# II. GENERAL INFORMATION ABOUT STATE HEALTH CARE REFORM INITIATIVES

## State Health Care Reform Activity

All 50 states, plus the District of Columbia, responded to the survey, with the vast majority of states (98%) reporting engagement in health care reform activity as of late 1997 - early 1998, when the data were collected. Table 1 shows that a 12% larger majority of states reported involvement in health care reform activity of some kind in 1997-98 than in 1995. Fifty states (98%) reported health care reform activity in 1997-98, compared to 44 states (86%) in 1995. Only one state (2%) reported no health care reform activity as of 1997-1998, compared to seven states (14%) in 1995. Nineteen states (37%) reported they are experimenting with multiple types of reforms, reflecting a small increase from the 15 states (29%) reporting multiple types of reforms in 1995.

**Table 1**

**Number and Percent of States Involved in Health Care Reform**

| Reforms | 1995 # States | 1995 % of States | 1997–98 # States | 1997–98 % of States | 95–97/98 % Change |
|---|---|---|---|---|---|
| No Reform | 7 | 14% | 1 | 2% | -12% |
| Any Reform | 44 | 86% | 50 | 98% | +12% |
| Multiple Reforms | 15 | 29% | 19 | 37% | +8% |

Matrix 1 on the next page shows the extent of state health care reform activity by state as reported.

Table 2 indicates the number and percentage of states involved in health care reform by area of focus, that is, whether their reforms are focusing on physical health only, behavioral health only, both physical and behavioral health, insurance reform, and the like. (Because of the number of states that are engaged in multiple areas of reform**,** the total number of reforms on Table 2 exceeds the total number of states.) As in 1995, most state reforms are focusing on Medicaid, and most involve application of managed care approaches.

Consistent with the finding that more states are involved in health care reform in general in 1997-98 than in 1995, 17% more states reported involvement in reform activity focusing on both the physical and behavioral health care arenas, and 4% more states reported involvement in reforms focusing on behavioral health care only. The number of states involved in reforms focusing on physical health only reportedly has held steady since 1995.

Table 2 also shows that four states (8%) reported involvement in insurance reform, down from 12% in 1995, and four states (8%) reported involvement in comprehensive health care reform, that is, reforms affecting an entire state's population; this also

## Matrix 1

## Extent of State Health Care Reform Activity as of Late 1997–Early 1998

Total Number of Reforms =73

* Other: State Reported General Behavioral Health System Reform, Not Medicaid or Managed Care

| | | No Reform | Medicaid and/or Managed Care Physical Health Only | Medicaid and/or Managed Care Behavioral Health Only | Medicaid and/or Managed Care Physical Health and Behavioral Health | Insurance Reform | Comprehensive Reform | Other* |
|---|---|---|---|---|---|---|---|---|
| Alabama | AL | | | | ● | | | |
| Alaska | AK | | | | ● | | | |
| Arizona | AZ | | | ● | | | | |
| Arkansas | AR | | | ● | ● | | | |
| California | CA | | | | ● | | | |
| Colorado | CO | | | | ● | | | |
| Connecticut | CT | | | | ● | | | |
| Delaware | DE | | | | ● | | | |
| District of Columbia | DC | | | | ● | | | |
| Florida | FL | | | ● | ● | | ● | |
| Georgia | GA | | | | | | | ● |
| Hawaii | HI | | | | ● | | | |
| Idaho | ID | | | | ● | | | |
| Illinois | IL | | | | ● | | | ● |
| Indiana | IN | | | ● | ● | | | |
| Iowa | IA | | | ● | | | | |
| Kansas | KS | | | ● | ● | | | |
| Kentucky | KY | | | | ● | ● | | |
| Louisiana | LA | | | | ● | | | ● |
| Maine | ME | | | ● | ● | | | |
| Maryland | MD | | | | ● | | | |
| Massachusetts | MA | | | | ● | | ● | |
| Michigan | MI | | | | ● | | | |
| Minnesota | MN | | | | ● | ● | ● | |
| Mississippi | MS | | ● | | | | | |
| Missouri | MO | | | | ● | | | |
| Montana | MT | | ● | ● | | | | |
| Nebraska | NE | | | | ● | | | |
| Nevada | NV | | | | ● | | | |
| New Hampshire | NH | | | | ● | | | |
| New Jersey | NJ | | | ● | ● | | | |
| New Mexico | NM | | | | ● | | | |
| New York | NY | | | | ● | | | |
| North Carolina | NC | | | ● | ● | ● | | |
| North Dakota | ND | | | | ● | | | |
| Ohio | OH | | | | ● | | | |
| Oklahoma | OK | | | | ● | | | |
| Oregon | OR | | | | ● | | ● | |
| Pennsylvania | PA | | | | ● | | | |
| Rhode Island | RI | | | | ● | | | |
| South Carolina | SC | | | ● | ● | | | |
| South Dakota | SD | | ● | | | | | |
| Tennessee | TN | | | | ● | | | |
| Texas | TX | | | ● | ● | ● | | |
| Utah | UT | | | | ● | | | |
| Vermont | VT | | | | ● | | | |
| Virginia | VA | | ● | ● | | | | |
| Washington | WA | | | ● | ● | | | |
| West Virginia | WV | | ● | | | | | |
| Wisconsin | WI | | | ● | ● | | | |
| Wyoming (No Reform) | WY | ● | | | | | | |
| N=51 | | 1 | 5 | 15 | 42 | 4 | 4 | 3 |

**Table 2**

**Number and Percent of States Involved in Health Care Reform by Focus of Reform**

| Focus of Reform | 1995 # States | 1995 % of States | 1997–98 # States | 1997–98 % of States | 95–97/98 Change |
|---|---|---|---|---|---|
| Medicaid and/or Managed Care Reform Physical Health Only | 5 | 10% | 5 | 10% | 0% |
| Medicaid and/or Managed Care Reform Behavioral Health Only | 13 | 25% | 15 | 29% | +4% |
| Medicaid and/or Managed Care Reform Physical Health and Behavioral Health | 33 | 65% | 42 | 82% | +17% |
| Insurance Reform | 6 | 12% | 4 | 8% | -4% |
| Comprehensive Reform | 5 | 10% | 4 | 8% | -2% |
| Other | 0 | 0% | 3 | 6% | +6% |

represents a slight decline from 1995. Again, it should be noted that states may be undertaking several types of reform simultaneously. Further, because this survey had a bias toward capturing information about reforms affecting behavioral health service delivery, states may have under-reported their involvement in reforms affecting physical health only, insurance reform, and others.

