
XII. HIGHLIGHTS AND ISSUES FOR FURTHER CONSIDERATION

This section highlights the major findings of the 1997-98 State Survey, presenting them according to: 1) changes that have occurred since the 1995 survey, 2) areas that have remained constant since 1995, and 3) differences between reforms with carve out and integrated designs. In addition, issues needing further consideration are identified, based upon results of the 1995 and 1997-98 surveys as well as the 1997 Impact Analysis.

Changes Since the 1995 State Survey

The 1997-98 State Survey found the following changes to have occurred in state managed care activity since the 1995 baseline state survey:

State Involvement in Managed Care

- A 12% larger majority of states reported involvement in managed care reforms in 1997-98 than in 1995. Ninety-eight percent of states (all but one) reported involvement in managed care activity affecting behavioral health service delivery to children and adolescents and their families in 1997-98, compared to 86% (all but seven states) in 1995.
- States are developing greater experience with managed care, with over half of the states (52%) reporting that they are in mid to late stage implementation of their managed care reforms, compared to 1995, in which only 21% of states reported being that far along.

Involvement of Key Stakeholders in System Planning and Refinement

- While families are more involved in the planning and implementation of managed care reforms in 1997-98 than they were in 1995, they reportedly still lack *significant* involvement in 60% of managed care reforms.
- Child welfare systems also have increased their role in planning and implementation of reforms since 1995, but, like families, reportedly still lack significant involvement in over 60% of reforms.
- State substance abuse agency staff were the least likely stakeholder group to have increased their involvement in the planning and implementation of managed care reforms, with a reported lack of significant involvement in 80% of reforms.
- While state child mental health staff were the most likely stakeholder group to increase their involvement in the planning and implementation of managed care reforms since 1995, they reportedly continue to lack significant involvement in nearly half (47%) of reforms.

Types of Managed Care Organizations (MCOs) Used

- There has been a reported increase in the states' use of for-profit managed care companies since 1995, with 47% of reforms utilizing commercial companies in 1997-98, compared to 33% of reforms in 1995.

-
- There has been an increase in the use of government entities as managed care organizations since 1995, with 29% of reforms utilizing government entities as MCOs in 1997-98, compared to 20% of reforms in 1995.

Differential Coverage for Children and Adolescents with Serious Disorders

- There has been a slight (5%) growth in incorporation in managed care reforms of differential coverage for children and adolescents with serious disorders since 1995. There has been an even larger growth (31%) in differential coverage for adults with serious and persistent mental illness.
- There has been a 36% increase since 1995 in reforms including the SSI (Supplemental Security Income) population in managed care systems.

Risk Structuring

- States report a small increase in the use of risk-based financing since 1995, with 92% of reforms in 1997-98 reportedly using capitation or case rate financing, compared to 88% of reforms in 1995.
- There has been a reported reduction in the percentage of reforms using risk adjustment mechanisms for children and adolescents with serious disorders, with 47% of reforms reportedly utilizing risk adjustment mechanisms in 1997-98, compared to 61% in 1995.
- There has been greater movement since 1995 in states' pushing full risk to managed care organizations, with MCOs having full risk in 72% of reforms in 1997-98, compared to 31% of reforms in 1995.

Outcomes Monitoring

- There has been a reported 14% increase since 1995 in the percentage of reforms that are using families of children and adolescents with behavioral health problems and providers as sources of information in outcomes monitoring.

Findings Remaining Constant Since the 1995 State Survey

The 1997-98 State Survey found the following to have remained unchanged since 1995:

Statewide Reforms, Not Demonstrations

- As in 1995, most state managed care reforms (77%) were reported to be statewide, rather than demonstration projects.

Inclusion of Substance Abuse

- As in 1995, substance abuse services were more likely to be included in integrated physical health/behavioral health reforms (93%) than in behavioral health carve outs (71%).

Planning and Oversight Authority

- As in 1995, state Medicaid agencies play the dominant role in planning and overseeing most managed care reforms, with Medicaid reportedly having or sharing lead responsibility in nearly three-quarters of reforms, compared to state mental health agencies' having or sharing the lead in slightly over half of reforms and state substance abuse agencies having or sharing a lead role in about one quarter of reforms.

