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.