As Table 2 indicates, respondents reported a total of 73 reforms occurring in 50 states. However, with respect to reforms involving managed care approaches with implications for children and adolescents with behavioral health problems and their families—the primary focus of the Health Care Reform Tracking Project—respondents provided more detailed descriptive data on 43 reforms occurring in 39 states. *All of the data that follow pertain to these 43 reforms underway in 39 states.*

Table 3, pages 8 through 18, describes the 43 reforms that are analyzed in this report. Table 3 also draws from a report prepared by the Lewin Group for the SAMHSA Managed Care Tracking System that profiles public sector managed behavioral health care and other reforms[1].

## Design Characteristics

Of the 43 managed care reforms described by states as being underway or in the planning stages, 28 of them, or 65%, were characterized as behavioral health "carve-outs," defined as reforms in which behavioral health financing and administration are separate from (that is, "carved out" from) the financing and administration of physical health services (Table 4). Fifteen of the 43 reforms (35%) were characterized as

[1] *The Lewin Group* (1998). SAMHSA managed care tracking system: State profiles of public sector managed behavioral healthcare and other reforms. Rockville, MD: Substance Abuse and Mental Health Services Administration.

## Table 3

## Description of State Health Care Reforms

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Alaska | New regulations require prior authorization of mental health rehab services; planning underway for a MH carve out | N/A | MH carve out being planned | Planning | N/A |
| Arizona | AZ has had an 1115 waiver since beginning of Medicaid. OBRA 89 allowed for expansion to include MH services for children. Beginning 10/90, AZ began a phase-in of a capitated, managed MH program, first with children and adults with serious mental illness, then adult substance abuse and general MH. | 1115 | BH carve out | Late | Revised capitation rates paid to local community based nonprofits responsible for providing full continuum of care; new rates based on utilization and population in each geographic area; encouraged regional nonprofit agencies to form networks, employ risk-based subcontracts and use managed care principles. |
| Arkansas | "Benefit Arkansas" is a behavioral health managed care program for children and adolescents under age 21; covers 120,000 eligible lives. | 1915(b) | BH carve out | Early | N/A |
| California | Medicaid MH services previously were delivered in two separate programs, one administered by the state and one by the counties. CA's reform consolidates these two programs at the county level. | 1915(b) | MH carve out | Middle | N/A |
| Colorado | CO operates a capitated statewide managed care program for Medicaid MH services. | 1915(b) | MH carve out | Middle | There has been increased involvement of families, coordination with the child welfare system and with EPSDT. MCOs are now required to involve family advocates. |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Connecticut | "Connecticut Access" enrolls 216,000 AFDC and related subgroups into one of 11 health plans providing physical and behavioral health services. | 1915(b) | Integrated PH/BH | Middle | 1. Improved/created a definition of medically necessary services for behavioral health treatment of children that includes chronic, long term care and prevention.<br>2. Made change to allow for disenrollment of children entering state psychiatric hospital.<br>3. New requirement that MCOs provide step-down care for child welfare population.<br>4. Improved language for EPSDT compliance. |
| Delaware | Three commercial MCOs offer PH and limited BH services (equivalent of 30 outpatient visits); State Division of Child Mental Health Services serves as MCO for children and adolescents with moderate to severe BH disorders without benefit limits. | 1115 | Integrated PH/BH with partial carve out for children and adolescents with moderate to severe BH disorders | Middle | Information systems have been improved, but "inception was remarkably smooth - no major post hoc fixes." |
| District of Columbia | Eight focus groups currently are planning a BH carve out.<br>(Note. DC also has an 1115 waiver for a managed care program providing PH and BH services for children with special needs, i.e., with chronic physical and developmental disabilities, which was not reported on in this survey.) | N/A | BH carve out being planned | Planning | N/A |
| Florida | Statewide Medicaid utilization management of all psychiatric inpatient admissions and high utilizers of MH services. (Note. FL also has a 1915 (b) waiver for a MH carve out pilot in a five-county area in the Tampa Bay area, which was not reported on in this survey.) | N/A | Utilization management | Early | None |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Hawaii | Enrolls TANF and general assistance populations into statewide managed care and expands medical assistance to low income persons. By combining these populations, HI created a large purchasing pool to purchase medical, dental, and limited BH services for non SED and non SPMI. | 1115 | Integrated PH/BH | Late | N/A |