Financing and Risk Structuring

- States reported little change since 1995 in the types of dollars used to finance managed care reforms, with 100% of reforms involving Medicaid dollars, 56% involving mental health dollars, 32% involving child welfare monies, and 27% using substance abuse dollars.
- There was no reported instance in 1997-98 of states with integrated designs requiring that a certain percentage of the capitation be allocated to behavioral health services.
- Half of reforms reportedly push risk down to the service provider level.

Comparison between Reforms with Carve Out and Integrated Designs

In addition to reporting on the current status and changes in state managed care activity, the 1997-98 State Survey allowed for comparisons between states with behavioral health carve outs (defined as reforms in which behavioral health financing and administration are separate from the financing and administration of physical health services) and states with integrated physical health/behavioral health designs (in which the financing and administration of physical and behavioral health are integrated). Among the differences between carve outs and integrated reforms reported by stakeholders in the 1997-98 state survey are the following.

Planning, Orientation and Training

- Families were three times as likely to be involved in planning carve outs than in planning integrated reforms.
- Planning for integrated reforms was less likely to include a discrete planning focus on any of the following special populations of children and adolescents: children with serious emotional disorders (20% of integrated reforms included this focus, compared to 78% of carve outs); children involved in the child welfare system (33% of integrated reforms, compared to 56% of carve outs); adolescents with substance abuse problems (20% of integrated reforms, compared to 26% of carve outs); culturally diverse children and adolescents (7% of integrated reforms, compared to 26% of carve outs).
- Integrated reforms were twice as likely *not* to provide training and orientation related to the goals and operations of managed care reforms for stakeholder groups, such as families, providers and child welfare systems, than carve outs.

-
- Carve outs were two to three times as likely to provide training and orientation for MCOs and providers related to adolescent substance abuse treatment, children with serious emotional disorders or child welfare system issues.

Design Issues

- Nearly two-thirds of carve outs (64%) incorporate differential coverage for children in general, compared to 53% of integrated reforms, and over half of carve outs (57%) provide differential coverage for children with serious disorders, compared to one-third (33%) of integrated reforms.
- Most carve outs (89%) were reported to provide both acute care (i.e., brief, short-term treatment) and some level of extended care, compared to fewer than half (47%) of integrated reforms that provide both acute and some extended care.
- Carve outs are more likely to incorporate system of care values and principles in managed care policy documents and contract requirements than integrated reforms, with 89-96% of carve outs reportedly incorporating system of care goals, compared to 40-67% of integrated reforms.
- Over half (52%) of carve outs include special management mechanisms for children with serious disorders, compared to 36% of integrated reforms.
- Virtually all integrated reforms (96%) utilize multiple statewide MCOs, in comparison to only 27% of carve outs that do so. (The Tracking Project's 1997 Impact Analysis found that use of multiple MCOs creates problems for families, providers and child welfare systems in that each MCO uses different authorization, billing, credentialing and reporting processes, interprets medical necessity differently and utilizes different provider networks.)

Service Delivery

- Three-quarters of carve outs reportedly expand home and community-based services for children and adolescents with behavioral health problems, compared to only 20% of integrated reforms.
- Carve outs were nearly twice as likely as integrated reforms (100% versus 54%) to build on existing systems of care in their managed care service delivery systems.
- Carve outs were more likely than integrated reforms (67% versus 45%) to have case management systems that include traditional public sector functions of advocacy, brokering and linkage to services, in addition to traditional managed care case management functions of utilization management.
- Carve outs were more likely than integrated reforms (45% versus 29%) to have made changes in medical necessity definitions to reflect psychosocial necessity criteria.

-
- Carve outs were over twice as likely to have level of care criteria in place for children with serious disorders than integrated reforms (81% versus 38%), and over seven times as likely to have practice guidelines for adolescent substance abuse treatment (58% versus 7%).
 - Eighty-eight percent of carve outs reportedly include provisions to ensure the inclusion of culturally diverse and indigenous providers in service delivery networks, compared to 64% of integrated reforms.

