services reportedly have been compromised as a result of managed care (**Table 44**).

Table 44

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Increased case management/care coordination	71%	82%	21%	58%	-13%
Decreased case management/care coordination	6%	0%	8%	3%	-3%
No effect	23%	18%	71%	39%	16%

Support and Facilitation of Systems of Care

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

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

The 2000 and 2003 State Surveys took a slightly different perspective and examined whether managed care systems, in general, have facilitated and supported the further development of local systems of care for children and adolescents with serious behavioral health disorders. Similar to 2000 findings, 70% of the systems were thought to facilitate and support local systems of care in 2003 (**Table 45**).

Table 45

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care systems facilitate and support local system of care development and operation	75%	90%	44%	70%	-5%
Managed care systems do not facilitate and support local system of care development and operation	25%	10%	56%	30%	5%

Again consistent with the earlier survey results, the difference between carve outs and integrated systems was substantial. Managed care systems reportedly are supportive of systems of care in the majority of the carve outs (90%) but in less than half (44%) of the integrated systems.

Stakeholders in the impact analyses explained that managed care systems with carve out designs have facilitated the development of local systems of care primarily by allowing for coverage and payment for services that are linked to the system of care philosophy and by creating incentives for the development and use of these services. However, in both impact analyses, stakeholders in most states with integrated physical health-behavioral health designs felt that managed care systems impeded system of care development, based on their assessment that the design and features of the managed care system were discrepant with the system of care philosophy and approach. This is seen in the 2003 State Survey results, as only 10% of the carve outs, but 56% of the integrated systems do not support the development of local systems of care according to respondents.

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

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

The state surveys have consistently found striking differences between behavioral health carve outs and integrated systems in the extent to which system of care values and principles are included in their system documents, and thus incorporated into managed care systems. **Table 46** shows that behavioral health carve outs have a much higher rate of inclusion of all of these principles, with the exception of a broad array of community-based services, which is reportedly included in the majority of systems regardless of design. Nearly all carve outs (more than 90%) include family involvement, individualized/flexible care, and cultural competence, and the other principles are included by more that 80% of the carve outs. Other than a broad service array, none of the values and principles reach these high levels of inclusion in the integrated systems.

Table 46
Percent of Managed Care Systems Incorporating System of Care Values and Principles

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Broad array of community-based services	72%	85%	86%	92%	89%	17%	4%
Family involvement	79%	88%	91%	31%	69%	-10%	-19%
Individualized, flexible care	79%	79%	91%	54%	77%	-2%	-2%
Interagency treatment/service planning	77%	85%	86%	38%	69%	-8%	-16%
Case management	86%	79%	82%	69%	77%	-9%	-2%
Cultural competence	81%	79%	95%	54%	80%	-1%	1%
None of the above values and principles	Not Asked	Not Asked	0%	0%	0%	NA	NA

NA=Not Applicable

Of note is the observation that the incorporation of the principle of a broad service array has increased over time (a 17% increase from 1997/98 to 2003), largely due to increased incorporation of this principle in integrated systems. Slight declines in the reported incorporation of other system of care principles were found since 1997/98.

VII. Financing and Risk

Agency Financing Sources for Managed Care Systems

Table 47 displays managed care systems by the types of agencies contributing to financing the systems.

Table 47

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

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Medicaid agency	100%	91%	100%	100%	100%	0%	9%
Mental health agency	56%	76%	86%	0%	50%	-6%	-26%
Child welfare agency	32%	21%	41%	13%	29%	-3%	8%
Juvenile justice agency	15%	9%	18%	0%	11%	-4%	2%
Education agency	12%	0%	14%	6%	11%	-1%	11%
Substance abuse agency	27%	9%	50%	6%	32%	5%	23%
Health agency	17%	6%	23%	6%	16%	-1%	10%
MR/DD agency	Not Asked	3%	18%	6%	13%	NA	10%
Other	5%	3%	5%	0%	3%	-2%	0%

NA=Not Applicable

As has been the case throughout the Tracking Project, the state Medicaid agency is the primary contributor of funds to managed care systems, contributing to 100% of the systems in the 2003 State Survey. The state mental health authority contributes to most carve outs (86%) but to none of the integrated systems in the sample. Since 2000, there has been a 26% decline in the percentage of managed care systems to which the mental health agency contributes funds, including a 10% decline in financing of carve outs and a 13% decline in financing of integrated systems. From 2000 to 2003, there has been a 9% increase in the percentage of managed care systems to which Medicaid contributes funds; all of the increase has occurred within carve outs.

The Tracking Project has found consistently over time that, in comparison to the large proportion of managed care systems to which state Medicaid and state mental health agencies contribute funds, the proportion of managed care systems to which other child-serving agencies contribute financing is relatively small. Although the 2003 data show increases since 2000 in the percentage of managed care systems in which other child-serving agencies (i.e., non-Medicaid and non-mental health) are contributing funds, these other agencies still contribute in relatively few cases. Child welfare and state substance abuse agencies contribute

funds to slightly less than one-third of the systems. Other agencies (e.g., juvenile justice, health, and education) contribute to fewer than 17% of the systems. As has been found throughout the Tracking Project, carve outs are far more likely than integrated systems to include dollars contributed by other child-serving (non-Medicaid and non-mental health) agencies.

Table 48 displays this information in a slightly different way. It shows the increase (16%) in the percentage of systems that are funded only by Medicaid, the decline (22%) in the percentage of systems funded by both Medicaid and mental health, and the slight increase (5%) in the percentage of systems with multiple agencies contributing dollars. It also shows that other child-serving agencies are significantly more likely to contribute to carve outs than to integrated systems.

Table 48

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

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Medicaid agency only contributing	40%	39%	26%	14%	81%	42%	2%	3%	16%
Medicaid and behavioral health agencies both contributing	20%	20%	35%	23%	0%	13%	-7%	-7%	-22%
Other agencies contributing in addition to Medicaid and behavioral health agencies	40%	41%	39%	63%	19%	45%	4%	3%	5%

Types of Revenue Used To Finance Managed Care Systems

Table 49 indicates the percentage of managed care systems by the types of revenue financing the systems.

Table 49

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Medicaid	97%	95%	100%	97%	0%
State general revenue	67%	64%	44%	55%	-12%
Block grant	45%	50%	0%	29%	-16%
Child welfare (e.g., Title IV-E, IV-B)	21%	27%	0%	16%	-5%
TANF	12%	14%	19%	16%	4%
SCHIP	45%	41%	50%	45%	0%
Other	9%	9%	0%	5%	-4%

Consistent with the agency source of funds, Medicaid revenue is the type of financing used in most systems (97%), followed by state general revenue (55% of systems); State Children's Health Insurance Program (SCHIP — 45% of systems); block grant (29% of systems, all carve outs); child welfare (16% of systems); and Temporary Assistance to Needy Families (TANF - 16% of systems). Consistent with the finding noted previously regarding a decline in the percentage of systems to which state mental health agencies contribute dollars, **Table 49** also shows a decline in the use of state general revenue and block grant financing.

As has been found consistently throughout the Tracking Project, integrated systems are slightly more likely than carve outs to use SCHIP and TANF dollars, in addition to Medicaid. Carve outs, however, are significantly more likely to use state general revenue, block grant, and child welfare dollars, in addition to Medicaid. In 2003, reportedly no integrated systems were using block grant or Title IV-E or IV-B (i.e., child welfare) dollars, compared to half of the carve outs using block grant funds and more than a quarter (27%) using child welfare dollars. These findings also are consistent with the previously discussed finding that only carve outs are covering non-Medicaid populations (and thus are drawing on non-Medicaid dollars).

Table 50 provides a more extensive breakdown of the agencies and types of revenue financing managed care systems.

Table 50

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

Agency Source	2003						
	Type of Revenue						
	Medicaid	General Revenue	Block Grant	Child Welfare (Title IV-E, IV-B)	TANF	SCHIP	Other
Medicaid agency	97%	39%	0%	0%	16%	45%	0%
Mental health agency	16%	37%	29%	0%	3%	11%	5%
Child welfare agency	5%	11%	3%	21%	3%	3%	0%
Juvenile justice agency	0%	3%	0%	5%	3%	3%	0%
Education agency	3%	8%	0%	0%	0%	3%	0%
Substance abuse agency	11%	16%	11%	3%	0%	3%	0%
Health agency	8%	8%	0%	0%	0%	3%	0%
MR/DD agency	11%	3%	0%	3%	0%	3%	0%
Other	3%	0%	0%	0%	0%	0%	3%

When these data are stratified by carve outs versus integrated systems (**Tables 51** and **52**), a distinct picture emerges of the greater extent to which carve outs are using multiple types of revenue contributed by multiple agencies. Even with carve outs more extensive use of multiple types of revenue contributed by multiple agencies, however, fewer than a third of managed care systems overall are using dollars contributed by non-Medicaid and non-mental health agencies (**Table 47**).

Table 51

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

Agency Source	2003						
	Type of Revenue						
	Medicaid	General Revenue	Block Grant	Child Welfare	TANF	SCHIP	Other
Medicaid agency	95%	36%	0%	0%	14%	41%	0%
Mental health agency	27%	64%	50%	0%	5%	18%	9%
Child welfare agency	9%	18%	5%	27%	5%	5%	0%
Juvenile justice agency	0%	5%	0%	9%	5%	5%	0%
Education agency	5%	9%	0%	0%	0%	5%	0%
Substance abuse agency	14%	27%	18%	5%	0%	5%	0%
Health agency	14%	9%	0%	0%	0%	5%	0%
MR/DD agency	14%	5%	0%	5%	0%	5%	0%
Other	0%	0%	0%	0%	0%	0%	5%

Table 52

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

Agency Source	2003						
	Type of Revenue						
	Medicaid	General Revenue	Block Grant	Child Welfare	TANF	SCHIP	Other
Medicaid agency	100%	44%	0%	0%	19%	50%	0%
Mental health agency	0%	0%	0%	0%	0%	0%	0%
Child welfare agency	0%	0%	0%	13%	0%	0%	0%
Juvenile justice agency	0%	0%	0%	0%	0%	0%	0%
Education agency	0%	6%	0%	0%	0%	0%	0%
Substance abuse agency	6%	0%	0%	0%	0%	0%	0%
Health agency	0%	6%	0%	0%	0%	0%	0%
MR/DD agency	6%	0%	0%	0%	0%	0%	0%
Other	6%	0%	0%	0%	0%	0%	0%

The significance of the types of revenue and agencies financing managed care systems has to do with the fact that many of the populations of children enrolled in publicly financed managed care rely on multiple funding streams and agencies for behavioral health service delivery. This is true, for example, of children involved in the child welfare and juvenile justice systems, children receiving Supplemental Security Income (SSI), children with serious disorders who may not qualify for SSI, and children with co-occurring mental health and substance abuse disorders or mental health and developmental disabilities or chronic physical illnesses. Historically, there has been fragmentation across these funding streams and agencies, creating cost inefficiencies and confusion for families and providers. Managed care as a technology provides an opportunity to "blend" dollars and to rationalize the delivery system. The Tracking Project has found consistently that carve outs take greater advantage of this opportunity with respect to children with behavioral health disorders than do integrated systems, although neither carve outs nor integrated systems are utilizing this potential to any significant extent.

Matrix 4 displays the agencies contributing to managed care systems in the 2003 sample by state.

States Alpha List		Matrix 4: Agencies Contributing to Financing the Managed Care System								
		Medicaid Agency	Mental Health Agency	Child Welfare Agency	Juvenile Justice Agency	Education Agency	Substance Abuse Agency	Health Agency	MR/DD Agency	Other
Carve Out Design										
Arizona	AZ	●	●				●			
California	CA	●	●	●	●	●	●	●	●	
Colorado	CO	●	●	●						
Delaware	DE	●	●			●	●			
Florida	FL	●								
Georgia	GA	●	●							
Hawaii	HI	●	●							
Indiana	IN	●	●							
Iowa	IA	●	●							
Maryland	MD	●	●							
Massachusetts	MA	●	●							
Michigan	MI	●	●				●	●	●	
Nebraska	NE	●								
New Jersey	NJ	●	●	●						
Oregon	OR	●	●	●	●	●	●	●	●	
Pennsylvania	PA	●	●	●			●			
Tennessee	TN	●	●	●			●	●		
Texas	TX	●	●				●	●		●
Utah	UT	●	●	●	●		●		●	
Washington	WA	●	●							
West Virginia	WV	●	●	●			●			
Wisconsin 2	WI	●	●	●	●					
Integrated Design										
Connecticut	CT	●								
District of Columbia	DC	●								
Illionois	IL	●								
Minnesota	MN	●					●		●	
Missouri	MO	●								
Nevada	NV	●								
New Mexico	NM	●								
New York	NY	●								
North Dakota 1	ND	●								
North Dakota 2	ND	●								
Ohio	OH									
Oklahoma	OK	●								
Rhode Island	RI	●		●				●		
South Dakota	SD	●								
Vermont	VT	●		●		●				
Virginia	VA	●								
Wisconsin 1	WI	●								
Carve Outs		22	19	9	4	3	11	5	4	1
Integrated		16	0	2	0	1	1	1	1	0
Total		**38**	**19**	**11**	**4**	**4**	**12**	**6**	**5**	**1**

Use of Medicaid Outside of Managed Care Systems

In a further effort to gauge the potential for fragmentation and cost shifting between managed care systems and other systems providing behavioral health services to children and adolescents, the Tracking Project has explored whether there are Medicaid dollars left outside of managed care systems that are being used by other child-serving agencies for behavioral health care. Over the past decade, states consistently have reported that some Medicaid dollars for children's behavioral health services are left outside of the managed care system in fee-for-service arrangements. As shown on **Table 53**, this was reported to be the case in 100% of the managed care systems in the 2003 sample.

Table 53

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care systems in which other systems use Medicaid dollars outside of managed care system	91%	100%	100%	100%	9%

As shown on **Table 54**, the following child-serving agencies were reported to be using Medicaid dollars outside of the managed care system for children's behavioral health services: child welfare (in 72% of the systems); mental health, education, and mental retardation/ developmental disabilities (in 67% each); substance abuse (58%); juvenile justice (56%); and, health (44%). This raises issues of service coordination and "boundary management" that are discussed more fully in other sections of this report. It is clear, however, that, as has been consistently found by the Tracking Project, other child-serving agencies continue to have access to Medicaid dollars outside of managed care arrangements. This may create a safety net for vulnerable children should the managed care system fail to provide necessary services. On the other hand, it perpetuates opportunities for fragmentation and cost shifting.

Table 54

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Mental health agency	50%	43%	100%	67%	17%
Child welfare agency	72%	71%	73%	72%	0%
Juvenile justice agency	59%	48%	67%	56%	-3%
Education agency	81%	62%	73%	67%	-14%
Substance abuse agency	50%	38%	87%	58%	8%
Health agency	41%	43%	47%	44%	3%
MR/DD agency	72%	71%	60%	67%	-5%
Other	13%	0%	0%	0%	-13%

Cost Shifting

Interestingly, given the fragmentation in financing and service responsibility that seems to persist, in half of managed care systems in 2003 (50%), cost shifting reportedly is not occurring, an improvement compared to reports of cost shifting in 2000. In 2000, cost shifting reportedly was occurring in two-thirds of the managed care systems, as compared with reports of cost shifting in only half of the systems in 2003. Carve outs were less likely to have reported cost shifting than were integrated systems. Possibly due to the later stages of development of managed care systems, progress has been made on resolving boundary issues. Additionally, as discussed earlier, there were some gains since 2000, at least by carve outs, in drawing in financing from multiple agencies, which may help to reduce cost shifting incentives (**Table 55**).

Table 55

Percent of Managed Care Systems with Reports of Cost Shifting

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Cost shifting is not occurring	32%	55%	43%	50%	18%
Cost shifting is occurring from the managed care system to other child-serving systems	36%	25%	57%	38%	2%
Cost shifting is occurring from other child-serving system into the managed care systems	43%	45%	43%	44%	1%

When cost shifting is reported in 2003, there tends to be cost shifting from the managed care system to other child-serving agencies reported more for integrated systems than for carve outs, which was found in 2000 as well. This may be because integrated systems are identifying children but, with the more traditional, acute care benefit typically found in integrated systems, are limiting the duration and scope of care and passing children along to other systems.

Drawing conclusions about cost shifting remains problematic, as has been the case throughout the Tracking Project, since few systems (11%) actually track and monitor cost shifting (**Table 56**).

Table 56

Percent of Reforms Tracking and Monitoring Cost Shifting

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care systems tracking cost shifting	16%	14%	6%	11%	-5%

Clarification of Responsibility Across Child-Serving Systems

The Tracking Project also has explored over time whether managed care systems incorporate strategies to clarify responsibility for providing and paying for behavioral health services across child-serving systems. As **Table 57** shows, over two-thirds of managed care systems in 2003 reportedly do incorporate such strategies, with carve outs being more likely to do so than integrated systems.

Table 57

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care systems clarify responsibility	64%	77%	59%	69%	5%
Managed care systems do not clarify responsibility	36%	23%	41%	31%	-5%

Additional analyses show that in managed care systems with strategies for clarifying responsibilities across child-serving systems, there also is less cost shifting reported, as was the case in 2000. In 2003, cost shifting was reported in 34% of managed care systems with strategies for clarifying service or payment responsibility, as compared to 58% of systems in which there were no such strategies.

Use of Risk-Based Financing

As **Table 58** shows, since 2000, there has been a 16% increase reported in the percentage of managed care systems using capitation, a 7% decline in the percentage using case rates, and a 5% decline in the percentage using neither. In other words, some systems seem to have moved toward more use of full-blown risk models since 2000. This may reflect an increasing sophistication with managed care on the part of state purchasers and/or an outgrowth of state budget problems.

Both carve outs and integrated systems reportedly have increased the use of capitation, with carve outs reporting a 14% increase in the use of capitation and integrated systems, a 5% increase. Carve outs still remain less likely to use capitation than integrated systems (68% of carve outs do versus 93% of integrated systems), but the gap seems to be narrowing.

Table 58
Percent of Managed Care Systems Using Capitation and/or Case Rates

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Capitation	88%	92%	62%	68%	93%	78%	-10%	-14%	16%
Case Rates	Not Asked	16%	26%	18%	20%	19%	NA	3%	-7%
Neither	12%	11%	24%	27%	7%	19%	7%	8%	-5%

NA=Not Applicable

Table 59 provides reported examples of capitation and case rate approaches by state.

Table 59
Examples of Capitation or Case Rate Approaches by State

State	Type of System (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate (P/Month or P/Year)	Amount of Case Rate (P/Month or P/Year)
Arizona AZ	Carve Out	Children and adolescents–behavioral health only.	$27.49 pmpm–average $19.81–$31.79 pmpm–range	
		Adults–behavioral health only.	$19.82 pmpm–average $12.63–$29.44 pmpm–range	
		Adults–with serious and persistent mental illness	$63.48 pmpm–average $46.14–$81.11 pmpm–range	
		SCHIP–Children and adolescents BH only.	$11.33 pmpm–average $6.92–$18.00 pmpm–range	
Delaware DE	Carve Out	Children and adolescents–behavioral health only.		$4,239 pmpm
Hawaii HI	Carve Out	Children and adolescents with serious emotional disorders.	$214 pmpm	
Indiana IN	Carve Out	Children and adolescents with serious emotional disorders.		$1,670 pmpm
Iowa IA	Carve Out	Adults and children and adolescents–behavioral health only.	$30 pmpm–average	
Michigan MI	Carve Out	Children and adolescents–behavioral health only.	$9.26 pmpm	
		Adults–behavioral health only.	$54.02 pmpm	

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

Table 59 continued
Examples of Capitation or Case Rate Approaches by State

State	Type of System (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate (P/Month or P/Year)	Amount of Case Rate (P/Month or P/Year)
Missouri MO	Integrated	Category of Aid 1–TANF Adults, TANF Children, Medicaid for children, refugee and Medicaid for Pregnant Women. Average monthly rate of $145.31 (inlcudes maternity supplemental payments).	$145.31 pmpm–average	
		Category of Aid 1–TANF Foster Care, Child Welfare Services, Division of Youth Services, and Foster Care. Average monthly capitation rate of $135.64.	$135.64 pmpm–average	
		Category of Aid 5–MC+ for kids (SCHIP) and TANF Traditional. Average Monthly capitation rate of $90.91 (includes maternity supplemental payments).	$90.91 pmpm–average	
Nevada NV	Integrated	Adults and children and adolescents–physical and behavioral health.	$342 pmpm	
New York NY	Integrated	Adults and children and adolescents–physical and behavioral health.	$159 pmpm	
Pennsylvania PA	Carve Out	Other: There are separate rates for different categories of assistance.	$75–$120 pmpm–range	

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

Table 59 continued
Examples of Capitation or Case Rate Approaches by State

State	Type of System (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate (P/Month or P/Year)	Amount of Case Rate (P/Month or P/Year)
Rhode Island RI	Integrated	Adults and children and adolescents–physical and behavioral health.	$75–$180 pmpm–range	
		Children and adolescents with serious emotional disorders.	$300–$550 pmpm–range	
		Children and adolescents in the child welfare system.	$440 pmpm–average	
		Children with special health care needs.	$300–$550 pmpm–range	
South Dakota SD	Integrated	PCP's receive a case management fee of $3 pmpm.	$3 pmpm	
Tennessee TN	Carve Out	Children and adolescents with serious emotional disorders.	$319.41 pmpm	
		Adults with serious and persistent mental illnesses.	$319.41 pmpm	
Texas TX	Carve Out	Children and adolescents–behavioral health only (TANF only).	$4.38 pmpm	
		Adults–behavioral health only (TANF only).	$18.32 pmpm	
		Children and adolescents with serious emotional disorders (TANF only).	$40.76 pmpm	
		Adults with serious and persistent mental illnesses (SSI).	$71.42 pmpm	
Vermont VT	Integrated	Adolescents with serious and persistent mental illness.	$1,091.19 pmpm	

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

Table 59 continued
Examples of Capitation or Case Rate Approaches by State

State	Type of System (Carve Out or Integrated)	Capitated Population	Amount of Captitation Rate (P/Month or P/Year)	Amount of Case Rate (P/Month or P/Year)
Washington WA	Carve Out	Nondisabled children and adolescents–behavioral health only.	$15.76 pmpm	
		Nondisabled adults–behavioral health only.	$13.03 pmpm	
		Disabled children.	$76.42 pmpm	
		Disabled adults.	$126.65 pmpm	
Wisconsin 2 WI	Carve Out	Children and adolescents with serious emotional disorders:		
		Children ComeFirst (Dane County).	$1,620.89 pmpm (Medicaid Capitation only. Does not include other funds.)	
		Wraparound Milwaukee	$1,557 pmpm (Medicaid Capitation only. Does not include other funds.)	