| Indiana | The Hoosier Assurance Plan is a risk sharing managed care system for non-Medicaid public behavioral health services, operated by the State Division of Mental Health, which acts as a purchasing agent, contracting with qualified managed care providers offering an array of individualized mental health and addictions care. Creates a priority for individuals with greatest need. Incorporates separate case rates for children with serious emotional disorders and for adolescents with substance abuse problems. | N/A | BH carve out | Early – for children and adolescents with serious emotional disorders<br><br>Middle – for addictions services | Recent implementation of case rate for children and adolescents with serious emotional disorders. |
| Iowa | IA has 1915(b) waivers to operate two statewide carve outs for Medicaid recipients — one for mental health services and one for substance abuse services. | 1915(b) - for both MH and SA carve outs | MH carve out<br>SA carve out | Middle - for both MH and SA carve outs | Implemented joint planning among MCO, providers, social workers, families and youth regarding substance abuse treatment. Through new MCO performance standards, implemented state policy to prohibit discharge of children and adolescents from 24-hour services until safe environment is available. Also, created new levels of alternative services. |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Kentucky | KY has a 1915(b) waiver to implement "Kentucky Access," a BH carve out that will be operated regionally through noncompetitive regional provider networks. (Note. KY also has an 1115 waiver for physical health managed care that includes limited MH services and inpatient medical detoxification, which is not reported on in this survey.) | 1915(b) | BH carve out | Proposal approved; planning underway | N/A |
| Maine | ME is planning a BH managed care reform that will include both Medicaid and non-Medicaid BH funding, and which will involve 3-7 network managers for specified areas within the state with responsibility to enroll providers, develop the service array, and ensure care coordination. ME anticipates contracting with an MCO for ASO functions of utilization management, claims processing and data management, with the state focusing on quality assurance. | N/A (but anticipating 1915(b)) | BH carve out being planned | Proposal | N/A (but state notes that coordination of data among state agencies is recent change as a result of planning for managed care). |
| Maryland | Physical health and substance abuse services are integrated and provided by MCOs as part of MD's "HealthChoice" physical health plan. Mental health services are provided through a carve out administered by the state Mental Hygiene Administration in conjunction with local Core Service Agencies and a BHO that provides ASO functions. | 1115 | Integrated PH/SA<br><br>MH carve out | Middle - for integrated PH/SA<br><br>Early - for MH carve out | No changes reported for integrated PH/SA<br><br>Small changes in utilization management protocols for MH Carve Out |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Massachusetts | MA has an 1115 waiver that allows Medicaid consumers two choices for health care: enrollment in an HMO for physical health and limited BH services, or use of the Primary Care Clinician Program with access to a BH carve out operated by a private BHO under contract with the state on a shared risk basis. (Note. The survey reports on the BH carve out only). | 1992-96 : 1915(b)<br><br>1996-present: 1115 | BH carve out | Late | Expanded Medicaid eligibility and integrated Medicaid and certain non-Medicaid funding (i.e., acute inpatient/diversionary and emergency services dollars). |
| Michigan | MI is involved in a statewide Medicaid managed care reform using a 1915(b) waiver that includes a BH carve out. The existing community mental health service programs will be the primary providers. The state MH agency also is negotiating with the state child welfare system to utilize joint funding for up to 6 pilot sites using a blended case rate to serve multi-system children. | 1915(b) | BH carve out | Proposal | N/A |
| Minnesota | MN utilizes the HMO model through an 1115 waiver to provide physical health and limited behavioral health services to Medicaid and low income populations. (Note. MN also has a 1915(b) waiver for a Consolidated Chemical Dependency Treatment Fund, which allocates funds to counties and Indian reservations on a formula grant basis for management of chemical dependency services, which was not reported on for this survey.) | 1115 | Integrated PH/BH | Middle | Prepaid children's mental health collaboratives are in planning stage; fee for service collaboratives already exist based on the CASSP model of coordinated services for children and adolescents with serious emotional disorders and their families. |