Financing

- Carve outs reportedly were over nine times as likely to place limits on MCO profits as integrated reforms (75% versus 8%), and over three times as likely to place limits on MCO administrative costs (80% versus 23%).
- There was no reported instance of an integrated reform's requiring reinvestment of savings back into child and adolescent behavioral health services, while 76% of carve outs reportedly have such requirements.
- Integrated reforms were less likely than carve outs to blend funds from across systems to finance managed care, relying mainly on Medicaid dollars.
- Carve outs were more likely than integrated reforms (61% versus 43%) to have changed capitation rates based on actual experience with managed care.
- Nearly three-quarters of carve outs (71%) reportedly have built in mechanisms to adjust rates based on actual experience with managed care, compared to half (50%) of integrated reforms.
- Over half of carve outs (52%) reportedly are financing family organizations to play some formal role in implementation and/or monitoring of managed care, compared to 31% of integrated reforms.

Monitoring

- There was no reported instance of carve outs' not involving families of children and adolescents with behavioral health problems in some way in quality assurance processes, while nearly a third (31%) of integrated reforms reportedly do not include these families in quality assurance processes, even though all of these reforms are providing behavioral health services.
- One hundred percent of carve outs reportedly include a quality assurance focus on children and adolescents with behavioral health services, compared to 62% of integrated reforms.
- Eighty-two percent of carve outs reportedly monitor clinical outcomes for children and adolescents with behavioral health problems, compared to fewer than a quarter (23%) of integrated reforms.
- Virtually all carve outs (96%) reportedly measure satisfaction of families who have children and adolescents with behavioral health problems, compared to only 62% of integrated reforms.

-
- Three-quarters of carve outs (75%) reportedly measure youth satisfaction, compared to only 38% of integrated reforms.
 - Virtually all carve outs (93%) reportedly use families of children and adolescents with behavioral health problems as sources of information for outcomes monitoring, compared to 55% of integrated reforms.
 - Forty-four percent of carve outs reportedly utilize family organizations (i.e., families of children and adolescents with behavioral health disorders) in formal ways to monitor outcomes, compared to none of the integrated reforms.
 - Carve outs reportedly are almost twice as likely than integrated reforms (48% versus 27%) to use child welfare systems as sources of information for monitoring outcomes.

Issues for Further Consideration

- Comparisons between reforms with carve out and integrated designs corroborate findings from the Tracking Project's 1997 Impact Analysis that states with carve out designs tend to incorporate planning, design, service delivery, financing, and monitoring approaches that are more favorable to children and adolescents with behavioral health disorders than do states with integrated designs. The many differences in implications for children and adolescents with behavioral health disorders and their families between carve outs and integrated reforms found in both the 1997 Impact Analysis and the 1997-98 State Survey do not necessarily mean that there are *inherent* problems with an integrated design. However, they do suggest that states with carve outs engage in planning and implementation processes that more clearly focus on this population, and this focus leads to more favorable system characteristics. Additional attention to design differences and their impact is needed to further assess these observations.
- Reforms continue to be widespread and are implemented as statewide reforms rather than as demonstrations. However, states are further along in the reform process, and, as a result, there is a significantly larger experience base with managed care than there was in 1995. Since initial implementation, many states have made changes and refinements to their managed care systems based upon this experience. There is much to be learned from the nature of these system refinements, the problems they are designed to address, and their impact on ameliorating system issues. These changes, the basis for them, and their effects are the focus of a "maturational" analysis to be included as part of the 1999 Impact Analysis.
- Over a quarter of all reforms continue to manage mental health and substance abuse services separately. As noted in 1995, the separation of the management of mental health and substance abuse services raises concerns, given the known

co-morbidity of mental health and substance abuse disorders. It appears that the need for greater coordination and integration of mental health and substance abuse services within managed care systems remains in many states.