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

Rate Changes and Sufficiency Assessments

Most managed care systems reportedly have changed the rates paid to MCOs since 2000, with over half (57%) reportedly increasing rates, and the remainder (43%) decreasing rates (**Tables 60** and **61**). The percentage of systems increasing rates has fallen since 2000, however, when 80% of systems that changed rates reportedly increased rates and 20% decreased them. Again, this may be due to a certain settling in the managed care landscape and/or state budget problems.

Table 60
Percent of Managed Care Systems Reporting Changes in Capitation or Case Rates

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Rate changes reported	53%	83%	89%	75%	82%	29%	-1%
No rate changes reported	47%	17%	11%	25%	18%	-29%	1%

Table 61
Direction of Rate Changes in Managed Care Systems Reporting Changes in Rates

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Rates have increased	80%	75%	67%	57%	-23%
Rates have decreased	20%	25%	33%	43%	23%

As was the case in 2000 as well, about two-thirds of managed care systems reportedly assess on some systematic basis the sufficiency of rates paid to MCOs, with most then making adjustments in rates based on this assessment (**Tables 62** and **63**). As was also the case in 2000, carve outs are more likely than integrated systems to assess the sufficiency of rates for children's behavioral health services; 81% of carve outs do so versus only 42% of integrated systems.

Table 62
Percent of Managed Care Systems that Assess the Sufficiency of Rates

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care systems assess the sufficiency of rates	61%	81%	42%	64%	3%
Managed care systems do not assess rate sufficiency	39%	19%	58%	36%	-3%

Table 63

Percent of Managed Care Systems that have Made Rate Adjustments Based on Assessments of Rate Sufficiency

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care systems have made rate adjustments based on assessments of sufficiency	53%	67%	75%	69%	16%
Managed care systems have not made rate adjustments based on assessments of sufficiency	47%	33%	25%	31%	-16%

Required Allocation of a Percentage of the Rate to Behavioral Health

As **Table 64** shows, none of the integrated managed care systems specify that a percentage of the rate paid to MCOs be allocated for behavioral health services; this has been a consistent finding over the past decade. The impact analyses also found that most states do not know how much of the rate is going to behavioral health services for children in integrated systems.

Table 64

Percent of Integrated Managed Care Systems that Require a Specified Percentage of the Rate to be Allocated to Behavioral Health

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care systems require specified percentage of rate to be allocated to behavioral health	0%	0%	NA	0%	0%	0%	0%
Managed care systems do not require specified percentage of rate to be allocated to behavioral health	100%	100%	NA	100%	100%	0%	0%

NA=Not Applicable

Use of Risk Adjusted Rates and Other Risk Adjustment Mechanisms

As shown on **Table 65**, only about a third of managed care systems (31%) reportedly use risk adjusted rates specifically for high-need child populations, a very small (2%) increase over 2000, driven solely by a small increase in use of risk adjusted rates by carve outs. Integrated systems actually show a small decline in use of risk adjusted rates.

Table 65

Percent of Managed Care Systems Using Risk Adjusted Rates for High-Need Populations of Children and Adolescents of Rate Sufficiency

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care systems using risk adjusted rates for high-need populations	29%	27%	35%	31%	2%

Table 66 shows that only 13% of managed care systems in the 2003 sample (5 states) incorporate risk adjusted rates for children with serious emotional disorders, with carve outs more likely to do so. Ten percent of systems (4 states) incorporate risk adjusted rates for children in the child welfare system, with integrated systems more likely to do so. Eight percent of systems (3 states) incorporate risk adjusted rates for youth involved in the juvenile justice system, with integrated systems more likely to do so.

Table 66

Percent of All Managed Care Systems that Incorporate Risk Adjusted Rates for Various Populations of High-Need Children and Adolescents

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Risk adjusted rates for children in child welfare system	11%	5%	18%	10%	-1%
Risk adjusted rates for children in juvenile justice system	6%	5%	12%	8%	2%
Risk adjusted rates for children with serious behavioral health disorders	20%	18%	6%	13%	-7%

As **Table 67** shows, few managed care systems use other types of risk adjustment mechanisms for children with serious behavioral health disorders, such as: stop-loss arrangements (used by 13% of systems, mainly integrated systems); risk corridors (used by 13% of systems, mainly in carve outs); reinsurance (used by 10% of systems, mainly in integrated systems); and risk pools (used in 3%, representing two carve outs, a 14% decline in use of risk pools by carve outs since 2000). In general, the use of risk adjustment mechanisms reportedly has declined slightly since 2000. This decline is found not only in integrated systems, which as discussed earlier, have dropped coverage of these high-need populations to a greater extent than carve outs since 2000; declines in use of various risk adjustment mechanisms are found in carve outs as well.

Table 67

Percent of Managed Care Systems that Incorporate Various Risk Adjustment Mechanisms

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Stop Loss	11%	5%	24%	13%	2%
Risk Corridors	14%	18%	6%	13%	-1%
Reinsurance	17%	5%	18%	10%	-7%
Risk Pools	17%	5%	0%	3%	-14%
Other	14%	9%	6%	8%	-6%

The Tracking Project consistently has found a low reported incidence of the use of risk adjusted rates and other types of risk adjustment mechanisms for children with serious behavioral health disorders and children involved in child welfare and juvenile justice systems within publicly financed managed care systems. This has been a troubling finding, given that these populations can be expected to use more services and higher cost services; without risk adjustment mechanisms, there are incentives to underserve these vulnerable children.

Risk Sharing

In about half of managed care systems (46%), MCOs reportedly have all of the benefit and all of the risk, representing little change from 2000 (**Table 68**). Integrated systems are far more likely than carve outs to place full risk with the MCO; 69% of integrated systems structure risk in this way, compared to 32% of carve outs. In only 17% of systems do states reportedly have all the benefit and all the risk. These arrangements are found more in carve outs and tend to represent Administrative Service Organization (ASO) arrangements. In a little over a quarter of the systems (29%), MCOs and states share benefit and risk, about the same as in 2000, and these arrangements are found more in carve outs than in integrated systems (36% of carve outs versus 15% of integrated systems). In sum, just as integrated systems are more likely to utilize full blown capitation, they also are more likely than carve outs to utilize risk structuring arrangements that are arguably “riskier” for high-need populations of children with behavioral health disorders.

Table 68
Percent of Managed Care Systems by Type of Risk Sharing Arrangement

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
MCOs have all the benefit and all the risk	31%	59%	45%	32%	69%	46%	15%	-13%	1%
State has all the benefit and all the risk	6%	0%	10%	23%	8%	17%	NA	17%	7%
MCOs and state share risk and share benefit	47%	22%	31%	36%	15%	28%	-18%	7%	-2%
MCO and state share risk only	9%	6%	7%	0%	8%	3%	-6%	-3%	-4%
MCO and state share benefit only	0%	13%	7%	9%	0%	6%	6%	-7%	-1%

NA=Not Applicable

Representing a change from 2000, in roughly half (53%) of managed care systems, providers do not share risk, with little reported differences between carve outs and integrated systems. In 2000, providers reportedly had no risk in only 25% of systems. Most of the change since 2000 in risk-sharing arrangements with providers seems to be driven by carve outs. In 2000, providers reportedly had no risk in only 18% of carve outs, compared to 55% in 2003. In 2000, the Tracking Project noted an increase from 1997/98 in the percentage of managed care systems that pushed risk to the provider level and speculated that this was developmental. In other words, as states and providers both acquired more experience with managed care, there seemed to be increasing interest on the part of both to have providers assume some degree of risk. However, this trend seems to have reversed course since 2000. Again only speculating, this may be because states reportedly are less engaged in raising rates in 2003 and, therefore, providers are less willing to also assume risk, or it may be because of failed risk sharing arrangements with providers in the past (**Table 69**).

Table 69
Percent of Managed Care Systems that Share Risk with Service Providers

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Providers share risk	50%	75%	45%	50%	47%	-3%	-28%
Providers have no risk	50%	25%	55%	50%	53%	3%	28%

In the 47% of managed care systems that do share risk with providers, risk sharing arrangements include subcapitation and bonuses/penalties tied to performance (used by 56% each in systems that share risk), and case rates (used by 44% of the systems that share risk). Use of subcapitation and performance-based bonuses/penalties represent the major increases in use of risk sharing arrangements with providers by systems employing risk sharing (**Table 70**).

Table 70

Percent of Managed Care Systems that Share Risk with Providers by Type of Risk Sharing Arrangement

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Subcapitation	50%	41%	44%	71%	56%	6%	15%
Case rates	Not asked	41%	44%	43%	44%	NA	3%
Bonuses/penalties tied to performance	Not asked	41%	56%	57%	56%	NA	15%

NA=Not Applicable

Limits on MCO Profits and Administrative Costs

As shown on **Table 71**, nearly 61% of managed care systems reportedly place a limit on MCO administrative costs, with carve outs being far more likely to do so (71% of carve outs versus 42% of integrated systems). Fewer than half of managed care systems (42%) limit MCO profits; again, carve outs are far more likely to do so (57% of carve outs versus 17% of integrated systems). In general, there has been a moderate decline since 2000 in the percentage of systems that limit MCO profits and a slight increase in the percentage that limit administrative costs.

Table 71

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

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Systems that limit MCO profits	48%	55%	57%	17%	42%	-6%	-13%
Systems that limit MCO administrative costs	58%	50%	71%	42%	61%	3%	11%

MCO Performance Incentives

Table 72 shows that less than a quarter of managed care systems tie bonuses/penalties to MCO performance for children's behavioral health service delivery, with carve outs being more likely to do so. Overall, there has been a slight decline (4%) reported since 2000 in use of performance-based bonuses/penalties.

Table 72

Percent of Managed Care Systems with Bonuses or Penalties for MCOs Based on Performance

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Systems with bonuses or penalties based on MCO performance	27%	27%	15%	23%	-4%

VIII. Clinical Decision Making and Management Mechanisms

Medical Necessity Criteria

Early state surveys revealed that nearly all states (86% in 1997/98) used medical necessity criteria in their managed care systems. Given their widespread use, the feedback provided by stakeholders regarding medical necessity criteria assumes particular significance. Stakeholders from most states in both impact analyses felt that the initial implementation of medical necessity criteria was problematic. Reported problems included narrow definitions of medical necessity based on a medical model, failure to consider the need to link treatment with the appropriate social and environmental supports, and inconsistent interpretation and application of medical necessity criteria across MCOs. An additional problem identified by stakeholders was overly rigid interpretation of medical necessity criteria by some MCOs, resulting in a serious barrier to service delivery by limiting both the types and duration of services for children and their families.

The 2000 and 2003 State Surveys built on these earlier findings and added items to: 1) determine the extent to which medical necessity criteria permit the consideration of psychosocial and environmental factors in clinical decision making, and 2) assess how MCO interpretation and application of medical necessity criteria affects clinical decision making and service delivery.

The 2003 State Survey found that the majority of managed care systems (89%) reportedly now have medical necessity criteria that allow for consideration of environmental and psychosocial factors in clinical decision making. **Table 73** shows that most carve outs (91%) and integrated systems (87%) have medical necessity criteria that include psychosocial and environmental considerations. In comparison with 2000 findings, the greatest increase in the use of broad medical necessity criteria is in the integrated systems –71% of the integrated systems reportedly used broad medical necessity criteria in 2000 as compared with 87% of integrated systems in 2003.

Table 73

Percent of Managed Care Systems in which Medical Necessity Criteria Allow Consideration of Psychosocial and Environmental Factors

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Medical necessity criteria allow for psychosocial and environmental factors	82%	91%	87%	89%	7%
Medical necessity criteria do not allow for psychosocial and environmental factors	18%	9%	13%	11%	-7%

Problems reportedly persist in some systems, however, with respect to MCO interpretation of medical necessity criteria (**Table 74**). In both the 2000 and 2003 State Surveys, MCOs in about three-fourths of the managed care systems (73% in 2003) reportedly interpret medical necessity criteria broadly enough to include psychosocial and environmental factors. However, in some managed care systems (20% of carve outs and 27% of integrated systems), rigid MCO interpretation of these criteria may still present a barrier to service delivery. Thus, although most managed care systems have medical necessity criteria that permit consideration of psychosocial and environmental factors in clinical decision making, MCOs in some systems may still interpret and apply these criteria rigidly, without sufficient attention to these factors.

Table 74

Percent of Managed Care Systems in which Medical Necessity Criteria Allow Consideration of Psychosocial and Environmental Factors

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Medical necessity criteria are interpreted narrowly by MCOs	26%	20%	27%	23%	-3%
Medical necessity criteria are interpreted broadly to include psychosocial and environmental factors	74%	80%	73%	77%	3%

Level of Care and Patient Placement Criteria

The state surveys have studied the use of clinical decision making criteria, including level of care criteria for children's mental health and patient placement criteria for substance abuse services, that are specific to children and adolescents. Since 2000, there has been a substantial increase in the percent of managed care systems that use child-specific clinical decision making criteria. In 2003, almost all managed care systems (94%) reported the of use child-specific criteria, as compared to 63% of the systems in 2000 (**Table 75**). The increase from 2000 to 2003 is especially noticeable for the integrated systems, with 38% using child-specific level of care and/or patient placement criteria in 2000, in comparison with 92% in 2003.

Table 75

Percent of Managed Care Systems that Incorporate Child-Specific Clinical Decision Making Criteria

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care systems incorporate child-specific clinical decision making criteria	62%	63%	95%	92%	94%	32%	31%
Systems do not incorporate child-specific clinical decision making criteria	38%	37%	5%	8%	6%	-32%	-31%

In the 2003 State Survey, of the 33 managed care systems that reported having child-specific clinical decision making criteria, almost all (97%) have level of care criteria for children's mental health, and about two-thirds (65%) have patient placement criteria specific to adolescent substance abuse treatment. These results are consistent with 2002 findings indicating that level of care criteria for children's mental health are more common than decision making criteria for adolescent substance abuse treatment. However, the percent of managed care systems that use patient placement criteria for adolescent substance abuse has increased from 41% in 2000 to 65% in 2003 (**Table 76**).

Table 76

Type of Criteria in Managed Care Systems that Include Child-Specific Criteria

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Level of care criteria for children's for mental health	100%	100%	91%	97%	-3%
Patient placement criteria for adolescent substance abuse	41%	60%	73%	65%	24%

The impact analyses raised questions about whether consistency in clinical decision making was improved by using level of care and patient placement criteria. Stakeholders noted a number of problem areas:

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

The 2000 and 2003 State Surveys explored this issue further across all states. In 2003, 94% of the managed care systems (as compared with 62% in 2000) reported improved consistency in clinical decision making (**Table 77**). Increases in reports of consistency in clinical decision making due to the use of child-specific criteria between 2000 and 2003 occurred in both carve outs (67% in 2000, up to 100% in 2003) and in integrated systems (33% in 2000 up to 82% in 2003). These findings are consistent with the finding of increased use of child-specific clinical decision making criteria in managed care systems, thus providing a vehicle for increasing consistency in clinical decision making.

Table 77

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Consistency in clinical decision making improved	62%	100%	82%	94%	32%
Consistency in clinical decision making not improved	38%	0%	18%	6%	-32%

Another potential contributor to the reported improvement in clinical decision making consistency is the use of clinical decision making criteria that are standardized across the state. As shown on **Table 78**, clinical decision making criteria reportedly are standardized across all MCOs in the state in about half of the managed care systems in both 2000 and 2003. It is interesting to note that the use of standardized statewide criteria by integrated systems increased from 0% in 2000 to 38% in 2003. This increase in standardization may be one reason for the reported substantial improvement in clinical decision making consistency in the integrated systems. It should be noted, however, that, even with standardization, the problem of differing interpretations of criteria by different MCOs and providers within a state could persist.

Table 78

Percent of Managed Care Systems in which Clinical Decision Making Criteria are Standardized Across the State

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Criteria are standardized across state	54%	59%	38%	50%	-4%
Criteria differ with each MCO	46%	41%	62%	50%	4%

Management Mechanisms

Survey findings reveal an increase in the reported use of various management mechanisms from 2000 to 2003. Most systems (82% or more) continue to report using the various management tools typically associated with managed care (prior authorization, concurrent review, and retrospective review). **Table 79** shows that the most commonly used management mechanism is prior authorization, used by 77% of the systems in 2000 and in 97% of the systems in 2003. Prior authorization was followed by concurrent review, used by 81% of the systems in 2003, and by concurrent review, used by 73% of the systems.

Table 79

Percent of Managed Care Systems Using Various Management Mechanisms

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Prior authorization	Not asked	88%	77%	95%	100%	97%	NA	9%	20%
Concurrent review	Not asked	Not asked	74%	86%	73%	81%	NA	NA	7%
Retrospective review	Not asked	Not asked	69%	82%	60%	73%	NA	NA	4%
Case management	89%	76%	66%	59%	73%	65%	-24%	-11%	-1%
No management mechanisms are used	Not asked	Not asked	Not asked	5%	7%	5%	NA	NA	NA
Other	Not asked	Not asked	6%	9%	0%	5%	NA	NA	-1%

NA=Not Applicable

In both 2000 and 2003, case management reportedly is used as a management tool by about two-thirds of the systems. It is interesting to note, however, that the use of case management as a management mechanism has declined since 1995 by 24%. Thus, although intensive case management services for children with serious and complex needs has increased as a result of managed care and is now used by all managed care systems (see **Table 42**), the use of case management as a management tool for the general population apparently has decreased over time.

Although the 2003 State Survey and previous surveys show extensive use of prior authorization as a management tool, stakeholders in most states in both impact analyses noted that prior authorization processes were often cumbersome, time consuming, confusing, and created barriers to access. These complaints were voiced less frequently in systems which routinely allowed a certain level of services without prior authorization. The 2000 and 2003 State Surveys explored the extent to which managed care systems allow certain services without prior authorization. In 2003, 86% of the systems (a 10% increase from 2000) reportedly allow provision of certain services without prior approval (**Table 80**).

Table 80

Percent of Managed Care Systems that Allow Provision of Certain Services up to a Specified Amount Without Prior Authorization

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Systems allow certain services without prior authorization	76%	86%	85%	86%	10%
Systems do not allow certain services without prior authorization	24%	14%	15%	14%	-10%

The 2003 State Survey asked states to specify which services are allowable without prior authorization. The service categories that most often are allowed without prior authorization are emergency services, outpatient services, assessment and diagnostic evaluation, and medication management. In some states, even greater flexibility is permitted.

Three-quarters of the systems reported having strategies to manage the utilization of intensive services, such as inpatient and residential treatment services in 2003 (**Table 81**). Control over utilization of intensive services is used at about the same rate by carve outs (77%) as by integrated systems (71%). More rigorous prior authorization requirements, more intensive clinical reviews of need, more frequent concurrent reviews, more intensive case management, more scrutiny of treatment plans, and more aggressive discharge and aftercare planning are among the strategies cited by respondents as examples of their efforts to manage the utilization of intensive services.

Table 81

Percent of Managed Care Systems with Strategies to Manage Utilization of Intensive Services

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Strategies to manage intensive services	80%	77%	71%	75%	-5%
No strategies to manage intensive services	20%	23%	29%	25%	5%

IX. Access

Initial Access to Behavioral Health Services

The impact analyses revealed that stakeholders in nearly all states studied felt that initial access to behavioral health services was easier as a result of managed care implementation, regardless of design, though some questions about potentially compromised initial access were raised in relation to managed care systems with integrated designs.

An assessment of the effect of managed care systems on initial access to behavioral health services in the 2000 and 2003 State Surveys found that, overall, initial access is considered to be improved by managed care systems in comparison with pre-managed care. Improved access was reported for 85% of the systems, up 15% from 70% in 2000 (**Table 82**). While 2000 results suggested that initial access is likely to be better in systems with carve out designs, in 2003 better initial access was reported equally by carve outs and integrated systems. Further, whereas initial access to behavioral health services reportedly had worsened in one-third of the integrated systems in 2000, this was not the case in 2003; initial access reportedly has worsened in only 7% of the integrated systems. This improvement in initial access to behavioral health care, and particularly the improvement in initial access over time reported for integrated systems, is significant given that improving access to behavioral health services is a goal reported for most managed care systems.

Table 82

Impact of Managed Care Systems on Initial Access to Behavioral Health Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Initial access to behavioral health services is better	70%	86%	85%	85%	15%
Initial access to behavioral health services is worse	15%	5%	7%	6%	-9%
No change	15%	9%	8%	9%	-6%

Access to Extended Care

Though improvement in initial access to behavioral health services is evident in the 2003 State Survey results, over time the Tracking Project has identified more problems associated with access to extended care. In both impact analyses, there was a widespread perception that it was more difficult to obtain care beyond a certain basic level and that accessing extended care services was more difficult post-managed care implementation. These reported difficulties stemmed from factors including authorization processes and tighter controls on admission and length of stay in hospitals, residential treatment centers, and other services. In addition, the typical emphasis in managed care systems on short-term treatment was identified by many stakeholders as a major problem; some asserted that managed care systems often do not sufficiently consider or serve children needing more than brief treatment.

Over time, the Tracking Project has found some improvement in access to extended care within managed care systems. As shown on **Table 83**, the 2003 State Survey found that access to extended care services reportedly has improved in nearly two-thirds of the managed care systems, a 26% increase from 2000. Carve outs were more likely to report improved access to extended care — improved access was reported for most carve outs (71%) but fewer than half of the integrated systems (46%). In 2003, few systems of either type reported that access to extended care is worse in comparison with pre-managed care. In about a third of the systems (32% overall and nearly half of the integrated systems), managed care has had no impact on access to extended care services, either positive or negative, according to respondents.