| Table 3 Description of State Health Care Reforms (Continued) | | | | | |
|---|---|---|---|---|---|
| **State** | **Description of Health Care Reform** | **Waiver** | **Type of Design** | **Stage of Development** | **Changes Since 1995** |
| Missouri | Physical health Medicaid managed care, with limited behavioral health benefit, for AFDC/TANF population and pregnant women and children (excluding children in state custody for behavioral health). | 1915(b) (state is requesting an 1115) | Integrated PH/BH | Middle | Department of Mental Health has agreed to provide wraparound, respite, and crisis home-based services, which health plans have not considered medically necessary in the past. |
| Montana | "Montana Mental Health Access Program" combines Medicaid mental health dollars, federal mental health block grant funding, and state general revenue for outpatient services and state hospital into mental health carve out managed by single statewide commercial MCO. | 1915(b) | MH carve out | Early | N/A |
| Nebraska | "Nebraska Health Connection MH/SA" is a Medicaid BH carve out covering AFDC/TANF, SOBRA and SSI populations, including children in child welfare. Is managed by a statewide commercial BHO. NE also operates a non-Medicaid behavioral health managed care initiative, in which a for-profit MCO provides ASO functions to manage state inpatient psychiatric and community behavioral health services. | 1915(b) | BH carve out | Middle | The state is in the process of reviewing state ward cases in which placement outside of Nebraska was needed to determine how to better serve these children in-state. |
| Nevada | Voluntary Medicaid managed care initiative for physical health and limited behavioral health services in Clark and Washoe Counties and in one rural area; does not include children with serious emotional disorders or those involved in child welfare. | N/A | Integrated PH/MH | Early | N/A |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| New Hampshire | Integrated PH/BH proposal to phase in Medicaid managed care, beginning with AFDC/TANF, then elderly, then disabled adults, then disabled children. NH currently has a voluntary Medicaid managed care program providing physical health and limited BH coverage. | 1115 (requested) | Integrated PH/MH | Proposal | N/A |
| New Jersey | Planning a Medicaid BH carve out to improve services and control costs; plans call for use of an MCO and integration of CASSP principles. | 1915(b) | BH carve out | Proposal | N/A |
| New Mexico | "SALUD" (New Mexico Partnership for Wellness and Health) is an integrated PH/BH Medicaid managed care program covering AFDC/TANF and SSI populations. Three MCOs were awarded contracts for physical health care with state-mandated subcontracts to BHOs. | 1915(b) | Integrated PH/BH | Early | None |
| New York | The "Partnership Plan" calls for an integrated basic health plan with limited behavioral health services and "special needs plans" (SNPs) for certain populations, including children and adolescents with serious emotional disorders. | 1115 | Integrated with partial carve outs | Proposal approved, planning underway | N/A |
| North Carolina | "Carolina Alternatives" is a Medicaid BH managed care program, covering children and adolescents only, operated by the state through local area offices. | 1915(b) | BH carve out | Late | 1. Established a level of care document and process<br>2. Clarified role of information to families, youth and advocates re grievance and appeals, access and choice. |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| North Dakota. | ND has a Primary Care Case Management Program through its 1915(b) waiver that does not include BH services and a pilot managed care project in one county that integrates PH/BH services. | 1915(b) | Integrated PH/BH | Early | None |
| Ohio | Medicaid managed care in which HMOs in 16 counties provide the full Medicaid benefit package of physical health services, along with some BH services, for AFDC/TANF and Healthy Start populations. | 1115 | Integrated PH/BH | Middle | N/A |
| Oklahoma | "SoonerCare" encompasses two Medicaid managed care programs— SoonerCare Plus and SoonerCare Choice. SoonerCare Plus operates in 3 urban areas of the state and includes integrated PH and BH services with an enhanced benefit package and capitation rate for adults and children identified by the state Medicaid agency as having special mental health needs (i.e., SED/SPMI). SoonerCare Choice is a Primary Care Case Management Program providing PH services only. | 1115 | Integrated PH/BH | Middle | In years one and two of SoonerCare Plus (the urban MCO portion of SoonerCare), children with SED and adults with SPMI were excluded from the program. In year three, the state allowed an optional enrollment of these populations with an enhanced benefit package and capitation rate. In year four, the state may make this mandatory. Also, state plans to enroll aged, blind and disabled Medicaid population in year 2000 and is currently increasing eligibility to 185% FPL. |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Oregon | The Oregon Health Plan is a managed care program for both Medicaid and non-Medicaid populations. It integrates PH and substance abuse services and is gradually phasing in mental health services after piloting MH carve outs. Currently, MH is integrated in some counties but remains a carve out in others. | 1115 | Integrated PH/SA<br><br>MH carve out | Middle | 1. The state has begun piloting inclusion of all children's intensive treatment services, including those used by children involved in the child welfare and juvenile justice systems, for full inclusion by year 2000.<br>2. Has provided training to MCOs, referral agencies, Medicaid agency and providers related to adolescent substance abuse treatment.<br>3. Has funded demonstration projects aimed at reducing waiting times for accessing substance abuse treatment. |
| Pennsylvania | "HealthChoices" is PA's mandatory Medicaid managed care program in which HMOs manage physical health services and behavioral health services are carved out, with counties having the first right of opportunity to manage BH services. Should counties not meet the standard set in the RFP, the bid for behavioral health is opened. The RFP requires coordination of care between the physical health HMOs and the BH MCOs. | 1915(b) | BH carve out | Early | Children with mental retardation have been moved from fee for-service to managed care. |
| Rhode Island | "RiteCare" is a Medicaid managed care program for AFDC/TANF and low income women and children that aims to improve health coverage for women and children through expanded Medicaid eligibility and increased access to physical health services and to limited BH services. | 1115 | Integrated PH/BH | Middle | N/A |
| Tennessee | "TennCare Partners" is a Medicaid managed care BH carve out operated by private BHOs. (TennCare provides PH services through private MCOs.) | 1115 | BH carve out | Late | N/A |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Texas | "STAR" (State of Texas Access Reform) is an integrated PH/BH Medicaid managed care program operating in 4 geographic regions with expectation to expand statewide by year 2000. HMOs provide physical and limited BH services, with most subcontracting BH services to BHOs. HMOs have option to provide "value added" BH services within capitation, and some do offer intensive, community-based services for children. In addition, TX mental health and substance abuse agencies are planning a BH carve out, called "Northstar", in the Dallas area to integrate publicly funded systems of mental health and chemical dependency services using Medicaid, state general revenue and federal block grant funds. Northstar will not include SA prevention or long term care (i.e., mental retardation). | 1915(b) | Integrated PH/BH<br><br>BH carve out (pilot) | Late<br><br>Proposal approved, planning underway | Decision to do a BH carve in 1999 in Dallas and 6 surrounding counties to evaluate against the current integrated approach. |
| Utah | The Utah Prepaid Mental Health Plan is a Medicaid mental health carve out in which the state's community mental health centers (CMHCs) act as the MCOs. | 1915(b) | MH carve out | Late | Efforts to make managed care system more closely parallel state MH agency preferred practices for children, youth and families. |
| Vermont | Vermont Health Access Plan is an integrated PH/BH Medicaid managed care program providing physical health and limited BH services. HMOs subcontract to two types of BHOs: a nonprofit joint venture between CMHCs and a commercial BHO, and a single commercial BHO. | 1115 | Integrated PH/BH | Middle | Efforts to refine the "gate" between the MCOs and the public mental health system. |