- In a significant proportion (40%) of all reforms, parity between behavioral health and physical health services has not been achieved, with behavioral health services subject to limits and co-payments that are not applied to physical health services. Concern during the national health care reform debate and more recently in state legislatures has focused on the parity issue. As noted in the 1995 State Survey report, arbitrary limits on behavioral health service delivery may result in greater use of hospitals instead of appropriate alternatives and, therefore, may not be as cost-effective as they appear. The same concerns about more restrictive day and visit limits and more onerous cost-sharing requirements for behavioral health remain given the results of the 1997-98 survey. Specific attention to these differential benefits for behavioral health is needed to assess their impact on access to appropriate services and on cost-effectiveness.
- The involvement of key stakeholders in planning and refining managed care systems has improved since the 1995 survey. However, when only involvement characterized as “significant” is considered, there is still a great deal of room for improvement with respect to all stakeholder groups—families, state children’s mental health staff, state substance abuse staff, and state child welfare staff. Although these stakeholders may be at the table, they do not necessarily have a significant influence in managed care planning and implementation processes. Without the significant participation of these stakeholders, the likelihood of reforms being attuned to the special needs of children is diminished. Stakeholder involvement and its effect on the design and features of managed care systems will continue to be an important focus of the Tracking Project.
- Although most reforms were reported to cover both acute and extended care services, Tracking Project findings suggest that significant behavioral health treatment dollars remain outside managed care systems to pay for extended care and services not covered by managed care systems. The fragmentation and discontinuity potentially created by the separation of acute and extended care is an issue needing further study, particularly with respect to the ability to serve children and adolescents whose treatment needs extend beyond limited, acute care. When extended care is not included in managed care systems, the need to create rational mechanisms for managing the boundaries between acute and extended care services, without compromising continuity of care, becomes paramount. Further study should be directed at the relationship between acute and extended care within managed care systems and with child-serving systems outside managed care systems.
- Many reforms, particularly those with integrated designs, limit coverage to the more traditional services typically covered by commercial insurance plans. Few of these reforms cover home-based services, respite services, wraparound

services, and other home and community-based services; carve out reforms are more likely to do so. Given widespread acceptance of the need for a wide array of home and community-based services for children and adolescents with behavioral health disorders, the effect of a limited array on children and families, as well as on the cost-effectiveness of services, is an area needing additional exploration through the impact analysis process.

- It appears that there is some recognition in the managed care planning process of the special behavioral health service needs of children. About 60% of the reforms reportedly provide differential coverage for children and adolescents, including such provisions as fewer limits, a broader service array, and increased flexibility or wraparound services. Somewhat fewer (49%) provide differential coverage or special provisions for children with serious behavioral health disorders, increased only slightly since 1995, and even fewer include special management mechanisms for this population. While some progress in attending to the needs of children in general, and to those with serious and complex problems in particular is evident, many reforms still have yet to address these needs. The incorporation of special provisions for children with serious disorders, and the effects of managed care on this population, are important areas for continued study.
- The interface between managed care reforms and previous efforts to develop community-based systems of care for children and adolescents with serious emotional disorders and their families remains murky. Findings from the 1997-98 survey indicate that managed care reforms have, to a significant extent, been built upon previous system of care development efforts and that system of care principles have been incorporated into managed care systems. These findings conflict with the results of the 1997 Impact Analysis in which stakeholders in only half of the states in the sample felt that this was the case. This relationship, and the impact of managed care reforms on systems of care, needs further exploration.
- The 1997-98 survey confirmed a trend noted in 1995 toward the use of for-profit MCOs and BHOs to manage behavioral health service delivery. This is significant given the pervasive viewpoint of stakeholders in the 1997 Impact Analysis that for-profit MCOs are accountable to shareholders, have little investment in the community, and that profits divert resources from services. Although they are seen as bringing expertise in information systems and in the technologies of managed care, they are also seen as lacking knowledge and understanding of the populations to be served—particularly children with serious behavioral health disorders. Further exploration of both the advantages and problems associated with the use of various types of MCOs is needed.
- Prior authorization is one of the most frequently used management mechanisms, according to the 1997-98 survey. Again, stakeholders interviewed in the 1997 Impact Analysis complained about these mechanisms in most states, describing

them as cumbersome, time consuming, confusing, and creating barriers to access. Providers and respondents from other child-serving systems expressed particular concerns, feeling that they caused unwarranted delays and intrusions into clinical decision-making. Some strategies were noted that reduced complaints, such as allowing a certain level of services routinely or requiring authorization only for higher levels of care. Additional investigation of strategies to make prior authorization and other management mechanisms more efficient and better accepted is needed.