Table 83

Impact of Managed Care Systems on Access to Extended Care Behavioral Health Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Access to extended behavioral health services is better	36%	71%	46%	62%	26%
Access to extended behavioral health services is worse	14%	5%	8%	6%	-8%
No change	50%	24%	46%	32%	-18%

Consistent with findings suggesting improved initial access, the 2003 State Survey found shorter wait lists for children's behavioral health services in more than half of the carve outs (57%) and about a third of the systems with integrated designs (38%) — half of the total sample of systems (**Table 84**). Only 9% of the systems across the entire sample reported longer wait lists for services, an 11% decline in reports of longer wait lists since 2000. Longer wait lists were more likely to be reported for integrated systems, 15% as compared with only 5% of the carve outs.

Table 84

Impact of Managed Care Systems on Waiting Lists for Children's Behavioral Health Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Waiting lists are shorter	48%	57%	38%	50%	2%
Waiting lists are longer	20%	5%	16%	9%	-11%
No change	32%	38%	46%	41%	9%

Access to Inpatient Services

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

The 2000 and 2003 State Survey explored this area, which was not examined in the previous all-state surveys. The surveys found that initial access to inpatient care is not considered to be more difficult in most cases as a result of managed care systems; only 11% of the systems reported this to be the case in 2003, and, in fact, nearly two-thirds of the systems in 2003 characterized initial access to inpatient treatment as easier than in the pre-managed care environment (**Table 85**). Much more significant, however, is the observation that inpatient lengths of stay are shorter — reported for most of the carve outs (71%) and nearly all of the integrated systems (93%) in 2003. No system reported longer lengths of hospital stays in 2003.

Table 85

Impact of Managed Care Systems on Access to Behavioral Health Inpatient Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Initial access is easier	Not asked	67%	57%	63%	NA
Initial access is more difficult	20%	10%	14%	11%	-9%
Average lengths of stay are shorter	63%	71%	93%	80%	17%
Average lengths of stay are longer	Not asked	0%	0%	0%	NA
No change	Not asked	10%	0%	6%	NA

NA=Not Applicable

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

The 2000 and 2003 State Surveys were used to explore these areas more fully and to obtain a better sense of the extent to which these problems are occurring. Most notable on **Table 86** is that most of the problems associated with changes in access and length of stay in inpatient care are more pronounced in systems with integrated designs than in carve outs. For example, premature discharge before stabilization, children discharged without needed services, and placement in community programs without the clinical capacity to serve them all reportedly occur more frequently in integrated systems. Only the use of residential treatment as a substitute for inpatient services was reported to a greater extent among carve outs — this practice reportedly occurs in 35% of the carve outs and 27% of the integrated systems.

Table 86

Problems Associated with Changes in Access to Behavioral Health Inpatient Services

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Premature discharge before stabilization from inpatient settings	29%	12%	27%	19%	-10%
Children discharged without needed services	33%	18%	27%	22%	-11%
Placement in community-based services lacking appropriate clinical capacity to serve them	29%	24%	40%	31%	2%
Increased use of residential treatment services as a substitute for inpatient	29%	35%	27%	31%	2%
Inappropriate use of child welfare emergency shelters	21%	6%	7%	6%	-15%
Inappropriate use of juvenile justice facilities	21%	12%	13%	13%	-9%
Discharge without a safe placement for children in child welfare	8%	0%	7%	3%	-5%
No negative effects have occurred	Not Asked	18%	13%	16%	NA
N/A (Access is not more difficult and lengths of stay are not shorter)	Not Asked	24%	20%	22%	NA
Other, Specify	Not Asked	35%	13%	25%	NA

NA=Not Applicable

Declines in a number of these negative effects were found from 2000 to 2003. In particular, problems such as children discharged without needed services, inappropriate use of child welfare emergency shelters and juvenile justice facilities, and premature discharge from inpatient settings without stabilization were reported by 9 to 21% fewer managed care systems in 2003 than in 2000. Still, serious negative effects resulting from the shorter inpatient length of stay reportedly are experienced by most systems; only 16% reported no negative effects from reduced access to and/or length of stay in inpatient settings.

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

The 2000 and 2003 State Surveys were used as a vehicle to explore the extent to which alternatives to hospitalization are being developed. Again, carve outs are more likely to do so, 81% as compared with 62% of the integrated systems in 2003 (**Table 87**). However, both carve outs and integrated systems indicated efforts to develop alternatives to hospitalization — nearly three-quarters (73%) overall have done so, an 11% increase from 2000. A concern is that 27% of the systems overall reportedly are not developing alternatives to hospitalization, this despite the finding that reduced length of stay in inpatient settings, and the associated problems, are widespread.

Table 87

Percent of Managed Care Systems Leading to the Development of Treatment Alternatives to Inpatient Hospitalization

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Treatment alternatives to hospitalization have been developed	62%	81%	62%	73%	11%
Treatment alternatives to hospitalization have not been developed	38%	19%	38%	27%	-11%

In states where alternatives are being developed, respondents specified a wide range of alternatives to hospitalizations, including:

- Crisis respite services
- Walk-in urgent care centers
- Mobile crisis teams
- Emergency psychiatric visits
- Home-based services
- Wraparound process for stabilization and support
- Intensive outpatient services
- Therapeutic foster care
- Crisis stabilization units
- Partial hospitalization/day treatment
- Short-term, sub-acute residential services
- Intensive care management
- Non-hospital detoxification
- Mentoring

X. Service Coordination

The results of the impact analyses were mixed with regard to the impact of managed care systems on the coordination of services to children and adolescents with behavioral health problems and their families. In both analyses, stakeholders in about half of the states felt that managed care had improved service coordination, while stakeholders in the other half believed that managed care impeded coordination of services. In the 1999 Impact Analysis, design of the managed care system appeared to be related to the effects on service coordination, with reports of improved coordination in all but one carve out, but in none of the systems with an integrated design.

Items were added to the 2000 and 2003 surveys to clarify and track the impact of managed care on service coordination between physical and behavioral health services, coordination between mental health and substance abuse services, and interagency coordination among child-serving systems. An additional item was added to the 2003 State Survey regarding the impact of managed care on coordination between mental health and child welfare systems.

Coordination of Physical Health and Behavioral Health Services

The impact analyses yielded numerous reports of inadequate identification and referral by primary care practitioners of children and adolescents with behavioral health problems, regardless of system design. In addition, respondents cited examples of poor communication between physical health and behavioral health providers and poor coordination of physical health and behavioral health treatment, noting that these problems pre-existed managed care reforms. Despite the expectation that managed care systems with integrated designs would result in improved coordination between primary care and behavioral health care, the impact analyses revealed little improvement in this area.

In an effort to track changes in physical health/behavioral health coordination, the 2000 and 2003 surveys investigated the effects of managed care on coordination between physical health and behavioral health services. As **Table 88** indicates, improved physical health/behavioral health coordination was reported for 67% of the systems in 2003, reflecting a small increase (7%) from the 2000 survey findings. In 30% of the systems, managed care reportedly has had no effect on service coordination.

Table 88

Impact of Managed Care Systems on Coordination Between Physical Health and Behavioral Health Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Coordination between physical health and behavioral health services has improved	60%	64%	71%	67%	7%
Coordination between physical health and behavioral heath services is worse	7%	5%	0%	3%	-4%
No effect	33%	31%	29%	30%	-3%

Previous Tracking Project findings suggested little difference in improved coordination between physical and behavioral health services based on the design of the managed care system, with fairly equal rates of improved coordination reported for carve outs and integrated systems. These results suggested that improved coordination is a result of specific efforts to address this issue, rather than a function of the design of the managed care system. In 2003, both carve outs and integrated systems showed improvement over 2000 in coordination between physical and behavioral health services, with 64% and 71% respectively reporting improvement in such coordination in comparison with pre-managed care. This reflects significant improvement in coordination between physical and behavioral health, up from 57% in 2000 to 71% in 2003, although there remains little difference between carve outs and integrated systems in the extent of improvement between physical and behavioral health care services.

Coordination of Mental Health and Substance Abuse Services

Stakeholders in the impact analyses reported that the coordination of mental health and substance abuse services was a problem that pre-existed managed care and was largely unaffected by the introduction of managed care. Parents and other stakeholders provided examples of how the lack of coordination was a particular obstacle to effectively serving youth who are dually diagnosed with mental health and substance abuse disorders.

As shown on **Table 89**, reports of improved coordination between mental health and substance abuse services as compared with pre-managed care increased from 52% of systems in the 2000 to 63% in the 2003. Improved coordination is more evident in carve outs (73%) than in integrated systems (46%), despite the fact that integrated systems are more likely to include substance abuse services than are carve outs. In 2003, no system reported that coordination between mental health and substance abuse services was worse as compared with pre-managed care; about one-third (37%) of the systems reported that managed care has had no effect on the coordination between mental health and substance abuse services.

Table 89

Impact of Managed Care Systems on Coordination Between Mental Health and Substance Abuse Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Coordination between mental health and substance abuse services has improved	52%	73%	46%	63%	11%
Coordination between mental health and substance abuse services is worse	3%	0%	0%	0%	-3%
No effect	45%	27%	54%	37%	-8%

Coordination Between Mental Health and Child Welfare Systems

Children and families served by the child welfare system often need extensive and intensive behavioral health services. The tightened timeframes for permanency decision making in the Adoption and Safe Families Act of 1997 make it even more important to ensure timely access to appropriate behavioral health services for these children and families. For these reasons, the Tracking Project includes a specific focus on children and families served by the child welfare system.

The 2003 State Survey added an item to specifically examine the impact of behavioral health managed care on coordination between mental health and child welfare systems. As **Table 90** indicates, improved coordination between mental health and child welfare compared with pre-managed care was reported for 61% of the systems. In 39% of the systems, the implementation of managed care has had no effect on mental health-child welfare coordination. Consistent with the other 2003 State Survey findings regarding service coordination, carve outs report a much higher level of improved coordination between child welfare and mental health (73% reported improved coordination) than do integrated systems (43%).

Table 90

Impact of Managed Care Systems on Coordination Between Mental Health and Child Welfare Systems in Comparison with Pre-Managed Care

	2003		
	Carve Out	Integrated	Total
Coordination between mental health and child welfare has improved	73%	43%	61%
Coordination between mental health and child welfare is worse	0%	0%	0%
No effect	27%	57%	39%

Interagency Coordination Among Child-Serving Systems

The impact analyses found that, in most states, problems resulting from the implementation of managed care have forced agencies to increase cross-system collaboration at both the state and local levels. **Table 91** shows a consistent finding for both the 2000 and 2003 State Surveys — in about two-thirds of the systems (65% in 2000 and 68% in 2003), managed care reportedly has resulted in improved interagency coordination among child-serving systems; managed care has had no effect on collaboration in about one-third of the systems. Improvement in interagency coordination across child-serving systems consistently has been found at a much higher rate in carve outs (81% reported improvement in 2003) than in integrated designs (46% reported improvement).

Table 91

Impact of Managed Care Systems on Interagency Coordination Among Child-serving Systems in Comparison with Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Interagency coordination has improved	65%	81%	46%	68%	4%
Interagency coordination is worse	6%	5%	0%	3%	-3%
No effect	29%	14%	54%	29%	0%

XI. Early Identification and Intervention

Early findings of the Tracking Project indicated that nearly all states included the Early Periodic Screening Diagnostic and Treatment Program (EPSDT) in their managed care systems. However, stakeholders in the impact analyses indicated that problems persisted with the early identification process. For example, primary care practitioners reportedly resisted conducting EPSDT screens because of a lack of appropriate reimbursement levels and/or a lack of referral mechanisms for behavioral health services. Beginning with the 2000 State Survey, the Tracking Project investigated the EPSDT screening process more specifically to assess whether EPSDT screens are conducted and whether the EPSDT screens have a behavioral health component. The 2003 State Survey added items to determine whether managed care systems have strategies to encourage primary care practitioners to conduct EPSDT screens, the percent of systems that are responsible for screening children entering the child welfare system, and the extent of behavioral health screening of children in the child welfare system.

As shown on **Table 92**, 2003 results indicate that the majority of managed care systems (76%) reportedly conduct EPSDT screens within managed care systems. This finding represents a 32% increase from the number of systems that reported including EPSDT screens in 2000, with both carve outs and integrated systems showing increases. However, integrated systems reportedly are more likely than carve outs to include EPSDT. All of the integrated systems in 2003 indicated that EPSDT screens are included within the managed care system, in comparison with 59% of the carve outs. The difference between carve outs and integrated systems may be explained by the fact that EPSDT screens typically are conducted by physical health care practitioners, and thus may be more likely to be reported by integrated systems.

Table 92

Percent of Managed Care Systems Conducting EPSDT Screens Within the Managed Care System

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
EPSDT screens are conducted within the managed care system	44%	59%	100%	76%	32%
EPSDT screens are not conducted within the managed care system	56%	41%	0%	24%	-32%

Of paramount importance for behavioral health care is the extent to which EPSDT screens include a mechanism for early detection of behavioral health problems. Both impact analyses suggested that contractual language often does not specify that a behavioral health assessment be conducted within EPSDT screens. However, for the 29 managed care systems in the 2003 State Survey, that include EPSDT screens, nearly all (90%) reportedly do have a behavioral health component (**Table 93**).

Table 93

Percent of Managed Care Systems Conducting EPSDT Screens Have Behavioral Health Component

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
EPSDT screens have behavioral health component	80%	86%	93%	90%	10%
EPSDT screens do not have behavioral health component	20%	14%	7%	10%	-10%

Although it is encouraging to find that most EPSDT screens include a behavioral health component, stakeholders interviewed for the impact analyses noted that the major focus of the screening process typically is on physical health issues, and that the behavioral health focus often is minimal.

The 2003 State Survey incorporated an additional item to investigate whether managed care systems include fiscal incentives or other strategies to encourage primary care practitioners to conduct EPSDT screens and, as needed, to make referrals for behavioral health services. As indicated on **Table 94**, slightly more than half of the systems (58%) reportedly include incentives or strategies to encourage primary care practitioners to conduct EPSDT screens and to make appropriate referrals for behavioral health services. Incentives are present at about the same rate for integrated systems (62%) and carve outs (55%).

Table 94

Percent of Managed Care Systems with Incentives or Strategies to Encourage Primary Care Practitioners to Conduct EPSDT Screens and Make Appropriate Referrals for Behavioral Health Services

	2003		
	Carve Out	Integrated	Total
Systems have incentives for strategies to encourage EPSDT screens and behavioral health referrals	55%	62%	58%
Systems do not have incentives or strategies to encourage EPSDT screens and behavioral health referrals	45%	38%	42%

The 2003 survey explored the types of incentives or strategies that are used by managed care systems to encourage primary care practitioners to conduct EPSDT screens and make appropriate behavioral health service referrals. As shown on **Table 95**, the strategy reported most frequently by managed care systems is monitoring for compliance (59% of systems), followed by training and providing information to primary care practitioners on referral options for behavioral health care (50% of systems).

Table 95
Types of Incentives or Strategies Used

	2003		
	Carve Out	Integrated	Total
Performance incentives	8%	30%	18%
Training	75%	20%	50%
Monitoring for compliance	75%	40%	59%
Monitoring behavioral health referrals	33%	0%	18%
Development and inclusion of a behavioral health component for EPSDT screens	42%	30%	36%
Enhanced rates for conducting screens	0%	50%	23%
Providing information to primary care practitioners on referral options for behavioral health care	75%	20%	50%
Contract requirement	0%	20%	9%
Other	25%	20%	23%

Another area explored in the 2003 State Survey is the proportion of managed care systems that are responsible for behavioral health screening of children entering state custody through the child welfare system. Slightly less than half (43%) of the systems reportedly are responsible for screening children entering state custody to identify mental health problems and treatment needs. Thirty-nine percent of the systems are not responsible for this screening; the remaining systems (18%) do not include children in state child welfare custody as a covered population (**Table 96**).

Table 96

Percent of Managed Care Systems Responsible for Screening Children in the Child Welfare System who Enter State Custody to Identify Mental Health Problems and Treatment Needs

	2003		
	Carve Out	Integrated	Total
Systems are responsible for behavioral health screening of children in child welfare entering state custody	45%	38%	43%
Systems are not responsible for behavioral health screening of children in child welfare entering state custody	50%	25%	39%
NA — Children in child welfare state custody are not covered	5%	37%	18%

In those managed care systems responsible for behavioral health screening for children entering child welfare custody, most children reportedly are screened in 77% of the systems.

XII. Cultural Competence

From its inception, the Tracking Project has investigated whether managed care systems incorporated specific system of care values and principles in their RFPs, contracts, and other key system documents. Impact analysis findings suggested that, despite the incorporation of cultural competence requirements in many systems, managed care implementation has had little, if any, effect on the overall level of cultural competence.

Cultural Competence Strategies

The 2000 and 2003 State Surveys included items to investigate cultural competence in greater depth. A range of strategies that potentially could be used to address and enhance cultural competence were presented to respondents so that they could indicate the specific strategies incorporated into their managed care systems.

Of all the strategies to enhance cultural competence, the provision of translation and interpreter services was identified as the most widely utilized strategy (86%) in managed care systems in 2003 (**Table 97**). According to respondents, the next most frequently used strategies are requirements in RFPs and contracts related to cultural competence, and outreach to culturally diverse populations (61% of the systems reportedly use each). Requirements in RFPs and contracts tend to be used more frequently in carve outs (76%) than in integrated systems (40%), while outreach to culturally diverse populations tends to be used more frequently in integrated systems (67% as compared with 57% of the carve outs).

The strategies of including culturally diverse providers in provider networks (58% of systems), specific planning for culturally diverse populations (56%), and training of MCOs and providers on cultural competence (47%) are found at much higher rates in carve outs than in integrated systems. Of note is the reported increase in specific planning for culturally diverse populations, which was reported in more than half (56%) of the systems in 2003, as compared with only a third of the systems in 2000 (a 23% increase). In both 2000 and 2003, about one-third of the managed care systems reportedly include the strategies of incorporating specialized services needed by culturally diverse populations and tracking utilization and/or outcomes by culturally diverse groups.

Specific Planning and Data Analysis for Culturally Diverse Populations

In both impact analyses, stakeholders in most states reported that managed care planning typically did not include a specific focus on culturally diverse groups or specific analyses of the needs of culturally diverse children and families. The impact analyses also suggested that few managed care systems were tracking service utilization and/or child outcomes by culturally diverse populations.

Table 97

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Specific planning for culturally diverse populations	33%	62%	47%	56%	23%
Requirements in RFPs and contracts related to cultural competence	85%	76%	40%	61%	-24%
Training of MCOs and/or providers on cultural competence	42%	71%	13%	47%	5%
Outreach to culturally diverse populations	58%	57%	67%	61%	3%
Inclusion of specialized services needed by culturally diverse populations	36%	43%	20%	33%	-3%
Inclusion of culturally diverse providers in provider networks	64%	67%	47%	58%	-6%
Translation/Interpreter services	82%	90%	80%	86%	4%
Tracking utilization and/or outcomes by culturally diverse groups	36%	43%	13%	31%	-5%
None	0%	5%	13%	8%	8%
Other	6%	5%	13%	8%	2%

As indicated on **Table 97**, slightly more than half (56%) of the managed care systems (62% of carve outs and 47% of the integrated systems) reportedly conduct specific planning for culturally diverse populations. The increase in planning for culturally diverse groups is encouraging as it represents a 23% increase from 2000 findings. However, as noted, both the 2000 and 2003 surveys found that only about one-third of the systems track service utilization and/or outcomes by culturally diverse groups.

Requirements for Cultural Competence

The impact analyses indicated that most states included requirements related to cultural competence in the managed care RFPs and contracts, and the 2000 State Survey results supported this finding, with 85% of managed care systems reporting the inclusion of cultural competence requirements in key system documents. Findings from the 2003 State Survey, however, show a 24% decrease in the percent of systems (61%) that include cultural competence requirements in managed care RFPs and contracts (**Table 97**). A much higher rate of inclusion of such requirements is reported by the carve outs (76%) than by the integrated systems (40%).

Comparing the requirements related to cultural competence under managed care with pre-managed care, more than three-quarters of the systems (78%) reported having stronger cultural competence requirements than previously, a 14% increase from 2000 (**Table 98**). Stronger cultural competence requirements were reported more frequently in carve outs (86%) than in systems with an integrated design (65%). No system reported weaker cultural competence requirements than before managed care; in 22% of the systems, managed care has had no effect on cultural competence requirements.

Table 98

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Cultural competence requirements are stronger in the managed care system	64%	86%	65%	78%	14%
Cultural competence requirements are weaker in the managed care system	3%	0%	0%	0%	-3%
No change	33%	14%	35%	22%	-11%

Inclusion of Culturally Diverse Providers

Findings from the impact analyses were contradictory regarding the inclusion of culturally diverse providers in managed care systems. Stakeholders in nearly half of the states in the 1997 sample felt that managed care had impeded the inclusion of culturally diverse providers, while in the 1999 sample, most stakeholders did not feel that managed care was an obstacle to the inclusion of culturally diverse providers.

To further explore this area, the state surveys have tracked the extent to which managed care systems have had a specific focus on including culturally diverse providers in their provider networks. The results indicate a steady reduction over time in the percent of managed care systems with specific strategies for including culturally diverse providers and practitioners in provider networks. Specific provisions or efforts for including culturally diverse providers were reported in 80% of managed care systems in 1997/98, 64% of the systems in 2000, and 58% of the systems in 2003 (see **Table 97**).

XIII. Family Involvement

Previous Tracking Project findings were mixed with respect to the impact of managed care on family involvement at both the system level in planning and management activities and at the service delivery level in the planning of services for their own children. For example, both impact analyses found that, even in states with requirements for the involvement of families in planning and delivering services to their own children, implementation was variable. The 2000 and 2003 State Surveys added items to further investigate family involvement at both the system and service delivery levels.