## Table 3 Description of State Health Care Reforms (Continued)

| State | Description of Health Care Reform | Waiver | Type of Design | Stage of Development | Changes Since 1995 |
|---|---|---|---|---|---|
| Washington | Mental Health Reform Act of 1989 created 14 Regional Support Networks (RSNs) and began implementation of prepaid health plans in 1993 under Medicaid waiver. RSNs act as MCOs for both community psychiatric inpatient and outpatient mental health and rehabilitation services. | 1915(b) | MH carve out | Middle | N/A |
| Wisconsin | WI is piloting a number of managed care approaches. This survey reports on two large county-based behavioral health carve outs for children with serious emotional disturbance — Children Come First in Dane Co. and Wraparound Milwaukee in Milwaukee Co. In addition, the state has a 1915(b) waiver for an integrated PH/BH Medicaid managed care program operated by HMOs and providing limited BH services. | 1915(b) | BH carve outs<br><br>Integrated PH/BH | Late | N/A |

"integrated," defined as reforms in which the financing and administration of physical and behavioral health are integrated, including instances where physical health plans may subcontract with specialty behavioral health plans. This survey does not treat such subcontracts with behavioral health care organizations as "carve outs," but, rather, as subcontracts within integrated designs.

**Table 4**

**Number and Percent of Reforms By Type of Design**

| | 1997–98 | | | |
|---|---|---|---|---|
| | Integrated | | Behavioral Health Carve Out or Partial Carve Out | |
| | # Reforms | % Reforms | # Reforms | % Reforms |
| **Total** | 15 | 35% | 28 | 65% |
| Mental Health Only | 0 | 0% | 8 | 29% |
| Substance Abuse Only | 2 | 13% | 1 | 4% |
| Mental Health and Substance Abuse | 13 | 87% | 19 | 68% |

As Table 4 shows, of the behavioral health carve-outs, 8 (29%) include mental health only; one (4%) includes substance abuse only; and 19 (68%) include both mental health and substance abuse. Thus, over one-quarter of behavioral health reforms are, in effect, managing mental health and substance abuse services quite separately, despite the known co-morbidity of mental health and substance abuse disorders.

Included in the category of behavioral health carve outs are two reforms which were described as " integrated with partial carve-outs," that is, having a design in which some acute care behavioral health services are integrated with physical health while others are split out for separate financing and administration (still in a managed care arrangement). Delaware and New York described their reforms in this way. In Delaware, for example, acute behavioral health services are integrated with physical health care financing and administration and are managed by commercial managed care organizations (MCOs), while behavioral health services for children needing more than brief, short-term care are financed and managed separately, though still in a managed care arrangement, by the Division of Children's Mental Health Services, acting as the MCO.

Also included in the behavioral health carve out category is one state (Florida) that characterized its reform as "other," describing application of some managed care technologies, such as utilization management and use of an administrative services organization (ASO), within its existing behavioral health system. There is also one state (Iowa) in the behavioral health category that has two separate carve outs—one for mental health and one for substance abuse.

Included in the 15 states with integrated designs are two states (Maryland and Oregon) that include only substance abuse services, not mental health services, within their physical health managed care reform. In both states, mental health services have been

carved out from physical health into separate mental health carve outs, while substance abuse has remained within the physical health care reform. While all of the other 13 states with integrated designs (87%) include both mental health and substance abuse services, along with physical health care, in their integrated designs, most of these states reported that their integrated reforms provide only very limited mental health and substance abuse services, as discussed more fully below.

Table 5 lists, by type of design, the 39 states that provided detailed descriptive information on 43 managed care reforms.

**Table 5**

**List of States by Type of Design of Managed Care Reform Underway or Being Planned 1997–98**

**Carve Out Designs (n=28)**

| Mental Health Only | Substance Abuse Only | Mental Health and Substance Abuse |
|---|---|---|
| Alaska<br>California<br>Colorado<br>Iowa<br>Montana<br>Oregon<br>Utah<br>Washington | Iowa | Arizona<br>Arkansas<br>Delaware<br>District of Columbia<br>Florida<br>Indiana<br>Kentucky<br>Maine<br>Maryland<br>Massachusetts<br>Michigan<br>Nebraska<br>New Jersey<br>New York<br>North Carolina<br>Pennsylvania<br>Tennessee<br>Texas<br>Wisconsin |

**Integrated Designs (N=15)**

| Physical Health and Mental Health and Substance Abuse | | | Physical Health and Substance Abuse |
|---|---|---|---|
| Connecticut<br>Hawaii<br>Minnesota<br>Missouri<br>Nevada | New Hampshire<br>New Mexico<br>North Dakota<br>Ohio<br>Oklahoma | Rhode Island<br>Texas<br>Vermont | Maryland<br>Oregon |

## Statewide Activity Versus Limited Geographic Areas

Table 6 indicates the percentage of reforms that are statewide versus limited to specific geographic areas. Over three-quarters (77%) of reforms are statewide; 23% of reforms are more limited. These percentages indicate a slight growth (3%) since 1995 in the number of reforms that are statewide and a corresponding 3% reduction in the percentage of reforms that are limited. Reforms continue to be widespread in nature in that most are not limited; indeed, even in states reporting implementation in limited geographic areas, most reported an intention of moving to statewide implementation at some point, which also was the case in 1995.

**Table 6**

**Percent of Reforms that are Statewide Versus in Limited Geographic Areas**

| | 1995 Total | 1997–98 Carve Out | 1997–98 Integrated | 1997–98 Total | 95–97/98 Change |
|---|---|---|---|---|---|
| Statewide | 74% | 79% | 73% | 77% | +3% |
| Limited Geographic Areas | 26% | 21% | 27% | 23% | -3% |

## Waiver Activity

As Table 7 indicates, in 1997-98, most reforms (86%) involved use of a Medicaid waiver, with 49% of all reforms involving use of a 1915(b) waiver and 37% of all reforms utilizing 1115 waivers. These percentages are consistent with 1995 findings as well, although there has been a slight growth (5%) in the percentage of 1915(b) waivers, reflecting the growth in behavioral health only reforms noted above. 1915(b), so-called Freedom of Choice, waivers allow states to waive only a few sections of the Medicaid regulations. 1115, Research and Demonstration, waivers allow for more extensive waiver of Medicaid regulations and, typically, are used by states for broad-based reforms. As in 1995, reforms using behavioral health carve outs were more likely, in 1997-98, to use 1915(b) waivers, while integrated physical/behavioral health reforms were more likely to use 1115 waivers.

