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

## Incorporation of Special Provisions for High-Need Populations

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

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

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

**Table 41**

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

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

NA=Not Applicable

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

## Types of Special Provisions

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

**Table 42**

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

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

NA=Not Applicable

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

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

**Table 43**

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

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

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

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

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

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

**Table 44**

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

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

## Support and Facilitation of Systems of Care

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

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

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

**Table 45**

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

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

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

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

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

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

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

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

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

NA=Not Applicable

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