Family Involvement Strategies

A range of strategies that potentially could be used to enhance family involvement within managed care systems at both the system and service delivery levels were presented to respondents, as shown on **Table 99.**

Table 99

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Requirements in RFPs and contracts for family involvement at the system level	55%	67%	6%	41%	-14%
Requirements in RFPs, contracts, and service delivery protocols for family involvement in planning and delivering services for their own children	52%	86%	13%	54%	2%
Focus in service delivery on families in addition to the identified child	64%	76%	50%	65%	1%
Coverage for and provision of family supports	58%	67%	25%	49%	-9%
Use of family advocates	48%	71%	6%	43%	-5%
Hiring family and/or youth in paid staff roles	27%	62%	6%	38%	11%
None	6%	0%	44%	19%	13%
Other	24%	14%	0%	8%	-16%

Consistent with 2000 results, the most frequently reported strategy, noted for nearly two-thirds of the systems in 2003 (65%), was the inclusion of a focus in service delivery on families, in addition to the child identified as in need of treatment. The second most frequently used strategy (reported in 54% of the systems) involves requirements in managed care system documents for family involvement in the planning and delivery of services for their own children. About half of the systems (49%) reportedly include coverage for and provision of family supports. Strategies used less frequently include the use of family advocates (43% of systems), requirements in RFPs and contracts for family involvement at the system level (41%), and hiring family and/or youth in paid staff roles (38%).

Marked differences between carve outs and integrated systems were found with respect to all the family involvement strategies. Between 62% and 86% of the carve outs reportedly include the various family involvement strategies, compared with only 6% of the integrated systems for three of the strategies to a high of 50% for only one strategy (focus on families in service delivery). Most noteworthy is that in 44% of the integrated systems, none of the family involvement strategies reportedly is used.

Requirements for Family Involvement

As noted above and shown on **Table 99**, more than half of the systems (54%) reportedly incorporate requirements for family involvement at the service delivery level and 41% of systems include requirements for family involvement at the system level. Similar to the 2000 findings, requirements at both levels are far more likely to be found in carve outs. Eighty-six percent of carve outs include requirements for family involvement at the service delivery level compared with 13% of the integrated systems, and 67% incorporate system-level requirements compared with only 6% of the integrated systems.

Both the 2000 and 2003 State Surveys explored whether family involvement requirements are stronger, weaker, or unchanged under managed care in comparison with pre-managed care. In 2003, slightly less than two-thirds (63%) of the systems reported that family involvement requirements are stronger under managed care, a 13% decrease from 2000 (**Table 100**). Again, a substantially higher proportion of the carve outs (86%) reportedly have stronger family involvement requirements in comparison with pre-managed care than do integrated systems (29%). No system reported in 2003 that family involvement requirements are weaker under managed care than previously; about one-third (37%) reported no change in family requirements.

Table 100

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Family involvement requirements are stronger in the managed care system	76%	86%	29%	63%	-13%
Family involvement requirements are weaker in the managed care system	6%	0%	0%	0%	-6%
No change	18%	14%	71%	37%	19%

Despite stronger family involvement requirements under managed care in most systems, stakeholders interviewed for both impact analyses identified discrepancies between managed care policy requirements for family involvement and what actually is taking place.

Family Involvement at the System Management Level

Previous Tracking Project activities indicated a trend over time toward greater family involvement at the system level. The 2000 and 2003 State Surveys specifically examined family involvement in managed care systems in various system-level activities.

As noted earlier, significant involvement by families in the planning, implementation, and monitoring of managed care was reported by 35% of the managed care systems, a 13% decrease from the 2000 State Survey (see **Table 16**). A significant level of family involvement in managed care planning, implementation, and refinement was found in half of the carve outs (a 14% decrease from 2000), but in only 8% of the systems with integrated designs. However, families reportedly have some involvement at the system level in more than half of all systems (56%), a 12% increase since 2000, indicating that system-level involvement has shifted in some cases from "significant" to "some".

Stakeholders in both impact analyses noted that funding a family organization to play various roles in the managed care system can be an effective vehicle for enhancing family involvement at the system level. As shown on **Table 101**, about half of all systems reportedly fund a family organization for various managed care roles, a finding that is consistent with previous survey results. As was true in previous survey findings, funding a family organization is much more likely in carve outs (71%) than in integrated systems (19%).

Table 101

Percent of Managed Care Systems Funding Family Organization for Managed Care System Role

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Family organization is funded to play role in managed care system	45%	47%	71%	19%	49%	4%	2%
Family organization is not funded to play role in managed care system	55%	53%	29%	81%	51%	-4%	-2%

In 2003, survey respondents were asked to describe the various roles that family organizations carry out in managed care systems. The roles specified by states for family organizations to fulfill are multi-faceted, including providing information and referral services to other families (4 states), providing family members to participate on policy and workgroups (6 states), advocating with parents for mental health services for their children (6 states), providing education for families on the managed care system, and conducting family surveys and interviews. Some specific examples include:

- In Texas, both the National Alliance for the Mentally Ill (NAMI) and the Mental Health Association (MHA) are funded to provide consumer and family education on the NorthStar managed care system and to be actively involved in policy decisions.
- In Hawaii, the statewide family organization provides a parent partner for each community mental health center. The role of the parent partners includes consultation, support, training, and advocacy for families. The organization also coordinates a statewide youth council that provides support and advocacy.

- Maryland funds the Maryland Coalition of Families for Children's Mental Health. Roles include serving on the Administrative Services Organization (ASO) Advisory Committee and on all other governing bodies and planning councils related to the managed care system.
- In New Jersey, the managed care system supports a Family Support Organization in each of ten geographic areas to provide support and advocacy for children and families needing care, as well as to participate in policy making at local and state levels.

In addition to involvement in system management, managed care systems involve families by providing education and training and helping them to navigate the grievance and appeals process when necessary. The 2003 State Survey found that 92% of the managed care systems reportedly have strategies to help families navigate the grievance and appeals process.

Family Involvement at the Service Delivery Level

Family Involvement in Service Planning

Results of both impact analyses indicated that many managed care systems included requirements for family involvement at the service delivery level, requiring at a minimum that families be involved in treatment planning for their own children. Exploration of this issue across all states, however, revealed that such requirements reportedly are found in only about half of managed care systems. Consistent with 2000 results, 54% of managed care systems in 2003 reportedly have requirements in RFPs, contracts, and service delivery protocols for family involvement in service planning for their own children (see **Table 99**). Stakeholders, including families, interviewed for the impact analyses noted that, even where such requirements exist, implementation often is mixed and varies from provider to provider.

Extent of Family Focus of Services

The 2000 and 2003 State Surveys investigated the level of family focus in service delivery by assessing whether the focus of services is on the family in addition to the identified child, whether family support services are covered and provided, and whether the system pays for services for family members if only the child is covered under the managed care system.

The perception of stakeholders in all states included in the 1999 Impact Analysis was that the focus of services in the managed care systems was limited to the child identified as in need of services, rather than on the entire family. Survey findings in 2000 and 2003 reflect a different picture. As in 2000, nearly two-thirds (65%) of the managed care systems in 2003 reportedly include a focus on families in service delivery (see **Table 99**). Family focus is found more frequently in carve outs than in integrated systems; 76% of the carve outs compared with half of the integrated systems reportedly focus on families, in addition to focusing on the identified child. In addition, about half of the managed care systems (49%) in 2003 reported that family support services are covered in the benefit package, with carve outs far more likely than systems with integrated designs to cover family support services (67% of carve outs versus 25% of integrated systems).

Recent surveys also investigated whether managed care systems pay for services to family members if only the child is covered. As shown on **Table 102**, about half of the systems in both 2000 and 2003 reportedly pay for services to family members when only the child is covered (49% in 2003). Again, carve outs are more likely to pay for services to a family member when only the child is covered — 55% of carve outs reported doing so as compared with 40% of integrated systems. The issue of coverage for family members is especially important due to the relationship between Medicaid and the State Children's Health Insurance Program (SCHIP) in many states. Findings from the 2000 State Survey indicate that over half of the SCHIP programs are based on an expansion of their states' Medicaid program, and, according to SCHIP guidelines, coverage is limited to the child only, leaving a question as to how services to family members, in support of the child's treatment, will be financed.

Table 102

Percent of Managed Care Systems that Pay for Services to Family Members if Only the Child is Covered

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Managed care system pays for services to family member	51%	55%	40%	49%	-2%
Managed care system does not pay for services to family members	49%	45%	60%	51%	2%

Practice of Relinquishing Custody to Obtain Services

The impact analyses resulted in questions with respect to the impact of managed care systems on the practice of families relinquishing custody in order to obtain needed but expensive treatment for their children. Some stakeholders reported that managed care had increased the need for families to relinquish custody; other interviewees noted that this practice was a pre-existing problem that had not been exacerbated by the introduction of managed care.

The 2000 and 2003 State Surveys were used to investigate this issue across all states, exploring whether managed care has improved, worsened, or had no effect on the pre-existing practice of families relinquishing custody in order to obtain behavioral health services. Consistent with the 2000 findings, in over 80% of managed care systems (equally for carve outs and integrated systems) the introduction of managed care reportedly has had no impact on the practice of relinquishing custody to obtain needed but expensive services (**Table 103**). In fact, where some impact was reported, there was more likely to be a positive impact on this practice. In 16% of the managed care systems, the practice reportedly has improved under managed care, while the practice has worsened under managed care in only 3% of the systems.

Table 103 Impact on Managed Care Systems on Practice of Relinquishing Custody					
	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Practice of relinquishing custody is worse under managed care	4%	0%	6%	3%	-1%
Practice of relinquishing custody has improved under managed care	13%	19%	13%	16%	3%
No effect, or NA—Families do not relinquish custody to child welfare to access behavioral health services	83%	81%	81%	81%	-2%

Program and Staff Roles for Families and Youth

Stakeholders in the impact analyses indicated that managed care had little impact on the use of family members or youth as paid staff or on the availability of family-operated programs. They indicated that both practices were rare prior to the advent of managed care, and continued to be a rarity.

The 2000 and 2003 surveys investigated the use of family advocates and other paid program and staff roles for family members, and findings are consistent for both points in time. As shown on **Table 99**, in 2003 less than half (43%) of the systems report the use of family advocates and an even smaller proportion (38%) hire family members and/or youth in paid staff roles. Both practices are far more likely to occur in carve outs (71% for family advocates, 62% for paid staff roles) than in systems with integrated designs (6% for both practices).

XIV. Providers

Since its inception, the Tracking Project has investigated and tracked a range of issues related to the impact of managed care on behavioral health providers, including both provider agencies and individual practitioners. The 2003 State Survey explored a number of provider-related issues, including how managed care has affected the inclusion of various types of providers in provider networks, the impact of new credentialing requirements on agencies and practitioners, administrative burden, reimbursement rates, and the financial viability of provider agencies. In addition, the survey assessed the extent to which front-line practitioners have the capacity to meet the goals of the managed care systems.

Provider Inclusion and Exclusion

Impact analysis results indicated that, in most states, managed care resulted in the participation of an expanded range of providers, but also made it more difficult for certain types of providers to participate. Reasons for the expanded range of providers noted by stakeholders were the inclusion of new types of practitioners and new types of provider agencies, as well as new services in the benefit plan, such as targeted case management, respite, and in-home services. At the same time, interviewees observed that smaller and nontraditional agencies were facing challenges, primarily due to a lack of infrastructure to meet the administrative and fiscal demands of managed care, particularly with respect to assuming financial risk.

The 2003 State Survey continued to investigate issues related to the inclusion or exclusion of providers from behavioral health managed care provider networks. As shown on **Table 104**, approximately two-thirds of managed care systems include school-based behavioral health providers (62%), certified addictions counselors (65%), and culturally diverse and indigenous providers (70%). About half of the managed care systems reportedly include child welfare providers, paraprofessionals, and student interns; only one-quarter (24%) include family members as providers.

Table 104

Percent of Managed Care Systems Including Various Types of Providers in Provider Networks

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Child welfare providers	53%	71%	31%	54%	1%
School-based behavioral health providers	62%	67%	56%	62%	0%
Certified addictions counselors	68%	76%	50%	65%	-3%
Culturally diverse and indigenous providers	82%	81%	56%	70%	-12%
Family members as providers	32%	33%	13%	24%	-8%
Paraprofessionals and student interns	50%	62%	25%	46%	-4%

Except for school-based behavioral health providers, inclusion of the various types of providers occurs far more frequently in carve outs than in integrated systems. For example, child welfare providers are reportedly included in provider networks by 71% of the carve outs as compared with only 31% of the integrated systems, and culturally diverse and indigenous providers are included by 81% of the carve outs as compared with 50% of the integrated systems.

It is interesting and encouraging to note that in both 2000 and 2003, about two-thirds of the managed care systems reported the inclusion of certified addictions counselors in managed care provider networks, an area that had been raised in the impact analyses as potentially problematic. Of concern, however, are the decreases from 2000 in the reported inclusion of culturally diverse providers (12% decrease) and of family members as providers (an 8% decrease).

Certification and Credentialing Requirements

The 1997/98 State Survey found that approximately one-third of managed care systems had new or revised standards or licensing requirements for individual practitioners or provider agencies. Stakeholders in both impact analyses observed that, in some states, the new requirements were more restrictive than previous requirements and, therefore, limited the types of professionals that could be included in provider networks. The 2000 and 2003 State Surveys investigated whether new certification or credentialing requirements limit the inclusion of particular types of providers. In addition, the surveys collected descriptive information on how new credentialing requirements affect provider inclusion in managed care systems.

Consistent with 2000 findings, respondents for two-thirds of the managed care systems (66%) in 2003 indicated that new credentialing and certification requirements were not impeding the inclusion of particular types of providers in provider networks; requirements posing impediments to provider participation were reported in only a third (34%) of the managed care systems (**Table 105**). Credentialing requirements are more frequently impediments to provider participation in integrated systems, with more than half (57%) reporting this as compared with only 19% of carve outs.

Table 105

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
New credentialing requirements are impeding the inclusion of particular types of providers	32%	19%	57%	34%	2%
New credentialing requirements are not impeding the inclusion of particular types of providers	68%	81%	43%	66%	-2%

Some states where credentialing and certification requirements are impediments provided more detailed information about how the requirements limit provider inclusion:

- Credentialing requirements in managed care organizations are more restrictive than state licensure requirements in some categories, thus excluding some qualified, licensed mental health professionals that are approved under Medicaid.
- Requirements eliminate Master's level clinicians other than social workers or marriage and family therapists, excluding other types of clinicians.
- Requirements specify that managed care entities contract with licensed community mental health agencies, thus eliminating other types of provider agencies.
- Cumbersome credentialing procedures that discourage the participation of providers.

Administrative Burden of Providers

Stakeholders in both impact analyses reported that managed care had resulted in substantial increases in administrative and paperwork requirements for providers. In addition to the new credentialing and licensing requirements described above, interviewees described new document requirements for service authorization, frequent utilization and concurrent reviews, and increased requirements to collect and report both encounter and outcome data.

The 2000 and 2003 State Surveys explored this issue further, by assessing whether administrative burden for providers under managed care is considered to be higher, lower, or unchanged from the previous system. In 2000, 61% of managed care systems reported that administrative burden was higher with managed care, supporting the observations noted in the impact analyses. Representing a dramatic change, however, in 2003 only 23% of the managed care systems reported that administrative burden is higher than pre-managed care (**Table 106**). About the same proportion of managed care systems (12% in 2000, and 15% in 2003) noted that administrative burden was lower under managed care; in 2003, 62% of managed care systems indicated that there has been no change in administrative burden as compared with pre-managed care.

Table 106
Impact of Managed Care Reforms on Administrative Burden for Providers

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Administrative burden is higher in the managed care system	61%	25%	20%	23%	-38%
Administrative burden is lower in the managed care system	12%	10%	20%	15%	3%
No change	27%	65%	60%	62%	35%

There are several potential explanations for the reduction in reports of higher provider administrative burden. This may be explained by the relative maturity of managed care systems; 90% are in late stages of implementation in 2003. Perceptions of increased administrative burden on providers may decrease as agencies and individual practitioners become accustomed to the new administrative and reporting requirements and as they increasingly have the infrastructure and systems in place to comply with managed care administrative, fiscal, and reporting requirements. In addition, managed care entities may have refined,

streamlined, and simplified administrative processes, resulting in reductions in administrative and paperwork requirements for providers. For example, there has been a steady increase in the proportion of managed care systems that allow provision of certain services up to a specified amount without prior authorization. Further, some states and MCOs offer consultation and ongoing training to providers to assist them in such tasks as completing reports and submitting claims. Finally, in a number of states, fewer MCOs currently are involved, as MCOs have pulled out of Medicaid markets and have consolidated. Fewer MCOs in a state typically translates into less administrative burden on providers.

Financial Viability of Providers

Provider Reimbursement Rates

Providers who were interviewed for the impact analyses reported that, in some managed care systems, provider payment rates were too low to support effective treatment and best practices. The 2000 and 2003 State Surveys investigated whether provider reimbursement rates in managed care systems are higher, lower, or unchanged than in the previous systems. In 2000, lower provider reimbursement rates were reported for nearly a third (32%) of the managed care systems. Representing a departure from previous findings, in 2003, only 13% of managed care systems reported lower provider reimbursement rates in comparison with pre-managed care. As shown on **Table 107**, about two-thirds (66%) of systems report that provider reimbursement rates are, in 2003, higher under managed care than previously (compared with higher rates reported for only 23% of the systems in 2000). Of note is that higher provider reimbursement rates under managed care than in the previous system are reported more often by systems with integrated designs (75%) than by carve outs (60%).

Table 107
Impact of Managed Care Systems on Provider Reimbursement Rates

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Provider reimbursement rates are higher in managed care systems	23%	60%	75%	66%	43%
Provider reimbursement rates are lower in managed care systems	32%	15%	8%	13%	-20%
No change	45%	25%	17%	21%	-23%

Again, a potential explanation is the maturity of the managed care systems and the changes that have occurred as managed care systems have evolved. As noted previously, changes in rates paid to MCOs since 2000 have occurred in most managed care systems (82%), and over half (57%) of these rate changes have been increases (see **Tables 60** and **61**). Thus, it appears that in addition to increased capitation and case rates for MCOs, provider reimbursement rates have been adjusted upwards.

Closures or Severe Financial Hardship

Reports of provider closures and financial hardship surfaced through the impact analyses, but few data were available to accurately judge the extent to which managed care resulted in providers experiencing severe financial hardship and/or having to cease operations. The 2000 and 2003 State Surveys investigated the impact of managed care on providers' financial viability.

According to survey respondents at both points in time, managed care has not led to closure or severe financial hardship for provider agencies in most systems. In 2003, 86% of the managed care systems reported no severe financial hardship, an even greater proportion of systems than in 2000 when 71% reported this (**Table 108**). Reports of provider financial hardship or closure have decreased from 27% in 2000 to 14% in 2003. This finding is not surprising, given the higher provider reimbursement rates, reported decrease in administrative burden, and few changes in licensing and credentialing requirements found in 2003. In addition, the closures of some types of programs or agencies may have occurred during the earlier stages of implementation. The reduction in provider closures or severe financial hardship for providers is another indicator of the "settling" in the public sector managed care landscape.

Table 108

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Systems are resulting in closure or severe financial hardship for some agencies	27%	19%	7%	14%	-13%
Systems are not resulting in closure or severe financial hardship for some agencies	73%	81%	93%	86%	13%

Capacity of Front-line Practitioners

In both impact analyses, respondents in most states indicated that managed care necessitated training for providers in new skills and approaches, including short-term outpatient treatment modalities, home and school-based services, and wraparound and intensive in-home services among others.

Given the documented need to provide training and technical assistance for providers and practitioners, the 2000 and 2003 State Surveys investigated whether front-line practitioners were considered to have the skills, knowledge, and attitudes to meet the goals of the managed care system. As indicated on **Table 109**, about three-quarters of managed care systems in both 2000 and 2003 reported that front-line practitioners have the capacity to function effectively in managed care systems, with carve outs somewhat more likely to report adequate capacity for front-line providers than integrated systems (80% versus 71%). In addition to training that has been provided to upgrade the capacity of front-line providers, respondents noted that more rigorous licensing criteria and accreditation standards have contributed to the improvement in practitioner skills and knowledge.

Table 109

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Front-line practitioners have skills, knowledge, & attitudes to function effectively	71%	80%	71%	76%	5%
Front-line practitioners do not have skills, knowledge, & attitudes to function effectively	29%	20%	29%	24%	-5%

XV. Accountability

Availability of Data for Managed Care Decision Making

In both impact analyses, stakeholders in most states reported that inadequate management information systems (MIS) were viewed as a major impediment to building effective and useful accountability systems into managed care. Even where MIS systems were judged to be adequate, a number of problems were identified with respect to obtaining and using data, such as difficulty in obtaining encounter data from MCOs and the lack of human resources to analyze data in a timely manner for use in system monitoring and refinements.

The 2000 and 2003 State Surveys assessed the extent to which adequate data are available to guide decision making regarding behavioral health services in managed care systems. The availability of data for behavioral health-related decision making in managed care has increased from 59% of the systems reporting adequate data in 2000 to 70% in 2003 (**Table 110**). However, in 2003 about one-third of managed care systems (30%) still do not have adequate data to guide decision making. Given the late stage of managed care implementation in almost all states, it is troubling that so many systems reportedly do not have data available for system monitoring and improvement.

Table 110

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

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Adequate data to guide decision making are available	59%	86%	47%	70%	11%
Adequate data to guide decision making are not available	41%	14%	53%	30%	-11%

Respondents specified the reasons for the lack of adequate data to guide decision making in those systems reporting inadequate data (**Table 111**). The most frequent reasons for lack of data availability are lack of encounter data and inadequate management information systems (each reported by 45% of systems with inadequate data), followed closely by lack of staff capacity to analyze data in a timely manner (36% of systems with inadequate data). It is possible that the severe budget cuts faced by many states have resulted in an inability to enhance the MIS infrastructure and capacity of state mental health and Medicaid agencies.