**Table 7**

**Percent of Reforms Involving Medicaid Waivers**

| Source | 1995 Total | 1997–98 Carve Out | 1997–98 Integrated | 1997–98 Total | 95–97/98 Change |
|---|---|---|---|---|---|
| Any Waiver | 84% | 82% | *100% | *86% | +2% |
| 1115 | 37% | 25% | 60% | 37% | 0% |
| 1915 (b) | 44% | 57% | 33% | 49% | +5% |
| | *One state reported existence of waiver but did not specify type | | | | |

## Substance Abuse Inclusion

As shown on Table 8, 79% of state reforms in 1997-98 included substance abuse services, a 4% increase since 1995. However, as in 1995, substance abuse services were far likelier to be included in integrated reforms than in behavioral health carve outs. In 1997-98, 93% of the integrated physical/behavioral health reforms included substance abuse services while only 71% of the behavioral health carve outs included substance abuse services along with mental health services. This is consistent with the 1995 survey, which also found that substance abuse services were more likely to be included in integrated designs than in carve outs.

**Table 8**

**Percent of Reforms Including Substance Abuse Services**

| | 1995 Total | 1997–98 Carve Out | 1997–98 Integrated | 1997–98 Total | 95–97/98 Change |
|---|---|---|---|---|---|
| Reforms Including Substance Abuse | 75% | 71% | 93% | 79% | +4% |

## Parity

As Table 9 indicates, in those reforms that include both physical and behavioral health, respondents reported that behavioral health coverage is equal to physical health coverage in 60% of the reforms. In the remaining 40% of the reforms, behavioral health coverage is more limited than physical health coverage. According to survey respondents, limits include both day and visit limits, as well as higher copayments and deductibles, for both mental health and substance abuse services. Two of the states reporting day and visit limits noted that these applied only to adult services, indicating that the Early Periodic Screening, Diagnosis and Treatment program (EPSDT) protected children from differential limits. (These two states' reforms are included in the 60% of reforms described as having parity, since they reportedly do have parity for children's behavioral health services, which is the focus of this report.)

**Table 9**

**Percent of Reforms with Parity Between Behavioral Health And Physical Health Services**

| | 1995 | 1997–98 | 95–97/98 Change |
|---|---|---|---|
| Reforms with Parity | 71% | 60% | -11% |
| Behavioral Health More Limited | 29% | 40% | +11% |

In 1995, a higher percentage of reforms (71%) were reported to include parity between physical health and behavioral health than in 1997-98. Given the larger number of reforms affecting both physical health and behavioral health, the 1997-98 results probably reflect a more accurate picture of the extent of parity for behavioral health in state managed care reforms.

## Stages of Implementation

In contrast to 1995, in which most state reforms (79%) were either in the planning or very early implementation stage and less than one-quarter were in middle to late implementation, reforms in 1997-98 were reported to be in more advanced stages of implementation. As Table 10 indicates, over half of the reforms (52%) were reported to be in middle to late implementation, over twice the percentage reported to be at this stage in 1995. States are developing increasing experience with managed care,

suggesting opportunity for greater information and technical exchange across states and a need to explore refinements that states are making to their managed care systems based on this growing experience. The 1997-98 survey captures some of these changes, and the Tracking Project will be exploring refinements in greater depth, including the reasoning behind them and their impact on children and adolescents with behavioral health disorders and their families, as the next impact analysis phase of the project is carried out in 1999.

**Table 10**

**Percent of Reforms By Stage of Implementation**

| | 1995 Total | 1997–98 Carve Out | 1997–98 Integrated | 1997–98 Total | 95–97/98 Change |
|---|---|---|---|---|---|
| Proposal | 35% | 21% | 7% | 16% | -19% |
| Proposal Approved, Planning Underway | 23% | 7% | 0% | 5% | -18% |
| Early Implementation (Less than 1 yr.) | 21% | 21% | 27% | 23% | +2% |
| Middle Implementation (1–3 Yrs.) | 12% | 29% | 53% | 33% | +21% |
| Late Implementation (More than 3 yrs.) | 9% | 21% | 13% | 19% | +10% |

## Planning and Oversight Responsibility

Table 11 describes states' responses to the question as to which state agency has lead responsibility for planning and overseeing implementation of behavioral health services in managed care reforms. In most cases, states identified more than one agency as having lead roles, with state Medicaid agencies and state mental health agencies, playing predominant roles. Medicaid was identified as having or sharing lead responsibility in 72% of reforms, state mental health agencies in 53% of reforms. State substance abuse agencies, in contrast, were identified as playing a less dominant role in planning and overseeing managed care reforms than are either Medicaid or mental health agencies, except in integrated reforms. This tends to corroborate findings from the Tracking Project's 1997 Impact Analysis, in which a broad variety of key stakeholder groups felt that substance abuse was a "poor stepsister" to both health and mental health in managed care planning and implementation.

**Table 11**

**Percent of Reforms By Lead Agency Responsibility**

| | 1997–98 Carve Out | 1997–98 Integrated | 1997–98 Total |
|---|---|---|---|
| Governor's Office | 14% | 0% | 9% |
| State Health Agency | 18% | 7% | 14% |
| State Medicaid Agency | 64% | 87% | 72% |
| State Mental Health Agency | 75% | 14% | 53% |
| State Substance Abuse Agency | 32% | 47% | 37% |

As might be expected, Medicaid was reported to play a greater lead role in reforms with an integrated design than in behavioral health carve outs. Medicaid was reported to play or share a lead role in 87% of the integrated reforms, compared to 64% of the carve outs. State mental health agencies were reported to play minimal roles in reforms involving integrated designs though substance abuse agencies reportedly have somewhat more input in integrated reforms. State mental health agencies were reported to have or share a lead role in 75% of the carve outs, creating some question as to the role of mental health agencies, if any, in the remaining 25% of carve outs. This question certainly was raised by some stakeholders interviewed for the 1997 Impact Analysis, who felt that Medicaid agencies were controlling the planning and implementation of reforms, even though the reforms involved behavioral health services, without adequate involvement from state mental health or substance abuse agencies. The Tracking Project will continue to explore this issue in the 1999 impact analysis phase.

