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.