Table 111 Reasons for Lack of Adequate Data in Systems with Inadequate Data					
	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Lack of encounter data	50%	0%	63%	45%	-5%
Lack of staff capacity to analyze	36%	67%	25%	36%	0%
Inadequate MIS System	57%	67%	38%	45%	-12%
Not tracking children's behavioral health services	21%	0%	0%	0%	-21%
Other	21%	67%	13%	27%	6%

Types of Performance Information Tracked

The previous state surveys found that the system performance information most likely to be tracked by managed care systems focused on access, service utilization, and cost. These findings were upheld in the 2003 State Survey. As shown on **Table 112**, the three types of performance measures tracked most frequently are:

- Child behavioral health service utilization (measured by 92% of systems)
- Access as gauged by child behavioral health penetration rates (71% of systems)
- Total cost of child behavioral health services (66% of systems)

Table 112 Percent of Managed Care Systems Tracking and Using Various Types of System Performance Information						
	2000 Total	2003			Percent of Change 2000–2003	2003 Information is Used for System Planning
		Carve Out	Integrated	Total		
Child behavioral health penetration rates	85%	95%	38%	71%	-14%	26%
Child behavioral health service utilization	100%	100%	81%	92%	-8%	66%
Child behavioral health services utilization by culturally diverse groups	75%	73%	19%	50%	-25%	26%
Behavioral health service utilization by children in child welfare	74%	86%	31%	63%	-11%	42%
Behavioral health service utilization by children in juvenile justice	46%	55%	6%	34%	-12%	21%
Total aggregate cost of child behavioral health services	93%	73%	56%	66%	-27%	42%
Cost per child served with behavioral health services	79%	73%	38%	58%	-21%	34%
Cost shifting among child-serving systems	16%	14%	6%	11%	-5%	8%

Service utilization rates for children's behavioral health are measured by all carve outs (100%) and most integrated systems (81%). For penetration rates and total cost of child behavioral health services, however, the differences between carve outs and integrated systems are more dramatic. Nearly all carve outs (95%), but few integrated systems (38%) track access as measured by child behavioral health penetration rates. Total aggregate cost of child behavioral health services is measured by 73% of carve outs as compared with 56% of integrated systems. Carve outs also are far more likely to track children's behavioral health service utilization by culturally diverse groups, by children in the child welfare system, and by children in the juvenile justice system.

Consistent with the 2000 findings, the two types of performance information least likely to be tracked by managed care systems are service utilization by children in juvenile justice, measured by 34% of the systems, and cost shifting among child-serving systems, tracked by only 11% of the systems. As noted earlier, reports of cost shifting have decreased from two-thirds of the managed care systems in 2000, to half of managed care systems in 2003 (see **Table 55**), although this phenomenon rarely is systematically tracked.

Although managed care systems are tracking some system performance information relative to children's behavioral health, findings indicate that this information is not always actually used for system planning purposes. The type of system information used most frequently by managed care systems is service utilization, reportedly used by two-thirds of the systems (66%), followed by service utilization by children in child welfare and total cost of child behavioral health services (both types of information reportedly used by 42% of the systems). For the other types of performance information, even if it is collected, respondents generally reported that the data are used for system planning in only a third or less of the systems. These findings are consistent with reports from the impact analyses that few data were available for system planning purposes. Stakeholders indicated that data were not in usable form or had not been released, and that little progress had been made in producing data to inform system planning, monitoring, and refinements. The gap between data that are collected and data that are available for decision-making in managed care systems reported in the 2003 State Survey indicates that generating data that are relevant and timely continues to be a problem for managed care systems.

Matrix 5 displays the types of performance information measured by managed care systems by state.

Matrix 5: Types of Performance Information Measured by Managed Care Systems Related to Child and Adolescent Behavioral Health Services by State

States Alpha List		Child Behavioral Health Penetration Rates	Child Behavioral Health Service Utilization	Child Behavioral Health Service Utilization by Culturally Diverse Groups	Child Behavioral Health Service Utilization by Children in Child Welfare System	Behavioral Health Service Utilization by Children in Juvenile Justice System	Total Cost of Child Behavioral Health Services	Cost per Child Served with Behavioral Health Services	Cost Shifting among child-serving systems
Carve Out Design									
Arizona	AZ	●	●	●	●	●	●	●	
California	CA	●	●	●	●			●	
Colorado	CO	●	●	●			●	●	
Delaware	DE	●	●	●	●	●	●	●	●
Florida	FL	●	●		●	●			●
Georgia	GA	●	●	●	●		●	●	●
Hawaii	HI	●	●	●	●	●	●	●	
Indiana	IN	●	●	●	●	●		●	
Iowa	IA	●	●		●		●	●	
Maryland	MD	●	●				●	●	
Massachusetts	MA	●	●		●	●	●	●	
Michigan	MI	●	●	●	●	●	●	●	
Nebraska	NE		●		●				
New Jersey	NJ	●	●	●	●	●	●	●	
Oregon	OR	●	●	●	●	●	●		
Pennsylvania	PA	●	●	●	●	●	●	●	
Tennessee	TN	●	●	●	●		●		
Texas	TX	●	●	●		●	●	●	
Utah	UT	●	●						
Washington	WA	●	●	●	●	●			
West Virginia	WV	●	●		●		●	●	
Wisconsin 2	WI	●	●	●	●	●	●	●	
Integrated Design									
District of Columbia	DC						●		
Illionois	IL		●						
Minnesota	MN	●	●	●			●	●	●
Missouri	MO	●	●		●				
Nevada	NV	●	●	●	●		●	●	
New Mexico	NM	●	●		●				
New York	NY		●						
North Dakota 1	ND		●				●	●	
North Dakota 2	ND		●				●	●	
Oklahoma	OK		●						
Rhode Island	RI	●	●		●		●	●	
South Dakota	SD			●			●		
Vermont	VT	●	●		●	●	●	●	
Virginia	VA		●				●		
Wisconsin 1	WI		●						

Note: Connecticut and Ohio did not provide complete responses.

Quality Measurement

Previous state surveys found that the majority of managed care systems incorporated some child-specific quality measures, with carve outs more likely to do so than systems with integrated designs. Consistent with these findings, most managed care systems (82%) in 2003 include some child-specific indicators in their quality measurement systems (**Table 113**). Carve outs reportedly are more likely to have child-specific measures — 95% as compared with 65% of the integrated systems.

Table 113

Percent of Managed Care Systems Incorporating Quality Measures Specific to Child and Adolescent Behavioral Health Services

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care system incorporates child-specific behavioral health quality measures	88%	71%	95%	65%	82%	-6%	11%
Managed care system does not incorporate child-specific behavioral health quality measures	12%	29%	5%	35%	18%	6%	-11%

The state surveys also have assessed the extent to which and ways in which families are involved in quality measurement activities in managed care systems. In 1997/98, 2000 and 2003, families reportedly were involved in quality measurement in some way in most systems (**Table 114**). As in the past, families are more likely to play a role in quality measurement processes in carve outs in 2003 (91% of systems) than in integrated systems (62% of systems). Overall, about one-fifth (21%) of the managed care systems reported no family involvement in quality measurement in 2003 (mostly integrated systems), representing a slight increase from previous findings.

Table 114

Percent of Managed Care Systems with Family Roles in Quality Measurement Processes

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Not involved	11%	13%	9%	38%	21%	10%	8%
Focus groups	44%	47%	68%	31%	53%	9%	6%
Surveys	77%	78%	82%	63%	74%	-3%	-4%
Design of quality measures and/or process	44%	44%	64%	6%	39%	-5%	-5%
Monitoring of quality measurement process	31%	44%	64%	6%	39%	8%	-5%
Other	11%	9%	32%	0%	18%	7%	9%

The 2003 State Survey investigated how families are involved in quality measurement activities, and found family roles reported in 2003 to be highly consistent with prior survey results. The most frequent way that families are involved in quality measurement is by responding to surveys; this was reported by three-fourths of the systems (74%). The next most frequently reported type of family role in quality measurement is participation in focus groups, indicated by 53% of the systems. Families are involved less frequently in designing quality measures or the measurement process and in monitoring the quality measurement process; 39% of the systems reported family involvement in these roles.

Carve outs are more likely than integrated systems to involve families in all capacities in the quality measurement process. For example, about two-thirds of the carve outs, as compared with only 6% of the integrated systems, reportedly include families in the design of quality measures and in monitoring of the quality measurement process.

Measurement of Clinical and Functional Outcomes

Since 1995 the state surveys have tracked the proportion of managed care systems measuring clinical and functional outcomes for children's behavioral health services. As indicated on **Table 115**, there reportedly has been a steady increase in the measurement of child clinical and functional outcomes, up from 51% in 1995 to 86% of the systems in 2003. In 2003, almost all carve outs (95%) and about three-fourths of the integrated systems (74%) reported that they measure child clinical and functional outcomes.

Table 115

Percent of Managed Care Systems Measuring Clinical and Functional Outcomes for Children's Behavioral Health Services

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Systems measuring clinical and functional outcomes	51%	63%	90%	95%	74%	86%	35%	23%	-4%
Systems not measuring clinical and functional outcomes	49%	37%	10%	5%	26%	14%	-35%	-23%	4%

Interviewees in both impact analyses reported that, even where outcome measurement systems existed, they were in early stages of development. Interestingly, despite the passage of time and the maturation of the managed care systems, the 2003 State Survey shows no change from 2000 in the reported stages of development of outcome measurement systems.

Table 116

Stage of Development of Measurement of Clinical and Functional Outcomes

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
In early stage of developing measurement system	44%	38%	55%	44%	0%
Developed but not yet implemented measurement system	4%	14%	0%	9%	5%
Implementing measurement system but do not yet have results	26%	19%	36%	25%	-1%
Implementing measurement system and have results	26%	29%	9%	22%	-4%

As shown on **Table 116**, outcome measurement continues to be characterized as being in an early stage of development in 44% of the managed care systems. Also consistent with 2000 findings, one-quarter of the systems reportedly have implemented an outcome measurement system but do not yet have results. Slightly less than one-quarter of the systems (22%) reportedly do have results related to clinical and functional outcomes for children's behavioral health care. Carve outs are more likely than systems with integrated designs (29% versus 9%) to have results from their outcome measurement systems.

Measurement of Satisfaction

Consistent with the findings related to measurement of clinical and functional outcomes, increases were reported in the measurement of parent satisfaction over time. As shown on **Table 117**, 82% of the managed care systems reported measuring parent satisfaction in 2003, up 13% from 1995, although a small decline was reported from 2000 to 2003. Carve outs are more likely (91%) than systems with integrated designs (69%) to measure parent satisfaction with behavioral health services.

Table 117

Percent of Reforms Measuring Parent and Youth Satisfaction with Behavioral Health Services

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Managed care systems measure parent satisfaction	69%	80%	91%	91%	69%	82%	13%	2%	-9%
Managed care systems measure youth satisfaction	60%	63%	56%	73%	31%	55%	-5%	-8%	-1%

The measurement of youth satisfaction continues to receive less attention than parent satisfaction; only 55% of the systems reported assessing youth satisfaction in 2003. Little change has been found over time in the measurement of youth satisfaction; overall, there has been a slight decline (5%) since 1995 in the percent of systems that measure youth satisfaction. These findings are consistent with the results of the impact analyses, which suggested considerable attention to the measurement of parent satisfaction but less attention to assessing youth satisfaction with behavioral health services. The 2003 results reflect a dramatic difference between carve outs and integrated systems with respect to measurement of youth satisfaction in that about three-quarters (73%) of the carve outs but only 31% of the integrated systems measure youth satisfaction.

Child and Adolescent Focus in Formal Evaluations

A substantial increase was noted in the proportion of managed care systems reporting that their formal evaluations have a child and adolescent focus, 78% of the systems in 2003 as compared with 55% of the systems in 2000 and 47% in 1997/98 (**Table 118**). Evaluations with a child and adolescent focus are far more likely to occur in carve outs (94%) than in systems with integrated designs (43%).

Table 118

Percent of Managed Care Systems with Evaluations Have a Child and Adolescent Focus

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Formal evaluation has child and adolescent focus	47%	55%	94%	43%	78%	31%	23%
Formal evaluation does not have child and adolescent focus	53%	45%	6%	57%	22%	-31%	-23%

Impact of Managed Care on System Performance

The 2000 and 2003 State Surveys explored the impact of managed care systems on various indicators:

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

As indicated on **Table 119**, the most striking finding for both 2000 and 2003 is that for many systems, the impact of managed care on these indicators is not known. For example, in 2003 the impact of managed care on total cost of child behavioral health services and on overall clinical and functional outcomes remains unknown in 58% of the systems, and the impact on the overall quality of child behavioral health services is unknown to nearly half of the systems (47%). Given managed care's goals of improving quality, containing costs, and improving accountability, the lack of information on system performance in these areas is a concern.

Table 119
Impact of Managed Care Reforms on System Performance — 2000 and 2003

	2000				2003			
	Increased	Decreased	No Effect	Don't Know	Increased	Decreased	No Effect	Don't Know
Child BH penetration rates	41%	8%	10%	41%	42%	5%	13%	39%
Overall child BH service utilization	34%	12%	12%	42%	63%	5%	8%	24%
Total cost of child BH services	24%	19%	16%	41%	24%	5%	13%	58%
Overall quality of child BH services	38%	7%	10%	45%	39%	0%	13%	47%
Overall clinical and functional outcomes	24%	3%	10%	63%	37%	0%	5%	58%
Overall family satisfaction with services	31%	0%	23%	46%	58%	0%	3%	39%
Incorporation of evidence-based practices	NA	NA	NA	NA	51%	0%	5%	43%

Where the impact of managed care was known, however, the results for the following indicators were in a positive direction and reflected improvements over 2000 findings:

- 63% of the systems reported an increase in child behavioral health service utilization, as compared with 34% in 2000
- 58% reported an increase in overall family satisfaction with services, as compared to 31% in 2000
- 37% reported an increase in overall child clinical and functional outcomes, as compared to 24% in 2000
- 51% reported an increase in the use of evidence-based practices (not tracked in the 2000 State Survey)

Child behavioral health penetration rates and the overall quality of child behavioral health services, reportedly have increased about 40% of the managed care systems in both 2000 and 2003.

Although controlling costs is a major goal of managed care, increased total costs were reported by 24% of the systems in both 2000 and 2003, decreased aggregate costs were reported by only 5% of the systems in 2003, and no effect on costs was reported by 13% of the managed care systems. It should be noted that "controlling costs" may refer to both reducing expenditures for behavioral health care or controlling the rate of growth of such expenditures, an area that requires further exploration. Thus, increased costs should not necessarily be interpreted as a negative outcome since the rate of increase may have been slowed in some systems.

For most of the system performance indices, carve outs achieved more positive outcomes than integrated systems, with differences ranging from 7% more carve outs reporting increased child penetration rates to 36% more carve outs reporting increased overall quality of child behavioral health services and increased incorporation of evidence-based practices (**Table 120**).

Table 120
Impact of Managed Care Reforms on System Performance — 2003

	Increased			Decreased			No Effect			Don't Know		
	Carve Out	Integrated	Total	Carve Out	Integrated	Total	Carve Out	Integrated	Total	Carve Out	Integrated	Total
Child BH penetration rates	45%	38%	42%	5%	6%	5%	14%	13%	13%	36%	44%	39%
Overall child BH service utilization	68%	56%	63%	9%	0%	5%	0%	19%	8%	23%	25%	24%
Total cost of child BH services	23%	25%	24%	9%	0%	5%	18%	6%	13%	50%	69%	58%
Overall quality of child BH services	55%	19%	39%	0%	0%	0%	5%	25%	13%	41%	56%	47%
Overall clinical and functional outcomes	41%	31%	37%	0%	0%	0%	5%	6%	5%	55%	63%	58%
Overall family satisfaction with services	64%	50%	58%	0%	0%	0%	0%	6%	3%	36%	44%	39%
Incorporation of evidence-based practices	67%	31%	51%	0%	0%	0%	5%	6%	5%	29%	63%	43%

XVI. General Update

A "general update" section was added to the 2003 State Survey, since it is the last in the series of all-state surveys in the Tracking Project. The effects of the current economic climate in the country — and any detrimental effects for behavioral health managed care systems — were examined, recognizing that many state governments are implementing cut-backs in health and human services in response to budget deficits. In addition, items were incorporated to explore perceived success in achieving the goals of managed care systems to date, as well as states' future plans for behavioral health managed care.

Effects of Current Fiscal Climate

Given the massive budget deficits facing most state governments, and the consequent cost cutting measures that many states are implementing, items were added to the 2003 State Survey to assess the extent to which the current fiscal climate is impacting managed care systems and in what ways. Over three-quarters of managed care systems (78%) reportedly are experiencing detrimental effects as a result of the nation's current economic climate (**Table 121**).

Table 121

Percent of Managed Care Reforms Reporting Detrimental Effects from Current Fiscal Climate

	2003		
	Carve Out	Integrated	Total
Current fiscal climate is having detrimental effects on managed care system	82%	73%	78%
Current fiscal climate is not having detrimental effects on managed care system	18%	27%	22%

The systems experiencing detrimental effects reportedly have taken a variety of measures to address fiscal problems (**Table 122**). The most frequently reported effects include:

- Reducing services to non-Medicaid, uninsured children and adolescents
- Eliminating specific populations from eligibility for the managed care system
- Reducing coverage of services or eliminating coverage for certain services
- Reducing levels of services, such as number of visits, length of stay, or duration
- Incorporating or raising co-pays
- Decreasing capitation or case rates to MCOs
- Implementing more stringent authorization procedures or policies

Table 122

Percent of Managed Care Reforms Reporting Detrimental Effects from Current Fiscal Climate

	2003		
	Carve Out	Integrated	Total
Lowered the federal poverty level eligibility cut-off	11%	27%	17%
Eliminated specific populations from eligibility for the managed care system	39%	27%	34%
Reduced coverage of services (i.e., eliminated coverage for certain services)	22%	36%	28%
Reduced levels of service (i.e., number of visits, length of stay, duration)	28%	27%	28%
Incorporated or raised co-pays	11%	55%	28%
Decreased provider reimbursement rates	28%	0%	17%
Decreased capitation or case rates to MCOs	28%	18%	24%
Implemented more stringent authorization procedures, guidelines, or policies	28%	18%	24%
Changed drug formulary	11%	36%	21%
Reduced services to non-Medicaid, uninsured children and adolescents	61%	18%	45%
Reduced interagency coordination	6%	9%	7%
Other	28%	27%	28%

Interestingly, integrated systems are far more likely to have incorporated or raised co-pays (55% did so) or changed drug formularies (36% reported this), and carve outs are far more likely to have reduced services to non-Medicaid, uninsured children (61% did so), a population that fewer integrated systems served to begin with, or eliminated specific populations from eligibility for the managed care system (39%).

- 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 reforms 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
  - Declines in investment in service capacity development

Perceived Success in Achieving Managed Care Goals

Perceptions of respondents (state child mental health directors and/or Medicaid agency staff) are that managed care systems have been, on balance, moderately to mostly successful in achieving their goals (containing costs, increasing access, expanding service array, improving quality, and improving accountability), with about a third of the systems falling into each of these categories overall. Carve outs reportedly have had greater success in goal achievement; 73% fall into the moderately or mostly successful categories combined, as compared with 56% of the integrated systems (**Table 123**).

Table 123

Ratings of Success of Managed Care System in Achieving Managed Care Goals

	Percent of Systems by Ratings of Success of Managed Care System in Achieving Managed Care Goals				
	1 Completely Successful	2 Mostly Successful	3 Moderately Successful	4 Marginally Successful	5 Not At All Successful
Carve Outs	18%	39%	34%	7%	2%
Integrated	8%	32%	24%	28%	9%
Total	13%	36%	30%	16%	5%

Considering individual goals, **Table 124** shows the mean ratings for each (1 to 5 scale, with 1 being completely successful and 5 not at all successful). Although the mean ratings cluster between "mostly" and "moderately" successful (between 2 and 3), results suggest that respondents perceive slightly greater success in improving access and improving accountability than with containing costs or improving quality. Overall, the least success is seen with respect to expanding the service array. Mean ratings also show that perceived success is greater in carve outs with respect to each of the managed care goals.

Table 124

Ratings of Success of Managed Care System in Achieving Managed Care Goals

	2003		
	Carve Out	Integrated	Total
Containing costs	2.50	3.25	2.61
Increasing access	2.27	2.81	2.50
Expanding service array	2.41	3.44	2.84
Improving quality	2.38	2.93	2.64
Improving accountability	2.24	2.94	2.54
Other	3.00	NA	3.00

NA=Not Applicable

Future Plans for Managed Behavioral Health Care

The 2003 State Survey found that managed care for behavioral health care is highly likely to continue in the future. No respondents indicated plans to phase out managed care in their states. In fact, in the majority of cases (89%), states reportedly plan to continue their present use of managed care technologies to manage behavioral health service delivery. Of those indicating potential changes, one state indicated plans to move to a non-risk based system, and four indicated plans to increase the use of ASO (Administrative Service Organization) arrangements (**Table 125**).

Table 125
Future Plans for Managed Behavioral Health Care

	2003		
	Carve Out	Integrated	Total
State plans to continue to use managed care technologies to manage behavioral health service delivery	100%	73%	89%
State plans to phase out managed care	0%	0%	0%
State plans to move to a non-risk-based system	0%	20%	3%
State plans to increase the use of administrative service organizations (ASOs)	5%	20%	11%
Other	14%	27%	19%

Thus, Tracking Project results indicate that managed care will continue into the foreseeable future, underscoring the need to implement the refinements and revisions that will ensure that these systems are successful in meeting the needs of children and adolescents with behavioral health disorders and their families.

HCRTP Health Care Reform Tracking Project

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

Child Welfare Special Analysis

Prepared by Jan McCarthy

I. Introduction

Background and Purpose of the Child Welfare Component

Children and families served by the child welfare system need intensive and extensive physical and behavioral health services. The federal Child and Family Services Review (CSFR) process[1] expects states to provide the services needed to meet the physical health, mental health, and educational needs of all children in the child welfare system, including those living at home with their parents and those in out-of-home placements. The CFSR process also charges states with enhancing the capacity of birth parents to meet the needs of their children. Because Medicaid is the primary funding source for many of the physical and behavioral health services that children and families in the child welfare system receive, they are directly impacted by public sector managed care initiatives. It is important for states to forge linkages across systems in order to ensure child safety, permanency, and well-being. Recognizing this, since 1996 the Tracking Project has tracked and analyzed the effects of managed care reforms on children and families served by the child welfare system.[2] The purposes of the Child Welfare Component of the Tracking Project are to:

[1] In March 2000, regulations went into effect for the Child and Family Services Review process, a new approach to federal oversight of state child welfare programs. Overseen by the Children's Bureau of the Administration for Children and Families, the review process consists of statewide self-assessments, as well as an on-site review in every state conducted by a team of federal, state, and peer reviewers. Information gathered through the review is used to examine the states' success in meeting the major goals of the child welfare system — child safety, permanency, and well-being. When states do not achieve "substantial conformity" with the required outcomes, they develop Program Improvement Plans to describe the changes they will make to reach substantial conformity.

