IV. SERVICES COVERED BY MANAGED CARE REFORMS

Coverage of Acute and Extended Care Services

One recommendation to states and communities from key stakeholders in the 1997 Impact Analysis was to include both acute and extended care services in managed care reforms. (For purposes of this study, “acute care” is defined as brief, short-term treatment with, in some cases, limited intermediate care also provided, and “extended care” is defined as care extending beyond the actute care stabilization phase, i.e., care required by children with more serious disorders and their families.) The Impact Analysis noted that inclusion of both types of services creates the potential to integrate care for a total eligible population and reduces the potential for cost shifting and for fragmentation at the service delivery level. According to the 1997-98 survey, 74% of all reforms include both acute and extended behavioral health care services. As is shown on Table 20, however, there are striking differences between carve out and integrated reforms regarding acute and extended care coverage. Only 11% of the carve out reforms reportedly are limited to acute care services. In contrast, 53% of the integrated reforms cover acute care services only, as is typical in a commercial health insurance model. As discussed more fully in the financing section of this report, typically only Medicaid dollars are used to finance integrated reforms. Eighty-nine percent of the carve outs were reported to include both acute and extended care services, as compared to only 47% of the integrated reforms. Carve outs are more likely to use public behavioral health dollars along with Medicaid dollars to finance the managed care system.

There may be some overreporting of the extent to which extended care services are covered by managed care reforms. The 1997 Impact Analysis found that, even in those states with carve outs that reported inclusion of extended care, significant behavioral health treatment dollars were left outside managed care systems in other child-serving systems, such as child welfare, that were being used to pay for extended care or for particular types of treatment not covered by the managed care system.

Table 20

Percent of Reforms Including Acute and Extended Care Services

Services Covered	1997–98		
	Carve Out	Integrated	Total
Acute Care Only	11%	53%	26%
Acute and Extended	89%	47%	74%

For the managed care reforms that are limited to acute care services only, respondents were asked to identify the system that is primarily responsible for providing extended behavioral health care services to children and adolescents. As Table 21 indicates, in 82% of these reforms, the systems most likely to be responsible for extended care

services are the public mental health system and the public substance abuse system. The next most frequently cited system with responsibility for extended care behavioral health services was the child welfare system, with 45% of the reforms identifying child welfare.

Table 21

Percent of Reforms by Responsibility for Extended Care

Responsible System	1997–98 % of Reforms
Public Mental Health or Substance Abuse System	82%
Child Welfare	45%
Other Child System	27%
Another Entity	18%

Coverage of Behavioral Health Services in Managed Care Systems

The 1997-98 survey asked respondents to identify which mental health and substance abuse services are covered under their managed care reforms. Matrices 2 and 3 show, by state, the children's mental health and adolescent substance abuse services that are covered under the managed care reform. The matrices also indicate which services reportedly are covered by another funding source.

The matrices indicate that for children's mental health services, 39% of the reforms reportedly cover most or all of the services identified in the survey under their managed care systems. ("Most or all services" was defined as a positive response to 80 to 100% of the services included on the list presented in the survey.) Similarly, for substance abuse services, 40% of the reforms reportedly cover most or all of the services listed. For both mental health and substance abuse services, reforms with carve out designs were more likely to cover more of the services. The difference was more significant, however, with respect to mental health services. Of the reforms with carve out designs, 58% cover most or all of the listed mental health services, compared with only 7% of the integrated reforms. With respect to substance abuse services, 44% of the carve out reforms cover most or all of the listed services, while 33% of the integrated reforms meet this standard.

The services most and least likely to be covered can also be derived from the matrices. In the children's mental health arena, managed care systems are most likely to cover assessment and diagnosis, outpatient psychotherapy, inpatient hospital services, day treatment/partial hospitalization, crisis services, and case management. Therapeutic foster care, therapeutic group homes, respite services, residential treatment services, and crisis residential services are the least likely children's mental health services to be covered in managed care systems. Coverage in reforms with integrated designs is more likely to be limited to the traditional mental health services typically included in commercial insurance plans, whereas reforms with carve out designs are more likely to include coverage for additional home and community-based services. To illustrate,

Matrix 2

Mental Health Services Covered By Reforms

● Covered Under Reform
○ Covered by Another Funding Source
N/A Not Available
SA Substance Abuse Only

