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.