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

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

Methodology of the Child Welfare Component

A specific focus on child welfare issues has been incorporated into each of the following aspects of the Tracking Project.

State Surveys

The Tracking Project incorporated items in the 1997/98, 2000 and 2003 State Surveys addressing the impact of managed care initiatives, specifically behavioral health managed care[3], on children in the child welfare system and their families. Since 1996, the Child Welfare League of America (CWLA) also has been conducting state surveys to track emerging trends in management, finance, and contracting that affect child welfare service delivery. In 2000, the Tracking Project and CWLA began coordinating their survey activities. Both the Tracking Project and the CWLA surveys included similar items to assess respondents' views of the effects of health and behavioral health managed care on children and families served by the child welfare system. The primary respondents in the surveys conducted by CWLA in 2000 and 2003 are state and county child welfare administrators. Primary respondents to the Health Care Reform Tracking Project State Surveys are directors of children's mental health services in all 50 states and the District of Columbia. In two previously published reports[4], findings from the CWLA survey are compared with Tracking Project findings. Findings from the 2003 CWLA Survey were not available at the time of this publication and, therefore, are not discussed in this special analysis. When the 2003 CWLA Survey is complete, findings from that survey will be compared with findings from the Tracking Project's 2003 State Survey in the report of the 2003 CWLA Management, Finance and Contracting Survey.[5]

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

[4] Stroul, B.A., Pires, S.A., and 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.

McCullough, C. and Schmitt, B. (2001) *2000-2001 Management, finance, and contracting survey final report*. Washington, D.C.: Child Welfare League of America Press.

[5] For more information about the 2003 CWLA Survey report, see www.cwla.org or contact jcollins@cwla.org.

Impact Analyses

Members with extensive experience in the child welfare system were added to the site visit teams that visited 18 states during the 1997 and 1999 Impact Analyses. These team members interviewed a range of stakeholders involved in child welfare, including state and local child welfare administrators; child welfare supervisors and caseworkers; child welfare providers; advocates; and birth, foster, and adoptive parents. In the 1999 Impact Analysis, additional interviews were conducted in the three states that were planning or implementing a child welfare managed care initiative. Child welfare findings from the 1999 Impact Analysis and these three child welfare managed care initiatives are described in a separate document[6], as well as in a special analysis in the 1999 Impact Analysis report.

Promising Approaches

The Promising Approaches Series of the Tracking Project is comprised of a number of thematic issue papers, each addressing a specific aspect of managed care systems affecting children with behavioral health disorders. Two papers in the series[7] address issues specific to children and families in the child welfare system. The first of the two papers, *A View from the Child Welfare System*, describes unique considerations for meeting the behavioral health needs of children in the child welfare system, and their families, within managed care systems. Promising approaches from four states and communities are described, and cross-site challenges and strategies are summarized.

The second of the two papers, *Making Interagency Initiatives Work for Children* and *Families in the Child Welfare System*, describes how the child welfare system is participating in collaborative interagency initiatives designed to serve children with serious and complex behavioral health disorders. It describes interagency initiatives in three states and communities and identifies strategies used in these sites to include the child welfare system in the initiative and to meet the behavioral health needs of children and families served by the child welfare system.

The Center for Health Services Research and Policy at George Washington University (GWU) is another partner in the Promising Approaches Series. GWU conducted a contract analysis and site visit project to provide insights on "what works" when children are enrolled in multiple public managed care initiatives (e.g., child welfare and Medicaid). Representatives from the Tracking Project and from CWLA participated in the GWU site visits and in the analysis of the findings.[8]

[6] McCarthy, J. and Valentine, C. (2000) *1999 Child welfare impact analysis, health care reform tracking project: tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

[7] These two documents are available on the web at www.gucchd.georgetown.edu or can be ordered in hard copy from deaconm@georgetown.edu 202/687-5000.

[8] Mauery, D. Richard, Collins, J., McCarthy, J., McCullough, C., and Pires, S. (2003). *Contracting for coordination of behavioral health services in privatized child welfare and Medicaid managed care.* Washington, D.C.: Center for Health Services Research and Policy, George Washington University. This paper is available on the web at www.chcs.org.

Consensus Conference

The Tracking Project held a consensus conference in the fall of 2003 to develop a set of agreed-upon recommendations for policy, practice, and research related to publicly financed managed care for children and adolescents with behavioral health disorders and their families. The recommendations are based on review and analysis of findings from the Tracking Project and related research studies. Child welfare researchers and policy makers were both presenters and participants in the Consensus Conference.

II. Results of the 2003 State Survey

In this section, findings from the 2003 State Survey related to the child welfare population are summarized. When helpful, findings from previous Tracking Project surveys and impact analyses are cited for purposes of comparison.

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

The 2003 State Survey found that 74% of the managed care systems cover children in the child welfare system who are eligible for Medicaid. Thirty-nine percent (15 systems) reportedly cover the *total* Medicaid population, including Medicaid-eligible children involved in child welfare, and 61% (23 systems) cover only a *portion* of the Medicaid population. Of the 23 systems that do not cover the total Medicaid population, 57% (13 systems) cover children in the child welfare system. Thus, 28 systems (74%) in the 2003 State Survey reported serving children in child welfare. Even though the great majority of managed care systems continue to cover children in child welfare, as **Table 1** indicates, there is a 17% decline in the coverage of the child welfare population since 2000 (from 91% to 74%).

Table 1
Systems Covering the Child Welfare Population

1995 State Survey	37%
1997/98 State Survey	60%
2000 State Survey	91% [9]
2003 State Survey	74%

As suggested earlier in this report, since 2000 there has been a reported decline in coverage of Medicaid populations that can be expected to use more and costlier services, including children involved in child welfare and juvenile justice systems and children eligible for Supplemental Security Income (SSI). This decline appears to be driven largely by decreases in the coverage of these populations of children by managed care systems with integrated designs; 80% of the carve outs cover children in the child welfare system, while only 38% of the integrated systems do so.

Although this information was not gathered previously, the 2003 State Survey specifically explored coverage for a subset of children in the child welfare system — those who are in the custody of the child welfare agency. Results indicate that children in state custody are covered by the majority of the managed care systems (66%).[10] In the majority (90%) of the systems covering children in state custody, enrollment of these children is mandatory rather than voluntary.

[9] The 2000 State Survey Report indicated that 82% of the systems reportedly covered children in child welfare. This percentage referred to those systems that did not cover the total Medicaid population. When the systems covering the total Medicaid population are included, the percentage covering children in child welfare in the 2000 State Survey increased to 91%.

[10] This percentage assumes that the 15 systems covering the total Medicaid population cover children in state custody. In addition, of the 13 systems that do not cover full Medicaid population, but do cover child welfare, 77% (10 systems) cover children in state custody. Thus 25 of the 38 systems (66%) responding to this question cover children in state custody.

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

Significant involvement of state child welfare staff in planning, implementing, and refining behavioral health managed care systems, which showed an increase in earlier surveys, has reportedly decreased since 2000 (**Table 2**). The 2000 State Survey found significant involvement of child welfare stakeholders in 46% of the systems, as compared with 21% in 2003. Half of the systems reported some involvement, and 29% report no involvement at all by state child welfare staff in managed care systems. This decrease could be the result of fewer managed care systems covering children in the child welfare system; however, it also might be related to the greater maturity of managed care systems, an acceptance of managed care as "business as usual," familiarity with how it works, and less concern about molding, crafting, and changing the system. All other stakeholder groups (See **Table 16**), except state juvenile justice staff, also reportedly lost ground in terms of being significantly involved in planning, implementing, and refining the managed care system.

Table 2
Child Welfare Stakeholder Involvement

	None	Some	Significant
1997/98 State Survey	7%	56%	37%
2000 State Survey	11%	43%	46%
2003 State Survey	29%	50%	21%

Discrete Planning for Children in the Child Welfare System

Similar to the trend regarding the involvement of child welfare stakeholders in managed care systems, in 2003, 25% fewer systems reported that they are engaged in a discrete planning process for children in the child welfare system (**Table 3**). Although there was a 24% increase between 1997/98 and 2000, the percentage of systems with a discrete planning process in 2003 dropped to 47%, almost equal to the 1997/98 level in which 48% of the systems reported discrete planning for the child welfare population. This, too, may be attributable to the relative maturity of the systems, and consequent decrease in the perceived need to plan or refine system operations.

Table 3
Percentage with a Discrete Planning Process for Children in the Child Welfare System

1997/98 State Survey	48%
2000 State Survey	72%
2003 State Survey	47%

Special Provisions for Children in the Child Welfare System

Although the percentage of managed care systems that incorporate special provisions for children and adolescents in the child welfare system has dropped from 87% in 2000 to 63% in 2003, the majority of systems continue to include some special provisions. The special provisions reported most frequently for children in the child welfare system in 2003

(**Table 4**) were interagency treatment and service planning, intensive case management, an expanded service array, and the wraparound services/process. Only 33% of the systems reported offering family support services for families involved in the child welfare system, and just 15% identified higher capitation or case rates as a special provision.

Even though certain special provisions are offered in nearly two-thirds of the systems, the fact that only 15% of the systems reportedly provide fiscal incentives through higher capitation or case rates raises the question as to whether managed care systems actually have the resources and incentive to ensure access to the special provisions that exist. One purpose of risk adjusted rates is to better match the level of risk taken by the managed care entity to the level of need of a high-risk, high-need population. Although the impact analyses clearly showed that children in the child welfare system need and use an extensive amount of services, the 2000 and 2003 surveys both found few systems adjusting rates for this population (15% or fewer).

Table 4
Special Provisions for Children in Child Welfare

Provisions	Percent of Systems with Provisions
Interagency treatment/service planning	51%
Intensive case management	51%
Expanded service array	46%
Wraparound services/process	46%
Family support services	33%
Higher capitation or case rates	15%
Flexible service dollars	26%
Other	5%

Mental Health Screening for Children Entering State Custody

The 2003 State Survey explored the extent to which managed care systems are responsible for screening children who enter state custody to identify mental health problems and treatment needs. Fewer than half of the systems (43%) reported that they are responsible for screening these children (**Table 5**).

Table 5

Percent of Managed Care Systems Responsible for Screening Children in the Child Welfare System who Enter State Custody to Identify Mental Health Problems and Treatment Needs

	2003		
	Carve Out	Integrated	Total
Systems are responsible for behavioral health screening of children in child welfare entering state custody	45%	38%	43%
Systems are not responsible for behavioral health screening of children in child welfare entering state custody	50%	25%	39%
NA — Children in child welfare state custody are not covered	5%	37%	18%

When asked to report the extent to which the mental health screening actually is conducted, 77% of the systems with responsibility for screening children entering custody indicated that most children are screened, 15% reported that some children are screened, and 8% indicated that few children are screened. None of the systems with this responsibility indicated that no children entering custody are screened.

Education and Training

The 2003 State Survey found that education and training about the goals and operations of the managed care system reportedly are being provided for the child welfare system in 61% of the systems. A similar percentage of the systems are providing education and training to other child-serving systems as well. While the Tracking Project found an increase in education and training of child welfare and other key stakeholders on the goals and operations of managed care systems from 1997/98 and 2000, less education and training seems to be occurring since 2000 with respect to almost all stakeholder groups. This is demonstrated in **Table 6**.

Table 6

Education and Training on Managed Care Provided to Child-serving Systems

Child-Serving System	1997/98	2000	2003
Child Welfare System	67%	72%	61%
Juvenile Justice System	Not Asked	63%	58%
Other Child-Serving Systems	64%	72%	45%

Decreased education and training on managed care may be related to the fact that most managed care systems are no longer in early implementation stages, and that child-serving systems may have greater familiarity with their goals and operation.

The 2003 State Survey found that there has been a slight increase in training and education provided to MCOs in order to increase their knowledge base related to serving children and adolescents in the child welfare system (a 5% increase from 52% of the systems in 2000 to 57% of the systems in 2003). This is consistent with an increase in training for MCOs regarding other populations of children served. However, training about other populations reportedly increased more significantly. For example, training about children with serious emotional disorders increased by 16% to 71% of the systems, and training related to youth in the juvenile justice system increased by 15% to 51% of the systems.

Service Coverage in Behavioral Health Managed Care Systems

Managed care systems cover a wide variety of mental health services. The following services are those most likely to be covered (reportedly covered by 80% or more of the systems):

- Assessment and diagnostic evaluation (95%)
- Outpatient psychotherapy (95%)
- Inpatient hospital services (95%)
- Medical management (87%)
- Home-based services (85%)
- Crisis services (85%)
- Day treatment/partial hospitalization (85%)
- Case management services (80%).

The following services, which are critical services for children/adolescents in the child welfare system, are those least likely to be covered by managed care systems (reportedly covered by less than 50% of the systems):

- Crisis residential services (44%)
- Behavioral aide services (41%)
- Therapeutic group homes (38%)
- Respite services (36%)
- Therapeutic nursery/preschool (26%)

Coverage of therapeutic foster care and residential treatment, two services frequently used by the child welfare system, increased slightly (by less than 4%) in 2003, and they still remain outside of managed care in approximately 40% of the systems. The 2000 State Survey found that 57% of the managed care systems covered therapeutic foster care and residential treatment; whereas in 2003, therapeutic foster care reportedly is covered by 59% of the systems, and residential treatment is covered by 61% of the systems.

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

Financing

■ Funding Sources for Behavioral Health Managed Care

The Tracking Project has consistently found over time that, in comparison to the large proportion of managed care systems to which state Medicaid (100%) and state mental health agencies (50%) contribute funds, the proportion of managed care systems to which other child-serving agencies contribute financing is relatively small. The percentage of managed care systems that include child welfare funds has increased slightly from 21% in 2000 to 29% in 2003, although this represents a decrease from the proportion of systems (32%) that included child welfare funds in 1997/98. However, the child welfare system continues to contribute funds in a greater percentage of the managed care systems than does education (11%), juvenile justice (11%), mental retardation/developmental disabilities (13%), and health (16%).

■ Use of Medicaid Outside of Managed Care Systems

The Tracking Project has found that over the past decade, states consistently have reported that some Medicaid dollars for children's behavioral health services are left outside of the managed care system in fee-for-service arrangements. This was reported to be the case in all of the managed care systems (100%) in the 2003 sample.

The child welfare system reportedly uses Medicaid dollars outside of the managed care system for children's behavioral health services more than other child-serving systems (**Table 7**). In both 2000 and 2003, the child welfare system had access to "outside" Medicaid funds in 72% of the managed care systems. Even though the child welfare system contributes some funds in 29% of the managed care systems according to 2003 results, substantial resources are being kept within child welfare systems to meet behavioral health treatment needs beyond what is provided through managed care systems. When children in the child welfare system require services outside of the managed care system, the child welfare system generally uses Medicaid funds under its control and other resources to provide these services. While having access to multiple funding streams creates a safety net for children in the child welfare system, it also presents an opportunity for cost shifting and fragmentation and can lead to confusion for families seeking services.

Table 7

Percent of Managed Care Systems in which Other Systems Use Medicaid Dollars for Behavioral Health Services Outside of the Managed Care System in 2003

Child-Serving System	Percent of Managed Care Systems
Child welfare agency	72%
Mental health agency	67%
Education agency	67%
MR/DD agency	67%
Substance abuse agency	58%
Juvenile justice agency	56%
Health agency	44%

■ Cost Shifting

Drawing conclusions about cost shifting remains problematic due to the fact that the percentage of managed care systems that actually track or monitor cost shifting among child-serving agencies, which was low in 2000 (16%), has decreased even further in 2003 to 11%. Perceptions about the direction of cost shifting remain consistent with 2000 findings. Cost shifting is perceived by respondents to the Tracking Project surveys to flow both ways — from the managed care system to other child-serving systems (36% in 2000, 38% in 2003) and from other child-serving systems into managed care systems (43% in 2000, 44% in 2003).

Findings from the CWLA 2000 Survey indicate that child welfare respondents view cost shifting differently. Similar to the Tracking Project respondents, very few states claimed to have the ability to actually track cost shifting to or from the child welfare system; however, child welfare respondents in the CWLA 2000 Survey were more likely to believe that managed care leads to a shift of costs to the child welfare system.

Clinical Decision Making Criteria

In the majority of systems (82% in 2000, 89% in 2003), medical necessity criteria continue to be sufficiently broad to allow for consideration of psychosocial and environmental factors in determining the appropriate types, levels, and duration of treatment and supports. This is critically important for the child welfare system because multiple factors must be considered in treatment planning and in planning for permanent placements.

Criteria for making clinical decisions also continue to be standardized statewide in half of the managed care systems (54% in 2000, 50% in 2003) and to differ with each MCO in the other half. When criteria differ with each MCO, continuity of care becomes compromised for children and families served by the child welfare system due to the multiple placement changes experienced by many children in this system. When children move to a different area that is covered by a different MCO, they may not be considered eligible for the same services and supports that they had access to through the previous MCO.

Access to Behavioral Health Services

■ Initial Access to Services and Access to Extended Care Services

As **Table 8** indicates, improvement in initial access to a basic level of behavioral health services (in comparison to pre-managed care) continues to be reported by most of the managed care systems (85% in 2003). Improvement in access to extended care services (services beyond short-term stabilization) reportedly increased significantly since 2000 (36% reported improvement in 2000, 62% in 2003). Shorter waiting lists for behavioral health services were reported in about half of the systems in both 2000 and 2003, and the percentage of systems whose waiting lists have gotten longer has decreased from 20% in 2000 to 9% in 2003.

The Tracking Project has not explored access to services by separate populations and, therefore, cannot determine whether children and families served by the child welfare system experience the same improvements in access to services that were reported for the total population served. However, if this significant improvement applies to children in

the child welfare system, it has positive implications for both improved services for children and reduced costs for the child welfare system, which frequently pays for extended care services not covered by managed care.

Table 8
Access to Behavioral Health Services

	2000		2003	
	Better	Worse	Better	Worse
Initial access to behavioral health services	70%	15%	86%	6%
Access to extended behavioral health services	36%	14%	62%	6%
Waiting lists for behavioral health services	48%	20%	50%	9%

Note — The remaining managed care systems reported no change in these three areas.

The 2003 State Survey found that almost all systems (95% in 2003) are covering both acute and extended care services (**Table 9**). Extended care was defined for survey respondents as care extending beyond short-term stabilization. This represents continuing good news for the child welfare system, since many children involved with child welfare require extended care behavioral health services, and especially because the child welfare agency is the primary agency providing extended care services outside of managed care (83% in 2003). However, because in almost all the systems both managed care and the child welfare systems are responsible for some behavioral health extended care services, coordination between the systems is critical.

Table 9
Percent of Systems Including Acute and Extended Care

Child-serving System	1997/98	2000	2003
Acute Care Only	26%	9%	5%
Acute and Extended Care	74%	88%	95%
Extended Care Only	0%	3%	0%

■ Access to Behavioral Health Inpatient Services

The 2003 State Survey results show continuing trends in access to behavioral health inpatient services. A small percentage of systems continue to report that initial access is more difficult (20% in 2000, 11% in 2003). In 2003, almost two-thirds (63%) reported that initial access to inpatient care is easier. The percentage of systems reporting that average lengths of stay are shorter increased from 63% in 2000 to 80% in 2003. No system reported that average lengths of stay are longer.

In both 2000 and 2003, respondents reported a number of problems resulting from decreased access and truncated inpatient lengths of stay. Several of these problems that have a direct impact on the child welfare system were reported with less frequency in 2003 than in 2000, suggesting some improvements. Inappropriate use of child welfare emergency shelters was cited by 21% of the systems reporting in 2000 but by only 6% of the systems in 2003. Children in the child welfare system discharged without a safe

placement dropped from 8% of the systems in 2000 to 3% (only 1 system) in 2003. The most frequently reported problem in 2000 associated with changes in access to inpatient care was children being discharged without needed services (33%). This too decreased in 2003 to 13% of the systems reporting.

The decrease in problems related specifically to the child welfare system is encouraging; however, the findings about shorter lengths of stay in inpatient care continue to have major implications for the child welfare system due to the serious emotional problems faced by many children involved with child welfare. Survey results underscore the need: 1) for child welfare workers and families to coordinate discharge plans carefully with the managed care system, and 2) to create alternatives to hospitalization, such as step-down services and family and community supports. In the majority of managed care systems (62% in 2000, 73% in 2003), a variety of alternatives to hospitalization reportedly are being developed.

■ Eligibility Based on Placement Setting

Respondents in the 2000 and 2003 State Surveys were asked whether there were any types of placements in which children in the child welfare or juvenile justice systems would lose eligibility for (and, thus, access to) services from the managed care system. Respondents for approximately three-quarters of the systems (73% in 2000, 79% in 2003) indicated that there are placements that result in loss of access to services through the managed care systems. The types of placements that typically make children ineligible for services from the managed care system are detention, incarceration, and placement in state-operated facilities. Ten percent of the systems (four states) responded that children are ineligible for the managed care system if they are in residential treatment facilities (RTFs), and one state indicated that when a child enters foster care he loses eligibility for managed care. Two states described geographic reasons for losing eligibility, e.g., if a child moves to an area of the state not covered by a managed care plan. Nursing homes and private institutions that use seclusion and restraint were each identified by one state as placements that cause children to lose eligibility for managed care.

Policies like this demonstrate how difficult it can be for children in both the child welfare and juvenile justice systems to obtain consistent and continuous care. Policies and practices that force change in type of coverage, providers, and services can lead to ineffective services, increased trauma, and poor outcomes for children and families.

Interagency Coordination

The 2000 and 2003 State Surveys assessed the impact of managed care systems on interagency coordination at both the service delivery and system levels, and results in both surveys demonstrated a promising trend — coordination at both the service and system levels is improving.

For approximately two-thirds of the systems (60% in 2000, 67% in 2003), respondents indicated that coordination between physical health and behavioral health services has improved. This is extremely important for the child welfare system, in which a major goal is child well-being, and coordinating services to meet both a child's physical health and mental health needs is a priority. Respondents also indicated improvement in coordination between mental health and substance abuse services (in 52% of the systems in 2000 and

63% in 2003) and improved interagency coordination among child-serving systems in general (65% in 2000, 68% in 2003). It is noteworthy that in 2003, coordination in each of these areas reportedly is worse in only 0% to 3% of the systems. For the remaining systems, managed care has had no effect on coordination.