## Involvement of Key Stakeholders in Planning and Implementation

The 1995 survey reported that, in nearly 40% of reforms, families had no involvement in initial planning or implementation, and that, in nearly one-third of reforms, state child mental health representatives had no involvement in initial planning and implementation. The 1997-98 survey asked respondents to indicate whether various stakeholders had no involvement, some involvement, or significant involvement in managed care planning and implementation. As shown on Table 12, both families and state child mental health representatives are becoming increasingly involved in the planning and implementation of reforms, both in initial planning and, even more so, in later stages of refining reforms.

Table 13 addresses the involvement of stakeholders in reforms that was characterized as “significant.” States reported in 1997-98 that families had significant involvement in *initial* planning of 28% of reforms and in 38% of later refinement and implementation processes. Families were nearly three times as likely to have significant involvement in the planning of behavioral health carve outs than in planning integrated reforms. They also were nearly twice as likely not to have been involved at all in the planning of integrated reforms. Thirty-six percent of behavioral health carve outs reported significantly involved families in initial planning and implementation and 47% in later refinement, compared to only 13% of integrated reforms that significantly involved families in either initial implementation or later refinement processes. Overall, while families increasingly have a seat at the table, over 60% of reforms are still characterized by respondents as lacking *significant* family involvement.

State child mental health staff were reported to have significant involvement in the initial planning and later refinement of about 68% of behavioral health carve outs, but in the initial planning of only 20% of integrated reforms, increasing their involvement to 33% of these reforms in later stages of refinement. Overall, state child mental health representatives are characterized as having significant involvement in over half of current reforms.

**Table 12**

**Percent of Reforms Involving Various Key Stakeholders in Planning–1997–98**

**Involvement In *Initial* Planning and Implementation**

| | Carve Out | | | Integrated | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Not Involved | Some Involvement | Significant Involvement | Not Involved | Some Involvement | Significant Involvement | Not Involved | Some Involvement | Significant Involvement |
| Families | 14% | 50% | 36% | 47% | 40% | 13% | 26% | 47% | 28% |
| State Child Mental Health Staff | 0% | 32% | 68% | 13% | 66% | 20% | 5% | 44% | 51% |
| State Substance Abuse Staff | *21% | 57% | 21% | 27% | 53% | 20% | 23% | 56% | 21% |
| State Child Welfare Staff | 14% | 68% | 18% | 27% | 60% | 13% | 19% | 65% | 16% |
| Other Child-Serving Systems | 18% | 64% | 14% | 40% | 47% | 13% | 26% | 58% | 14% |

*Are All Mental Health Only Reforms

**Involvement in *Current* Refinements**

| | Carve Out | | | Integrated | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Not Involved | Some Involvement | Significant Involvement | Not Involved | Some Involvement | Significant Involvement | Not Involved | Some Involvement | Significant Involvement |
| Families | 0% | 53% | 47% | 7% | 80% | 13% | 2% | 60% | 38% |
| State Child Mental Health Staff | 0% | 33% | 67% | 0% | 67% | 33% | 0% | 46% | 54% |
| State Substance Abuse Staff | *20% | 58% | 21% | 13% | 60% | 27% | 18% | 60% | 23% |
| State Child Welfare Staff | 7% | 57% | 36% | 7% | 53% | 40% | 7% | 56% | 37% |
| Other Child-Serving Systems | 18% | 57% | 25% | 33% | 53% | 13% | 21% | 58% | 21% |

*Are All Mental Health Only Reforms

In contrast to state child mental health staff, state substance abuse agency staff were reported to have significant involvement in the initial planning of only about 20% of either behavioral health carve outs or integrated reforms. Their involvement did not increase significantly in later refinement processes. State child welfare staff, on the other hand, while not having significant involvement in the initial planning of either type of reform (18% of carveouts and 13% of integrated reforms), increased their involvement to 36% in carve outs and 40% in integrated reforms in later stages of system refinement.

Other child-serving agencies (such as education and juvenile justice) had marginal significant involvement in initial planning of either type of reform and reportedly did not increase involvement significantly in later stages of implementation.

**Table 13**

**Percent of Reforms with *Significant* Involvement of Various Key Stakeholders**

| | 1997–98 | | | | | |
|---|---|---|---|---|---|---|
| | Initial Significant Involvement | | | Current Significant Involvement | | |
| | Carve Out | Integrated | Total | Carve Out | Integrated | Total |
| Families | 36% | 13% | 28% | 47% | 13% | 38% |
| State Child Mental Health Staff | 68% | 20% | 51% | 67% | 33% | 54% |
| State Substance Abuse Staff | 21% | 20% | 21% | 21% | 27% | 23% |
| State Child Welfare Staff | 18% | 13% | 16% | 36% | 40% | 37% |
| Other Child-Serving Systems | 14% | 13% | 14% | 25% | 13% | 21% |

The percentages in Tables 12 and 13 mirror findings from the 1997 Impact Analysis. Stakeholders interviewed for the Impact Analysis reported little significant involvement by most stakeholder groups in initial planning of reforms but increasing involvement by some, such as families and child mental health and child welfare staff, in later stages of refinement. Increased involvement was related both to increased awareness and advocacy on the part of certain stakeholders, such as families, as well as the need to address problems arising in initial implementation related to certain groups of children, such as those involved in child welfare and those with serious behavioral health problems.

