VII. Financing and Risk

Agency Financing Sources for Managed Care Systems

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

Table 47

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

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

NA=Not Applicable

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

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

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

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

Table 48

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

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

Types of Revenue Used To Finance Managed Care Systems

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

Table 49

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

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

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

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

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

Table 50

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

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

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

Table 51

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

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

Table 52

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

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

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

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

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

Use of Medicaid Outside of Managed Care Systems

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

Table 53

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

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

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

Table 54

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

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

Cost Shifting

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

Table 55

Percent of Managed Care Systems with Reports of Cost Shifting

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

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

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

Table 56

Percent of Reforms Tracking and Monitoring Cost Shifting

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

Clarification of Responsibility Across Child-Serving Systems

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

Table 57

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

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

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

Use of Risk-Based Financing

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

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

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

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

NA=Not Applicable

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

Table 59
Examples of Capitation or Case Rate Approaches by State

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

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

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

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

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

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

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

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

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

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

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

Rate Changes and Sufficiency Assessments

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

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

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

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

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

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

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

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

Table 63

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

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

Required Allocation of a Percentage of the Rate to Behavioral Health

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

Table 64

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

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

NA=Not Applicable

Use of Risk Adjusted Rates and Other Risk Adjustment Mechanisms

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

Table 65

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

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

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

Table 66

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

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

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

Table 67

Percent of Managed Care Systems that Incorporate Various Risk Adjustment Mechanisms

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

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

Risk Sharing

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

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

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

NA=Not Applicable

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

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

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

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

Table 70

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

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

NA=Not Applicable

Limits on MCO Profits and Administrative Costs

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

Table 71

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

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

MCO Performance Incentives

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

Table 72

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

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