The 2003 State Survey included an item specifically exploring the effect of managed care systems on interagency coordination between the mental health and child welfare systems in comparison to pre-managed care. In almost two-thirds of the systems (61%) coordination between the two systems reportedly has improved; no system indicated that coordination had worsened in comparison to pre-managed care. In 39% of the systems, managed care reportedly has had no effect on coordination between the child welfare and mental health systems.

Cultural Competence

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

The 2000 and 2003 State Surveys explored whether cultural competence requirements had changed in managed care systems as compared with the previous system. At both points in time, respondents indicated that in the majority of systems (64% in 2000, 78% in 2003) cultural competence requirements under the managed care system were stronger than in the previous system. In 2000, the most frequently cited strategy used to enhance cultural competence in managed care systems was cultural competence requirements in RFPs and contracts (found in 85% of the systems); however, fewer systems reportedly have such requirements in 2003 (61%). Other strategies noted in 2000 remain fairly consistently used among managed care systems in 2003. These include: translation services (82% in 2000, 86% in 2003), inclusion of culturally diverse providers in networks (64% in 2000, 58% in 2003), and outreach to culturally diverse populations (58% in 2000, 61% in 2003). Strategies that were used less frequently by managed care systems in 2000 generally continue to be noted less frequently in 2003; for example, only about a third of the systems track utilization and outcomes by culturally diverse groups (36% in 2000, 31% in 2003).

Family Issues

In the child welfare system, successful prevention of placement and reunification of families and children depend upon adequate services for both children and parents. A very significant finding in both the 2000 and 2003 State Surveys is that in two-thirds of the systems, the service delivery focus reportedly is on families, in addition to the identified child. This reflects a continued improvement over the findings in the 1999 Impact Analysis in which respondents in all nine systems in the sample felt that managed care focused treatment planning and services on the identified child, rather than on the entire family. The 2000 and 2003 State Surveys also found that about half of the systems pay for services to family members, even if only the identified child is covered. While this is a hopeful sign, it also means that in half of the systems, finding funds to provide services for family members continues to be an issue.

Survey findings for both 2000 and 2003 indicated that managed care systems have had no effect on the pre-existing practice of families having to relinquish custody in order to access behavioral health services for their children in most systems (83% in 2000, 81% in 2003). In a small percentage of the systems (13% in 2000, 16% in 2003) managed care reportedly has improved this situation. Managed care reportedly has exacerbated the practice of relinquishing custody in order to receive services in only one or two systems. In 2003, the General Accounting Office (GAO) reported that more than 12,000 families have relinquished custody of their children to the child welfare or juvenile justice systems in order to obtain mental health services. The GAO report cites private health insurance and Medicaid rules as contributing to this problem, although, consistent with the Tracking Project findings, it does not identify managed care itself as a causal factor.[11]

Inclusion of Child Welfare Providers in Behavioral Health Managed Care Systems

In both the 2000 and 2003 State Surveys respondents indicated whether various types of providers were included in managed care system provider networks. An extremely important finding is that only about half of the systems (53% in 2000, 54% in 2003) reportedly include child welfare providers (i.e., providers who traditionally have provided behavioral health services to children and families in the child welfare system), a finding with both fiscal and clinical implications. If a preferred provider is not in the managed care system network, the child welfare agency may be faced with the decision of either paying for that provider's services, or obtaining care from a provider in the network who may not be familiar with the child being referred or may not be generally knowledgeable about children in the child welfare system and their unique treatment needs. The inclusion or exclusion of child welfare providers also may affect continuity of services if children are forced to change providers as they move in and out of the child welfare system.

Accountability and Data

■ Tracking Utilization of Behavioral Health Services by Children in Child Welfare

Although most of the managed care systems track the use of behavioral health services by children in the child welfare system, there has been a slight decrease in tracking of this system information since the 2000 State Survey (74% in 2000, 63% in 2003). Although these data could be used in determining system performance and in making decisions about needed services, more systems track this information than those who actually use it for system planning. This gap between the information that is tracked on the child welfare population and its use for system planning narrowed somewhat in 2003 (35% of the systems used the data for system planning in 2000, 42% in 2003). While the reasons for not using these data in system planning were not determined by the state surveys, information gathered during the impact analyses indicated that it may be due to the form in which the data are gathered, the timeframes in which data are generated, and the lack of staff capacity to analyze the data.

[11] *Child welfare and juvenile justice — Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services.* (April 2003). Washington, D.C.: US General Accounting Office, Report #GAO-03-397.

III. Summary and Conclusions

Findings from the 2003 State Survey

Findings from the 2003 State Survey reflect both positive and negative changes related to children in the child welfare system who have behavioral health needs and their families.

- Findings that might be characterized as potentially having a **negative impact** on the child welfare population include the following:
  - Fewer systems than in 2000 reportedly, involve child welfare stakeholders significantly in planning, implementing, and refining managed care systems (down 25% to 21% of the systems).
  - Fewer systems have discrete planning processes for children in the child welfare system (down 25% to 47% of the systems).
  - Fewer systems incorporate special provisions for children in the child welfare system (down 24% to 63% of the systems)
  - Fewer systems include requirements in RFPs and contracts related to cultural competence (down 24% to 61% of the systems)
  - Fewer managed care systems reportedly include children in the child welfare system (down 17% to 74% of the systems).
  - Fewer managed care systems reportedly provide education or training for the child welfare system about managed care (down 11% to 61% of the systems).
  - Fewer systems track utilization of services by children in the child welfare system (down 11% to 63% of the systems).
  - Tracking of cost shifting, which was reported by only 16% of the systems in 2000, decreased slightly in 2003 with only 11% reportedly tracking it.
- Potentially **positive changes** found in the 2003 survey include the following:
  - More systems reported improved initial access to behavioral health services (up 15% to 85% of the systems)
  - More systems reported improved access to extended care behavioral health services (up 26% to 62% of the systems)
  - Problems that have a direct impact on the child welfare system related to reduced access and lengths of stay in inpatient care (e.g., inappropriate use of child welfare emergency shelters) were reported by 15% fewer systems in 2003 than in 2000 (3% - 13% of the systems).
  - A slight increase (5%) was reported in the percentage of managed care systems which reportedly provide training for MCOs to expand their knowledge about serving children in the child welfare system (57% of the systems)
  - Two-thirds of the systems (67%, a 7% increase) reported improved coordination between physical health and behavioral health services.

- In other areas important to children and families in the child welfare system, 2003 findings indicate **little or no change** from previous surveys:
  - Approximately half of the systems continue to include child welfare providers.
  - About half of the systems pay for services for family members even if only the identified child is covered.
  - The child welfare system continues to have access to Medicaid funds outside of managed care in 72% of the systems.
  - Few systems risk-adjust rates for children in the child welfare system.
  - Approximately 60% of the systems continue to cover two services frequently used in the child welfare system — therapeutic foster care and residential treatment.
  - The percentage of managed care systems that include funds from child welfare has remained fairly consistent since 1997/98 with a slight decrease in 2000 (currently 29% of the systems include child welfare funding).
  - Approximately 75% of the systems continue to report that there are placement types (e.g., detention and state operated facilities) in which children in the child welfare or juvenile justice systems would lose eligibility for services from managed care.
  - Respondents' perceptions about cost shifting have remained consistent. About one-third report cost shifts from managed care to other systems, and about 40% report cost shifts to the managed care system.
- The following new information gained in 2003 (not included in previous state surveys) helps to further elucidate issues related to children and families in the child welfare system in the context of behavioral health managed care systems:
  - For the first time, respondents indicated whether a subset of children in the child welfare system — those who are in state custody — were included in the managed care system. Approximately two-thirds of the systems (66%) include children in custody. In most states that cover children in custody, their enrollment is mandatory rather than voluntary.
  - The 2003 State Survey also found that 42% of the managed care systems are responsible for screening children who enter state custody to identify mental health problems and treatment needs.
  - Previous surveys queried respondents about whether interagency coordination had improved since the implementation of managed care. The 2003 State Survey asked specifically about coordination between the mental health and child welfare systems in comparison to pre-managed care. Almost two-thirds of the respondents (61%) report that coordination between the two systems has improved.

Continuing Challenges

- The Tracking Project has used a variety of methods to gather information over a 10-year period. This comprehensive, long-term view of publicly financed managed care provides a context within which to view the 2003 State Survey findings, as well as a perspective on the remaining challenges for making managed care work for children and families in the child welfare system. Some of the challenges, noted in previous phases of the Tracking Project that continue to exist, include the following:
  - Many systems have not yet created a structure or systematic strategies for reaching out to parents involved with the child welfare system in order to include them in service

planning for their own children and to request their input on system level issues.

- Many systems continue to focus primarily on the identified child. Family supports and services for other members of the family (so important for families involved with the child welfare system) often require referral and/or other community resources, which may or may not be available.
- Ensuring continuous care by not requiring children to change plans and providers when they change placements remains a challenge in many systems.
- Some managed care plans do not have sufficient service capacity or an adequate provider network to meet the needs of children and families in the child welfare system. Services such as crisis response and support, therapeutic foster care, respite care, residential care, post-adoption services, treatment for sexual abuse victims and for sexual offenders, and substance abuse treatment for parents are needed for families in the child welfare system.
- The capacity to track outcomes for children and families served by the child welfare system and to measure the effectiveness of services provided is lacking in many systems.
- Because Medicaid is the primary funding source for most managed care systems, it is a continuing challenge for states and communities to serve children who are not eligible for Medicaid. Thus, it is difficult to provide behavioral health services and supports for families involved in child protective services whose children are not eligible for Medicaid or not in state custody.

Strategies to Better Service the Child Welfare Population

Some of the strategies, noted in previous phases of the Tracking Project, that help make managed care work for children and families in the child welfare system are described below.

- **System-level strategies** include the following:
  - A commitment to serving children and families in the child welfare system. This involves viewing the child welfare system as a key partner; creating formal structures to ensure that child welfare system mandates, laws, and policies are accommodated; and addressing the child welfare outcomes of safety, permanency and well-being. It also means that MCOs/BHOs and providers understand the special needs of children and families in the child welfare system. When this commitment exists, the child welfare system often contributes resources to the system.
  - The managed care system is based on values and principles that support a family-centered, strengths-based approach.
  - Institutionalized problem solving strategies and communication structures between the managed care system and the child welfare system are in place to address problems that inevitably occur.
  - Systems that sustain their efforts describe long-term collaborative relationships among the systems as key to their success. Trust, respect, persistence, and dedication are words used to describe relationships among child welfare, mental health, and Medicaid agencies that work well together. Top-level commitment to these relationships is essential.

- Funding strategies are in place to maximize federal funds, share costs and savings across systems, resolve issues among public agencies and MCOs regarding who pays for what services, set comparable provider rates across systems, and pay for services not covered by the managed care system.
- In managed care systems that work well for children and families in the child welfare system, the child welfare agency is no longer alone in providing behavioral health services. The managed care system shares the expertise and the responsibility for developing a behavioral health care system that will work for children and families in the child welfare system.

■ **Individual child and family-level strategies** include the following:

- Systems have developed strategies to enhance community-based care options and reduce the child welfare system's historic reliance on out-of-home care and residential placement.
- Child welfare service plans (that address safety, permanency, and well-being) are incorporated into behavioral health treatment plans. MCOs/BHOs and behavioral health providers are conscious of safety and permanency issues. Child welfare service plans also reflect the behavioral health services needed to support achieving child/family safety and permanency.
- Children in the child welfare system experience many transitions — into the child welfare system (and often into an out-of-home placement), among different placements while in custody (between foster homes, from foster homes to group homes or residential treatment), reunification with their families and sometimes re-entry into foster care, to an adoptive home or guardianship arrangement, and to independence and reliance on the adult system. Managed care systems that work well for this group of children recognize these many transitions and plan ahead for them. For example, when children in custody are admitted for inpatient care, the BHO care manager is immediately involved in discharge planning and arranging community-based services that will support the permanency plan developed by the family, child welfare agency and the court.

Appendix A

2003 Survey of State Managed Care Initiatives Affecting Behavioral Health Services for Children and Adolescents and Their Families

Respondent Name: State:

Title/Agency: Date:

Phone: Fax: E-Mail:

If you are planning to describe more than one managed care initiative affecting behavioral health services (i.e., mental health and/or substance abuse services) for children and adolescents, please duplicate this form and complete a separate survey for each initiative.

Return completed survey to:

Rebecca Whitlock, CFS, MHC 2424K
FMHI, Research & Training Center for Children's Mental Health
13301 Bruce B. Downs Blvd. Tampa, FL 33612
Fax: 813-974-7376 Email: rwhitlock@fmhi.usf.edu

I. General Information about Managed Care System

1. Indicate the activity in your state since 2000 with respect to managed care initiatives affecting behavioral health services for children and adolescents.
(Check all that apply.)

   ☐ Started a managed care system
   ☐ Terminated a managed care system
   ☐ Continued to operate a managed care system

   If a managed care initiative was terminated, explain why.

2. Specify the currently operating managed care system that you are reporting on in this form:

   Name: _____
   Implementation Date: _____
   Briefly describe this managed care system: _____
   _____

3. Which of the following best characterizes the primary focus of the system? (Check only one.)

- ☐ Medicaid reform
- ☐ Public sector behavioral health system reform
- ☐ Medicaid and public behavioral health system reform
- ☐ Children's interagency reform
- ☐ Other, Specify _____

4. What are the current goals of the managed care system? (Check all that apply.)

- ☐ Contain costs
- ☐ Increase access
- ☐ Expand service array
- ☐ Improve quality
- ☐ Improve accountability
- ☐ Other, Specify _____

5. Does this system involve the use of a Medicaid waiver?

☐ Yes ☐ No

If yes, specify type of waiver _____

6. Which of the following best characterizes the design of this system? (Check only one.)

- ☐ Integrated design (i.e., administration and financing of physical health and behavioral health are integrated, including instances where physical health plans subcontract with behavioral health plans)
- ☐ Behavioral health carve out (i.e., behavioral health financing and administration are separate from physical health financing and administration)
- ☐ Integrated with partial carve out (i.e., some behavioral health services are integrated with the physical health system while splitting out others for separate management and financing)

7. Are substance abuse services included in this system?

☐ Yes ☐ No

If no, how are the administration and financing of substance abuse services handled? (Check only one.)

- ☐ There is a separate substance abuse managed care carve out
- ☐ Substance abuse is integrated with physical health
- ☐ Substance abuse remains fee for service

8. If this system includes both physical health and behavioral health services, is there parity between physical and behavioral health services?

☐ Yes ☐ No If no, check all of the following choices that apply.

☐ Behavioral health services are subject to higher co-payments and deductibles
☐ There are lifetime limits on behavioral health services
☐ There are day and/or visit limits on behavioral health services
☐ Other, specify _____

9. Who at the state level has the lead responsibility for planning and overseeing the operation of behavioral health services for this managed care system? (Check only one.)

☐ Governor's office
☐ State health agency
☐ State Medicaid agency
☐ State mental health agency
☐ State substance abuse agency
☐ Other, Specify _____

10. For which of the following populations does the managed care system include a discrete planning process? (Check all that apply.)

☐ Adolescents with substance abuse disorders
☐ Children and adolescents with serious emotional disorders
☐ Children and adolescents involved with the child welfare system
☐ Children and adolescents involved with the juvenile justice system
☐ Culturally diverse children and adolescents
☐ No discrete planning for special populations

11. In conjunction with the managed care system, is education and training about the goals and operation of the managed care system provided to any of the following groups? (Check all that apply.)

☐ Families
☐ Providers
☐ Child welfare system
☐ Juvenile justice system
☐ Other child-serving system
☐ No training
☐ Other, Specify _____

12. In your judgment, to what extent are each of the following currently involved in planning, refining, and implementing this system?

	Not Involved	Some Involvement	Significant Involvement
Families	☐	☐	☐
State child mental health staff	☐	☐	☐
State substance abuse staff	☐	☐	☐
State child welfare staff	☐	☐	☐
State juvenile justice staff	☐	☐	☐
State education staff	☐	☐	☐
Providers	☐	☐	☐

II. Populations Included

1. What is the population covered by this system? (Check all that apply.)
   - ☐ Total Medicaid population
   - ☐ Portion of Medicaid population
   - ☐ SCHIP population
   - ☐ Non-Medicaid, non-SCHIP population
   - ☐ Other, Specify _____

2. If the total Medicaid population is **NOT** covered, which of the following subgroups are covered? (Check all that apply.)
   - ☐ N/A (Total Medicaid population is covered)
   - ☐ TANF population
   - ☐ Poverty related population
   - ☐ Aged, blind, and disabled population (SSI)
   - ☐ Pregnant women and children
   - ☐ Children and adolescents in the child welfare system (**Indicate child welfare subpopulations below**)
     - ☐ Children in child welfare who are in state custody
     - ☐ Children in child welfare who are not in state custody
   - ☐ Children and adolescents in the juvenile justice system
   - ☐ Other, Specify _____

3. If children in the child welfare system who are in state custody are covered, is their enrollment voluntary or mandatory?

   ☐ Enrollment is voluntary
   ☐ Enrollment is mandatory
   ☐ N/A (Children in state custody are not covered)

   If enrollment is voluntary, to what extent are children in state custody enrolled in the managed care system?

   ☐ Most are enrolled
   ☐ About half are enrolled
   ☐ Less than half are enrolled
   ☐ Few are enrolled
   ☐ None are enrolled

4. Are there any types of placements in which children in the child welfare or juvenile justice systems would lose eligibility for services from the managed care system?

   ☐ Yes ☐ No

   Specify placements _____

III. Managed Care Organizations

1. What types of entities are used as managed care organizations (MCOs) for behavioral health services within the managed care system, including administrative services organizations (ASOs)? (Check all that apply.)

   ☐ For-profit managed health care organizations
   ☐ Nonprofit managed health care organizations
   ☐ For-profit behavioral health managed care organizations
   ☐ Nonprofit behavioral health managed care organizations
   ☐ Private, nonprofit agencies
   ☐ Government entities
   ☐ Other, Specify _____

2. Has there been a change since 2000 in the type of entity used to manage behavioral health services in the managed care system?

   ☐ Yes ☐ No

   If yes, explain.

3. How many MCOs are used in the managed care system to manage behavioral health services? (Check only one.)

   ☐ One MCO statewide
   ☐ One MCO per region
   ☐ Multiple MCOs statewide or within regions

4. In conjunction with the system, is training or education being provided to increase the knowledge base of MCOs related to serving the following populations? (Check all that apply.)

- ☐ Children and adolescents with serious emotional disorders
- ☐ Adolescents with substance abuse disorders
- ☐ Children and adolescents with co-occurring mental health and substance abuse disorders
- ☐ Children and adolescents involved with the child welfare system
- ☐ Children and adolescents involved with the juvenile justice system
- ☐ The Medicaid population in general
- ☐ Home and community-based service approaches
- ☐ System of care values and principles
- ☐ Coordination between physical health and behavioral health services
- ☐ No training
- ☐ Other, Specify _____

IV. Service Coverage and Capacity

1. For each type of mental health service, indicate how the service is covered. (Check all that apply.)

Service **Mental Health Services**	Covered Under Managed Care System	Covered Outside Managed Care System by Another Funding Source	Not Covered by the State through any Source
Assessment and diagnostic evaluation	☐	☐	☐
Outpatient psychotherapy (individual, family, and group)	☐	☐	☐
Medical management	☐	☐	☐
Home-based services	☐	☐	☐
Day treatment/partial hospitalization	☐	☐	☐
Crisis services	☐	☐	☐
Behavioral aide services	☐	☐	☐
Therapeutic foster care	☐	☐	☐
Therapeutic group homes	☐	☐	☐
Residential treatment centers	☐	☐	☐
Crisis residential services	☐	☐	☐
Inpatient hospital services	☐	☐	☐
Case management services	☐	☐	☐
School-based services	☐	☐	☐
Respite services	☐	☐	☐
Wraparound services/process	☐	☐	☐
Family support/education	☐	☐	☐
Transportation	☐	☐	☐
Mental health consultation	☐	☐	☐
Therapeutic nursery/preschool	☐	☐	☐
Other, Specify _____	☐	☐	☐

2. For each type of substance abuse service, indicate how the service is covered. (Check all that apply.)

Service **Substance Abuse Services**	Covered Under Managed Care System	Covered Outside Managed Care System by Another Funding Source	Not Covered by the State through any Source
Assessment and diagnostic evaluation	☐	☐	☐
Outpatient psychotherapy (individual, family, and group)	☐	☐	☐
Assessment and diagnostic evaluation	☐	☐	☐
Intensive outpatient services	☐	☐	☐
Outpatient individual counseling	☐	☐	☐
Outpatient group counseling	☐	☐	☐
Outpatient family counseling	☐	☐	☐
School-based services	☐	☐	☐
Day treatment	☐	☐	☐
Ambulatory detoxification	☐	☐	☐
Residential detoxification	☐	☐	☐
Inpatient detoxification	☐	☐	☐
Residential treatment	☐	☐	☐
Inpatient hospital services	☐	☐	☐
Partial hospitalization	☐	☐	☐
Methadone maintenance	☐	☐	☐
Relapse prevention	☐	☐	☐
Case management	☐	☐	☐
Other, Specify _____	☐	☐	☐

3. Does the managed care system include coverage for both acute (i.e., episodic, short-term) and extended (longer-term) behavioral health care services? (Check only one.)

☐ Acute care only
☐ Acute and extended care
☐ Extended care only

4. What other systems also are responsible, and have behavioral health service dollars, for extended behavioral health service provision? (Check all that apply.)

- ☐ Child mental health system
- ☐ Child welfare system
- ☐ Juvenile justice system
- ☐ Education system
- ☐ Substance abuse system
- ☐ No other systems have extended care behavioral health dollars
- ☐ Other, Specify _____

5. Based on current coverage, does the managed care system expand coverage of home and community-based services for children and adolescents in comparison with the pre-managed care system?

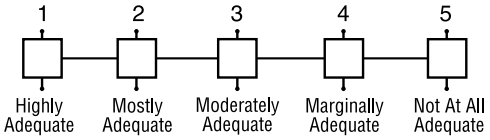
☐ Yes ☐ No

Specify services that have been added. _____

6. To what extent has the managed care system expanded the current availability of home and community-based services by bringing about the development of new service capacity?