## Planning for Special Populations

The survey explored whether states engaged in discrete planning to consider the needs of certain special populations in managed care reforms, including adolescents with substance abuse disorders, children and adolescents with serious emotional disorders, children and adolescents involved in the child welfare system, and culturally diverse children and adolescents. As shown on Table 14, most reforms did not include a discrete planning process for any of these populations, except for children with serious emotional disorders; planning for children and adolescents with serious emotional disorders was reported for 57% of the reforms. Nearly half (48%) of the behavioral health carve outs also included a planning focus on children involved in the child welfare system. States were least likely to have engaged in discrete planning for culturally diverse children (only 19% of reforms were reported to include this planning focus), as well as for adolescents with substance abuse disorders (specific planning was reported in only 24% of reforms).

The behavioral health carve outs were significantly more likely to have engaged in specialized planning for all of these populations. The disparity was most striking with respect to children and adolescents with serious emotional disorders; 78% of the carve out reforms planned specifically for this population as compared with only 20% of the integrated reforms. More than half of the carve out reforms included a discrete planning focus on children involved in the child welfare system, compared with one-third of the

integrated reforms. The carve out reforms were over three times as likely to focus on culturally diverse children than the integrated reforms in their planning processes—26% were reported to include discrete planning for culturally diverse children, compared to only 7% of the integrated reforms.

**Table 14**

**Percent of Reforms With Discrete Planning Process for Special Populations**

| | 1997–98 | | |
|---|---|---|---|
| | Carve Out | Integrated | Total |
| Adolescents with Substance Abuse Disorders | 26% | 20% | 24% |
| Children and Adolescents with Serious Emotional Disorders | 78% | 20% | 57% |
| Children and Adolescents Included in the Child Welfare System | 56% | 33% | 48% |
| Culturally Diverse Children and Adolescents | 26% | 7% | 19% |

Again, these reports corroborate findings from the 1997 Impact Analysis, which found that states began to focus on the special needs of these populations in response to problems that arose in implementation of managed care reforms, problems which stakeholders felt may have been avoided in the first place if there had been discrete planning done at the outset.

## Goals of Reforms

The survey requested that states identify the stated goals of their reforms. As shown on Table 15, most reforms have multiple objectives, with the following three identified most frequently by states, regardless of whether their reforms used carve out or integrated designs—cost containment, increased access and improved quality. However, there also were several noteworthy differences between the stated goals of carve outs and those of integrated reforms:

- Carve outs were more likely to report multiple goals than integrated designs.
- Cost containment was a goal in all (100%) of the integrated reforms, compared with 89% of the carve outs.
- Expansion of the service array was a goal in 82% of the carve outs, but in only 27% of the integrated reforms.
- Improving accountability was a goal in 71% of the carve outs, but in only 53% of the integrated designs.

These differences reflect, in general, the nuances between state policy objectives with regard to Medicaid physical health care, in which cost containment, quality, and

expanded access tend to be overriding issues in states, compared to Medicaid behavioral health care, where individual states may be as concerned about additional issues, such as expanding the service array or, as one state that checked “other” noted, improving service coordination.

**Table 15**

**Percent of Reforms By Types of Stated Goals**

| | 1997–98 | | |
|---|---|---|---|
| | Carve Out | Integrated | Total |
| Cost Containment | 89% | 100% | 93% |
| Increase Access | 93% | 93% | 93% |
| Expand Service Array | 82% | 27% | 63% |
| Improve Quality | 96% | 80% | 91% |
| Improve Accountability | 71% | 53% | 65% |
| Other | 7% | 0% | 16% |

## Orientation and Training for Stakeholder Groups

Table 16 indicates the extent to which states provided orientation or training for key stakeholders with respect to the goals and operations of managed care reforms. According to survey respondents, providers were most likely to receive orientation or training (79% of reforms reportedly involved provider training), followed by child welfare systems (67%), other child-serving systems (64%), and families (59%). A few states identified other stakeholders who received orientation, such as judges, legislators, and advocates (10% of reforms). Fifteen percent of reforms reportedly provided no training or orientation for any stakeholder group.

There were marked differences reported between carve outs and integrated designs with respect to training and orientation for stakeholders. The integrated designs were twice as likely to provide no training at all to any stakeholder group (23% of reforms).

**Table 16**

**Percent of Reforms Providing Training and Orientation to Stakeholder Groups About Goals and Operations of Reforms**

| | 1997–98 | | |
|---|---|---|---|
| | Carve Out | Integrated | Total |
| No Training | 12% | 23% | 15% |
| Families | 77% | 23% | 59% |
| Providers | 73% | 69% | 79% |
| Public Child Welfare Systems | 73% | 54% | 67% |
| Other Child-Serving Systems | 77% | 38% | 64% |
| Other | 15% | 0% | 10% |

Reportedly, only 23% of the integrated designs provided training and orientation for families, compared to 77% of the carve outs. Slightly more than half (54%) of the integrated designs provided orientation to child welfare systems, compared to nearly three-quarters (73%) of the carve outs. Over three-quarters of the carve outs also provided training to other child serving systems, such as education and juvenile justice, while only 38% of the integrated reforms did so.

Given the complexity of managed care reforms and their impact on certain stakeholders, such as families and child welfare systems, the survey results suggest that states with integrated designs may be paying insufficient attention to the need to educate key stakeholders about managed care reforms. Similarly, in the 1997 Impact Analysis, key stakeholders, particularly child welfare system representatives and families, reported being insufficiently oriented to the goals and operations of managed care systems. The Impact Analysis did find, however, mid-course corrections taking place in many states to better educate key stakeholders, a finding supported by the high percentages of stakeholder education reported for the behavioral health carve outs in the survey.