- Some movement toward broadening medical necessity criteria to include consideration of psychosocial and environmental factors was noted in the 1997-98 survey, a need identified in the 1997 Impact Analysis. Also consistent with the Impact Analysis is the finding that most states (72%) reportedly use some type of clinical decision-making criteria (level of care or patient placement criteria and practice guidelines) specific to children and adolescents. Stakeholders in the Impact Analysis felt that such criteria can improve the consistency in clinical decision-making and can be beneficial, so long as they are not applied with excessive rigidity. The impact of such criteria on the ability to access appropriate levels of care also requires additional attention.
- Managed care reforms reportedly involve extensive use of capitation financing (92% of reforms); case rates are used in comparatively few reforms. Concerns about the use of prior utilization data as the basis for deriving capitation and case rates were raised in 1995 and again in the 1997 Impact Analysis. In addition, questions were raised in the 1997 Impact Analysis about the sufficiency of capitation rates to guard against underservice and to expand service capacity. Although almost two-thirds of states incorporate mechanisms to reassess and adjust rates on a regular basis, fewer than half of the reforms reported changes in rates since initial implementation. Another issue in integrated reforms is that states typically do not require that a certain percentage of the capitation be allocated to behavioral health services, often resulting in a very small amount spent on behavioral health. The 1997-98 survey revealed no instance of such a requirement. The basis for capitation, the sufficiency of rates, provisions for reassessing the adequacy of rates, and the allocation for behavioral health are among the issues needing consideration.
- The 1997 Impact Analysis identified a trend toward putting MCOs at full risk, a trend confirmed by the 1997-98 survey. Since risk adjustment mechanisms were reported in fewer than half of the reforms, the resulting incentives and effects on service delivery should be studied. In particular, the impact on service delivery to high utilizer populations, such as children with serious disorders and children in the child welfare system, should be investigated further. In the Impact Analysis sample, most reforms did not push reform down to the provider level; this is reportedly occurring in half of the reforms analyzed for the 1997-98 State Survey. Providers interviewed in the Impact Analysis were receptive to assuming risk in exchange for greater flexibility in service delivery and decision making, but most

behavioral health providers have little experience in bearing risk. Continuing trends and effects with respect to risk management should be followed.

- Families appear to be increasingly involved in managed care system oversight and refinement, according to results of the 1997-98 survey. Individual family members and family organizations typically are involved by including them on state-level advisory, oversight, and planning structures in some cases with funding to support their participation. However, while most reforms reportedly involve families in some way, “significant” involvement of families occurs in only 38% of all reforms. Although family involvement is increasing, managed care systems have yet to embrace the principle of involving families as full partners.
- While most reforms (80%) reportedly include provisions to address the inclusion of culturally diverse and indigenous providers in provider networks, the 1997 Impact Analysis found that culturally diverse and indigenous providers often are unable to participate due to the lack of infrastructure or new credentialing requirements. Further exploration of the impact of managed care on culturally diverse and indigenous providers, and their participation in provider networks, is warranted, as well as elucidation of other strategies to ensure cultural competence in managed care systems.
- Quality measurement systems were reported for all reforms; the 1997 Impact Analysis suggested that such quality measurement focuses primarily on process measures. The majority of reforms reported having process measures specific to children and adolescents, suggesting some improvement from reports received during the 1997 Impact Analysis. Access, service utilization, parent satisfaction, and cost were the most frequently measured outcomes. Similar to 1995, clinical and functional outcomes are receiving comparatively less attention. The 1997 Impact Analysis also revealed that measurement approaches for assessing clinical and functional outcomes among children and adolescents were in early stages of development. Both approaches to measuring clinical and functional outcomes in behavioral health systems, and any emerging results, are critical areas for further study.
- The impact of managed care reforms on other child-serving systems is being measured in fewer than one-third of all reforms, according to the 1997-98 survey. The 1997 Impact Analysis revealed only one beginning attempt to systematically examine this area, although cost shifting to other child-serving systems was alleged by stakeholders in most states. Given the pervasive feelings among other child-serving systems that they are feeling the effects (and costs) of more “controlled” behavioral health service delivery, more reliable information about the shifting of children and costs is essential.