- ☐ Not at all
- ☐ Very little
- ☐ Somewhat
- ☐ Significantly

7. On a scale of 1 to 5, characterize the current adequacy of home and community-based service capacity for behavioral health services for children and adolescents in general in your state.



8. Is the managed care system incorporating or providing incentives for providers to use evidence-based practices?

☐ Yes ☐ No

If yes, in what ways is the managed care system encouraging or providing incentives for providers to utilize evidence-based practices? (Check all that apply.)

- ☐ Incorporating contract requirements
- ☐ Developing practice guidelines
- ☐ Developing special rates
- ☐ Providing training and/or consultation
- ☐ Monitoring through quality improvement protocols
- ☐ Other, Specify _____

Specify which evidence-based practices the managed care system is encouraging providers to incorporate: _____

9. Does the state require reinvestment of savings from the managed care system back into behavioral health services for children and adolescents?

☐ Yes ☐ No

10. Have there been savings from the managed care system to reinvest?

☐ Yes ☐ No

If yes, how are they being reinvested?

11. Besides reinvestment of savings from the managed care system, is the state investing in increasing service capacity for behavioral health services for children and adolescents and their families?

☐ Yes ☐ No

12. Has the managed care system made it easier to provide more flexible/individualized services?

☐ Yes ☐ No

13. To what extent are behavioral health services to infants, toddlers, and preschoolers provided through the managed care system? (Check only one.)

☐ None are provided
☐ Few are provided
☐ Many are provided

If services are provided to infants and toddlers, list the services provided most frequently.

V. Special Provisions for Children and Adolescents with Serious and Complex Behavioral Health Needs

1. Which of the following special provisions, if any, does the managed care system include for each of the following populations of children with serious and complex behavioral health needs. (Check all that apply.)

Special Provisions	For children with serious behavioral health disorders	For children involved in the child welfare system	For children involved in the juvenile justice system
Expanded service array	☐	☐	☐
Intensive case management	☐	☐	☐
Interagency treatment and service planning	☐	☐	☐
Wraparound services/process	☐	☐	☐
Family support services	☐	☐	☐
Higher capitation or case rates	☐	☐	☐
Flexible service dollars	☐	☐	☐
Other, specify	☐	☐	☐

2. What effect has the managed care system had on the provision of case management/care coordination services for children with serious and complex behavioral health needs? (Check only one.)

   ☐ Increased case management/care coordination services
   ☐ Decreased case management/care coordination services
   ☐ No effect

3. From the following list, check the system of care values and principles that are incorporated into the system's RFPs and contracts. (Check all that apply.)

   ☐ Broad array of community-based services
   ☐ Family involvement
   ☐ Individualized, flexible care
   ☐ Interagency treatment and service planning
   ☐ Case management
   ☐ Cultural competence
   ☐ None of the above values and principles

4. Does the managed care system facilitate and support the development and operation of local systems of care (defined as organized delivery systems for children with serious and complex behavioral health disorders that incorporate the above values and principles)?

☐ Yes ☐ No

VI. Financing and Risk

1. What dollars contribute to financing the managed care system? (Check all that apply)

Agency Source	Type of Revenue						
	Medicaid	General Revenue	Block Grant	Child Welfare (e.g. Title IV-E, IV-B)	TANF	SCHIP	Other, Specify
Medicaid Agency	☐	☐	☐	☐	☐	☐	☐
Mental Health Agency	☐	☐	☐	☐	☐	☐	☐
Child Welfare Agency	☐	☐	☐	☐	☐	☐	☐
Juvenile Justice Agency	☐	☐	☐	☐	☐	☐	☐
Education Agency	☐	☐	☐	☐	☐	☐	☐
Substance Abuse Agency	☐	☐	☐	☐	☐	☐	☐
Health Agency	☐	☐	☐	☐	☐	☐	☐
MR/DD Agency	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

2. Which systems are using Medicaid dollars for behavioral health services outside of the managed care system? (Check all that apply.)

☐ Mental Health
☐ Child Welfare
☐ Juvenile Justice
☐ Education
☐ Substance Abuse
☐ Health
☐ MR/DD
☐ No systems are using Medicaid dollars outside the managed care system.
☐ Other, Specify _____

3. Is cost shifting occurring between the managed care system and other children's systems? (Check all that apply.)

- ☐ Cost shifting is not occurring
- ☐ Cost shifting is occurring from the managed care system to other child-serving systems
- ☐ Cost shifting is occurring from other child-serving systems into the managed care system

4. Does the managed care system incorporate strategies to clarify responsibility for providing and paying for services across child-serving systems?

☐ Yes ☐ No

5. Does the managed care system involve use of capitation or case rate financing? (Check all that apply.)

- ☐ Capitation
- ☐ Case rates
- ☐ Neither capitation nor case rate financing

6. Have the capitation or case rates increased or decreased since 2000?

- ☐ Rates have increased
- ☐ Rates have decreased
- ☐ Rates have stayed the same
- ☐ N/A (Neither capitation nor case rates are used)

7. Does the managed care system assess the sufficiency of capitation or case rates for behavioral health services to children and adolescents, including high-need populations?

☐ Yes ☐ No ☐ N/A (Neither capitation nor case rates are used)

If yes, have rate adjustments been made based on these assessments?

☐ Yes ☐ No

8. If capitation or case rates include both physical and behavioral health, does the state require that a specified percentage of the rate be allocated to behavioral health care?

☐ Yes ☐ N/A (Neither capitation nor case rates are used)
☐ No ☐ There are separate rates for behavioral health

If yes, specify percentage _____

9. Does the managed care system incorporate risk adjusted rates for any of the following populations? (Check all that apply.)

- ☐ Children involved in the child welfare system
- ☐ Children involved in the juvenile justice system
- ☐ Children with serious behavioral health disorders
- ☐ No risk adjusted rates are incorporated
- ☐ Other, Specify _____

10. Does the managed care system incorporate other types of risk adjustment mechanisms? (Check all that apply.)

- ☐ Stop loss
- ☐ Risk corridors
- ☐ Reinsurance
- ☐ Risk pools
- ☐ No risk adjustment mechanisms are incorporated
- ☐ Other, Specify _____

11. In what way do the state and MCOs share the financial risks and benefits? (Check only one.)

- ☐ MCOs have all the benefit and all the risk
- ☐ State has all the benefit and all the risk
- ☐ MCOs and state share risk and share benefit
- ☐ MCO and state share risk only
- ☐ MCO and state share benefit only

12. In what ways is risk shared with providers? (Check all that apply.)

- ☐ Providers have no risk
- ☐ Subcapitation
- ☐ Case rates
- ☐ Bonuses/penalties tied to performance

13. Does the state put a limit on MCO profits?

☐ Yes ☐ No

14. Does the state put a limit on MCO administrative costs?

☐ Yes ☐ No

15. Does the system incorporate bonuses or penalties for MCOs based on performance related to behavioral health service delivery to children and adolescents?

☐ Yes ☐ No

16. If capitation or case rates are used, please complete the following matrix as applicable.

Population	**Amount of Capitation Rate** (Specify if annual or monthly)	**Amount of Case Rate** (Specify if annual or monthly)
Adults and children and adolescents-physical and behavioral health		
Children and adolescents — physical and behavioral health		
Adults and children and adolescents — behavioral health only		
Children and adolescents — behavioral health only		
Adults — behavioral health only		
Children and adolescents with serious emotional disorders		
Adults with serious and persistent mental illnesses		
Adolescents with substance abuse disorders		
Children and adolescents in the child welfare system		
Children and adolescent in the juvenile justice system		
Other, Specify _____		

VII. Clinical Decision Making and Mangement Mechanisms

1. Do medical necessity criteria allow for consideration of psychosocial and environmental considerations in clinical decision making?

   ☐ Yes ☐ No

   If yes, characterize the interpretation and application of medical necessity criteria by MCOs. (Check only one.)

   ☐ Medical necessity criteria are interpreted narrowly by MCOs
   ☐ Medical necessity criteria are interpreted broadly to include psychosocial and environmental considerations

2. Does the managed care system incorporate the following clinical decision making criteria? (Check all that apply.)

   ☐ Level of care criteria specific to children's mental health services
   ☐ Patient placement criteria specific to adolescent substance abuse treatment
   ☐ No child-specific clinical decision making criteria

3. Overall, has the use of clinical decision making criteria improved consistency in clinical decision making?

   ☐ Yes ☐ No

   If no, explain.

4. Are clinical decision making criteria standardized across the state? (Check only one.)

   ☐ Criteria are standardized across the state
   ☐ Criteria differ with each MCO

5. Which management mechanisms, if any, are utilized in the delivery of behavioral health services under this system? (Check all that apply.)

   ☐ Prior authorization
   ☐ Concurrent review
   ☐ Retrospective review
   ☐ Case management
   ☐ No management mechanisms are used
   ☐ Other, Specify

6. Does the managed care system allow for the provision of certain services up to a specified amount without prior authorization?

   ☐ Yes ☐ No

   If yes, describe services allowable without prior authorization.

7. Does the managed care system utilize specific strategies for managing the use of more intensive services, such as residential treatment services?

   ☐ Yes ☐ No

   If yes, describe strategies.

VIII. Access

1. **Currently**, how is initial access to a basic level of behavioral health services for children and adolescents affected by the managed care system in comparison to pre-managed care? (Check only one.)

   ☐ Initial access to behavioral health services is better
   ☐ Initial access to behavioral health services is worse
   ☐ No change

2. **Currently**, how is access to extended care services for children and adolescents (i.e., care extending beyond short-term stabilization) affected by the managed care system in comparison to pre-managed care? (Check only one.)

   ☐ Access to extended care behavioral health services is better
   ☐ Access to extended care behavioral health services is worse
   ☐ No change

3. **Currently**, what effect is the managed care system having on waiting lists for children's behavioral health services in comparison to pre-managed care? (Check only one.)

   ☐ Waiting lists are shorter
   ☐ Waiting lists are longer
   ☐ No change

4. **Currently**, is the managed care system having any of the following effects on access to behavioral health inpatient services for children and adolescents in comparison to pre-managed care? (Check all that apply)

   ☐ Initial access is easier
   ☐ Initial access is more difficult
   ☐ Average lengths of stay are shorter
   ☐ Average lengths of stay are longer
   ☐ No change

5. If access is more difficult or lengths of stay are shorter, indicate which, if any, of the following have resulted. (Check all that apply.)

   ☐ N/A (Access is not more difficult and lengths of stay are not shorter)
   ☐ Premature discharge before stabilization from inpatient settings
   ☐ Children discharged without needed services
   ☐ Placement in community-based services lacking appropriate clinical capacity
   ☐ Increased use of residential treatment services as a substitute for inpatient
   ☐ Inappropriate use of child welfare emergency shelters
   ☐ Inappropriate use of juvenile justice facilities
   ☐ Discharge without a safe placement for children in child welfare
   ☐ No negative effects have occurred.
   ☐ Other, Specify

6. Has the managed care system led to the development of treatment alternatives to hospitalization?

   ☐ Yes ☐ No

   Specify the types of alternatives that have developed.

IX. Service Coordination

1. **Currently**, what effect is the managed care system having on coordination between physical health and behavioral health services in comparison to pre-managed care? (Check only one.)
   - ☐ Coordination between physical health and behavioral health services is better
   - ☐ Coordination between physical health and behavioral health services is worse
   - ☐ No effect

2. **Currently**, what effect is the managed care system having on coordination between mental health and substance abuse services in comparison to pre-managed care? (Check only one.)
   - ☐ Coordination between mental health and substance abuse services is better
   - ☐ Coordination between mental health and substance abuse services is worse
   - ☐ No effect

3. **Currently**, what effect is the managed care system having on interagency coordination in general? (Check only one.)
   - ☐ Interagency coordination is better
   - ☐ Interagency coordination is worse
   - ☐ No effect

4. **Currently**, what effect is the managed care system having on coordination between mental health and child welfare services in comparison to pre-managed care? (Check only one.)
   - ☐ Coordination between mental health and child welfare services is better
   - ☐ Coordination between mental health and child welfare services is worse
   - ☐ No effect

X. Early Identification and Intervention

1. Are EPSDT screens conducted within the managed care system?
   - ☐ Yes ☐ No

2. Is there a behavioral health component to the EPSDT screening process within the managed care system?
   - ☐ Yes ☐ No

3. Are there incentives or strategies to encourage primary care practitioners to conduct EPSDT screens and to make appropriate referrals for behavioral health care?

☐ Yes ☐ No

If yes, specify which types of strategies or incentives are used. (Check all that apply.)

☐ Contract requirement
☐ Performance incentives
☐ Training
☐ Monitoring for compliance
☐ Monitoring behavioral health referrals
☐ Development and inclusion of a behavioral health component for EPSDT screens
☐ Enhanced rates for conducting screens
☐ Providing information to primary care practitioners on referral options for behavioral health care
☐ Other, Specify _____

4. Is the managed care system responsible for screening children in the child welfare system who enter state custody to identify mental health problems and treatment need?

☐ Yes ☐ No ☐ N/A (Children in state custody are not covered)

If yes, to what extent is screening actually conducted?

☐ Most children are screened
☐ Some children are screened
☐ Few children are screened
☐ No children are screened

XI. Cultural Competence

1. Which of the following strategies related to cultural competence are incorporated in the managed care system? (Check all that apply.)

☐ Specific planning for culturally diverse populations
☐ Requirements in RFPs and contracts related to cultural competence
☐ Training of MCOs and/or providers on cultural competence
☐ Outreach to culturally diverse populations
☐ Inclusion of specialized services needed by culturally diverse populations
☐ Inclusion of culturally diverse providers in provider networks
☐ Translation/interpreter services
☐ Tracking utilization and/or outcomes by culturally diverse groups
☐ None
☐ Other, Specify _____

2. Characterize the current cultural competence requirements in the managed care system as compared with the previous system. (Check only one.)
   - ☐ Cultural competence requirements are stronger in the managed care system
   - ☐ Cultural competence requirements are weaker in the managed care system
   - ☐ No change

XII. Family Involvement

1. Which of the following strategies related to family involvement are incorporated in the managed care system? (Check all that apply.)
   - ☐ Requirements in RFPs and contracts for family involvement at the system level
   - ☐ Requirements in RFPs, contracts, and service delivery protocols for family involvement in planning and delivering services for their own children
   - ☐ Focus in service delivery on families in addition to the identified child
   - ☐ Coverage for and provision of family supports
   - ☐ Use of family advocates
   - ☐ Hiring family and/or youth in paid staff roles
   - ☐ None
   - ☐ Other, Specify _____

2. Characterize the current family involvement requirements in the managed care system as compared with the previous system. (Check only one.)
   - ☐ Family involvement requirements are stronger in the managed care system
   - ☐ Family involvement requirements are weaker in the managed care system
   - ☐ No change

3. Does the managed care system pay for services to family members if only the child is covered?
   - ☐ Yes ☐ No

4. What effect has the managed care system had on the pre-existing issue of families having to relinquish custody to access behavioral health services? (Check only one.)
   - ☐ Practice of relinquishing custody has worsened under managed care
   - ☐ Practice of relinquishing custody has improved under managed care
   - ☐ No effect
   - ☐ N/A (Families do not relinquish custody to child welfare to access behavioral health services)

5. Does the managed care system incorporate strategies to help families navigate the grievance and appeals process and how to use it?
   - ☐ Yes ☐ No

6. Is the state funding a family organization to play some role in the managed care system?

☐ Yes ☐ No

If yes, describe role.

XIII. Providers

1. Are the following types of providers included in provider networks in the managed care system? (Check all that apply.)

☐ Child welfare providers
☐ School-based behavioral health providers
☐ Certified addictions counselors
☐ Culturally diverse and indigenous providers
☐ Family members as providers
☐ Paraprofessionals and student interns
☐ None of the above are included providers

2. Are certification or credentialing requirements in the managed care system impeding the inclusion of particular types of behavioral health service providers?

☐ Yes ☐ No

If yes, explain.

3. Since 2000, have provider reimbursement rates in the managed care system increased or decreased? (Check only one.)

☐ Provider reimbursement rates are higher
☐ Provider reimbursement rates are lower
☐ No change

4. Since 2000, has administrative burden for providers in the managed care increased or decreased? (Check only one.)

☐ Administrative burden is higher
☐ Administrative burden is lower
☐ No change

5. **Currently**, is the managed care system resulting in closure or severe financial hardship for particular types of children's behavioral health agencies?

☐ Yes ☐ No

If yes, explain.

6. Do front-line practitioners have the skills, knowledge, and attitudes to function effectively to meet the goals of the managed care system?

☐ Yes ☐ No

XIV. Accountability

1. Does the managed care system have adequate data to inform decision making with respect to behavioral health services for children and adolescents and their families?

   ☐ Yes ☐ No

   If adequate data are not available, indicate the reasons why. (Check all that apply.)

   ☐ Lack of encounter data
   ☐ Lack of staff capacity to analyze data
   ☐ Inadequate MIS system
   ☐ Not tracking children's behavioral health services
   ☐ Other, Specify _____

2. Does the managed care system incorporate quality measures specific to behavioral health services for children and adolescents and their families?

   ☐ Yes ☐ No

3. How are families involved in the quality measurement process? (Check all that apply.)

   ☐ Not involved
   ☐ Focus groups
   ☐ Surveys
   ☐ Involved in the design of the quality measures and/or process
   ☐ Involved in monitoring the quality measurement process
   ☐ Other, Specify _____

4. Characterize the stage of development of the measurement of clinical and functional outcomes specific to behavioral health services for children and adolescents. (Check only one.)

   ☐ Not measuring clinical and functional outcomes
   ☐ In early stage of developing measurement system
   ☐ Developed but not yet implemented measurement system
   ☐ Implementing measurement system but do not yet have results
   ☐ Implementing measurement system and have results

5. Does the managed care system measure parent and youth satisfaction with behavioral health services? (Check all that apply.)

   ☐ Not measuring parent or youth satisfaction
   ☐ Measuring parent satisfaction
   ☐ Measuring youth satisfaction

6. If there is a formal evaluation of the system, does it include a focus on children and adolescents with behavioral health disorders and their families?

   ☐ Yes ☐ No ☐ N/A (No formal evaluation)

7. Indicate by checking which, if any, of the following system performance information is tracked by the managed care system and whether data are being used to inform decision making. (Check all that apply.)

System Information	Not Tracked	Tracked	Information is Used for System Planning
Child behavioral health penetration rates	☐	☐	☐
Child behavioral health service utilization	☐	☐	☐
Child behavioral health service utilization by culturally diverse groups	☐	☐	☐
Behavioral health service utilization by children in child welfare	☐	☐	☐
Behavioral health service utilization by children in juvenile justice	☐	☐	☐
Total cost of child behavioral health services	☐	☐	☐
Cost per child served with behavioral health services	☐	☐	☐
Cost shifting among child-serving systems	☐	☐	☐

8. What has been the impact of the managed care system on the following system performance indicators?

System Information	Increased	Decreased	No Effect	Don't Know
Child behavioral health penetration rates	☐	☐	☐	☐
Child behavioral health service utilization	☐	☐	☐	☐
Total cost of child behavioral health services	☐	☐	☐	☐
Overall quality of child behavioral health services	☐	☐	☐	☐
Overall clinical and functional outcomes	☐	☐	☐	☐
Overall family satisfaction with services	☐	☐	☐	☐
Incorporation of evidence-based interventions	☐	☐	☐	☐

XV. General Update

1. Is the current fiscal climate (e.g., state budget deficit) having any detrimental effect on your managed care system?

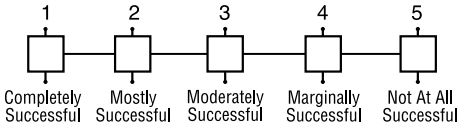
   ☐ Yes ☐ No

   If yes, indicate what detrimental effects the current economic climate is having on the behavioral health managed care system in your state. (Check all that apply.)

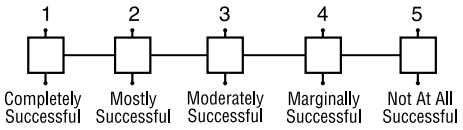
   ☐ Lowered the federal poverty level eligibility cut-off
   ☐ Eliminated specific populations from eligibility for the managed care system
   ☐ Reduced coverage of services (e.g., eliminated coverage for certain services)
   ☐ Reduced levels of service (i.e., number of visits, length of stay, duration of services)
   ☐ Incorporated or raised co-pays
   ☐ Decreased provider reimbursement rates
   ☐ Decreased capitation or case rates to MCOs
   ☐ Implemented more stringent authorization procedures, guidelines, or policies
   ☐ Changed drug formulary
   ☐ Reduced services to non-Medicaid, uninsured children and adolescents
   ☐ Reduced interagency coordination
   ☐ Other, Specify _____

2. In your opinion, how successful has the managed care system in your state been at achieving the following goals of managed care?

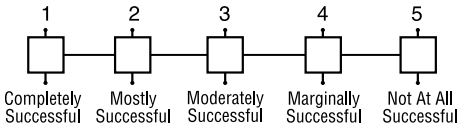
Containing costs



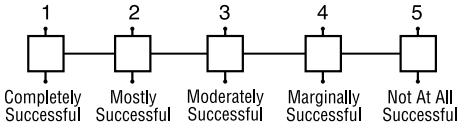
Increasing access



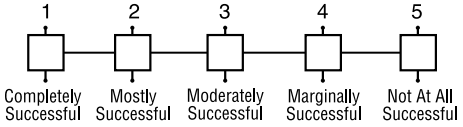
Expanding service array



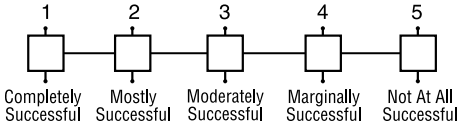
Improving quality



Improving accountability



Other, Specify



3. Indicate the future plans of your state with respect to managed behavioral health care. (Check all that apply.)

- ☐ Plan to continue to use managed care technologies to manage behavioral health service delivery
- ☐ Plan to phase out managed care
- ☐ Plan to move to a non-risk-based system
- ☐ Plan to increase use of administrative services organizations (ASOs)
- ☐ Other, Specify

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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.

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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 #213) No PDF available.

HCRTP Promising Approaches Series

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.

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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.

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

2003 State Survey

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
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National Technical Assistance Center for Children's Mental Health
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