		Assessment And Diagnosis	Outpatient Psychotherapy	Medical Management	Home-Based Services	Day Treatment/Partial Hospitalization	Crisis Services	Behavioral Aide Services	Therapeutic Foster-Care	Therapeutic Group Homes	Residential Treatment Centers	Crisis Residential Services	Inpatient Hospital Services	Case Management Services	School-Based Services	Respite Services	Wraparound Services
Carve Out (n=28)																	
Alaska	AK	○	●	○	●	●	○	●	○	○	●	●	●	●	●	●	●
Arizona	AZ	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●
Arkansas	AR	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
California	CA	●	●	○	●	●	●	●	●	○	○	○	●	●	●	○	○
Colorado	CO	●	●	●	●	●	●	○	○	○	●	●	●	●	●	●	●
Delaware	DE	●	●	●	●	●	●	●			●	●	●	●	○		●
District of Columbia (N/A)	DC																
Florida	FL	●○	●○	●○	●○	●○	●○	●○	●○	○	○	○	●○	●○	●○	○	●○
Indiana	IN	●	●	●		●	●		●				●	●			●
Iowa–Mental Health	IA	●	●	●	●	●	●		○	○	○	●	●	○	●	○	●○
Iowa–Substance Abuse (SA)	IA																
Kentucky	KY	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●
Maine	ME	●	●	○	●	●	●	●	●	●	●	●	●	●	●	●	●
Maryland	MD	●	●	●	●	●	●	●	○	○	●	●	●	●	●	●	●
Massachusetts	MA	●	●	●	●	●	●	●	○	○	●	●	●	●	●	●	●
Michigan	MI	●	●	●	●	●	●	●	●	○	○	●	●	●	○	●	●
Montana	MT	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Nebraska	NE	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●
New Jersey	NJ	●	●		●	●	●	●	●	●		●	●	●	○	●	●○
New York	NY	●	●	●	●	●	●	●	○	○	○	●	●	●	●	●	●
North Carolina	NC	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○	●○
Oregon	OR	●	●	●	●	●	●	●	○	○	○	○	●	●	●	●	●
Pennsylvania	PA	●	●	●	●	●	●	●	●○	●○	●	●	●	●	●○		●
Tennessee	TN	●	●	●	●	●	●	●	●	●	●	●	●	●	○	●	○
Texas (BH)	TX	●○	●○	●○	○	○	●○	○	○	○	○	○	●○	●○	○	○	○
Utah	UT	●	●	●		●	●	●		●	●	○	●	●	●○	○	●○
Washington	WA	●	●	○	●	●	●	●	○	○	●	○	●	●	○		●
Wisconsin	WI	●	●	●	●	●	●				●		●	●	●		
Integrated (n=15)																	
Connecticut	CT	●	●	●	○	●○	●○		○	○	○	○	●	○	○	○	○
Hawaii	HI	●	●	●	○	○	●○	○	○	○	●○	○	●○	●○	○	○	○
Maryland–Substance Abuse (SA)	MD																
Minnesota	MN	●○	●○	●○	●○	●○	●○		●○			○	●○	○	●○		
Missouri	MO	●	●	●	○	●	○	○	○	○	○	○	●	●○	●○	○	○
Nevada	NV	●	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○
New Hampshire	NH	●	●	●	●	●	●	●	○	○	○	●	●	●	○	○	○
New Mexico	NM	●○	●○	●	○	●	○	●	●	●	●	○	●	●○	○	○	○
North Dakota	ND	●	●	●	○	●	●	●	○	○	○	○	●	●	○	○	○
Ohio	OH	●	●										●				
Oklahoma	OK	●	●	●	●	●	●		●		●	●	●	●	●	●	●
Oregon–Substance Abuse (SA)	OR																
Rhode Island	RI	●○	●○	●○	○	○	○	○	○	○	○	○	●○	○	○	○	○
Texas (PH/BH)	TX	●○	●○	●○	○	○	●○	○	○	○	○	○	●○	●○	○	○	○
Vermont	VT	●○	●○	●	○	●○	●○	●○	○	○	○	●○	●	●○	●○	○	●○

Matrix 3

Substance Abuse Services Covered By Reforms

● Covered Under Reform
○ Covered by Another Funding Source
N/A Not Available
OP Optional
MH Mental Health Only

		Assessment and Diagnostic Evaluation	Intensive Outpatient Services	Outpatient Individual Counseling	Outpatient Group Counseling	Outpatient Family Counseling	School-Based Services	Day Treatment	Ambulatory Detoxification	Residential Detoxification	Inpatient Detoxification	Residential Treatment	Inpatient Hospital Services	Partial Hospitalization	Methadone Maintenance	Relapse Prevention	Case Management
Carve Out (n=28)																	
Alaska (N/A)	AK																
Arizona	AZ	●	●	●	●	●	○	●	●	●	●	●	●	●	●	○	●
Arkansas	AR	○	○	○	○	○		○		○	○	○			○		
California	CA			●									●				
Colorado (N/A)	CO																
Delaware	DE	●	●	●	●	●	○	●	●	●	●	●	●	●		●	●
District of Columbia (N/A)	DC																
Florida (N/A)	FL																
Indiana	IN	●	●	●	●	●	○	●	●	●	○	●	○	●	○	●	●
Iowa–Mental Health (MH)	IA																
Iowa–Substance Abuse	IA	●	●	●	●	●	○	●	●	●	●	●	●	●	●	●	●
Kentucky (N/A)	KY	●	●	●	●		○		●	●	○	●	○	●	○		●
Maine	ME	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
Maryland	MD	●	●	●	●	●		●	●	○	○	○	○	○	●	●	●
Massachusetts (N/A)	MA																
Michigan	MI	●	●	●	●	●		●		●	○	OP			●	○	○
Montana (N/A)	MT																
Nebraska (N/A)	NE																
New Jersey	NJ	●	●	●	●	●	○	●	●	●	●	●	●	●	●	●	●
New York	NY	●○	●○	●○	●○	●○	○	●○	○		●○	●○	●		●○	●○	
North Carolina	NC	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Oregon (N/A)	OR																
Pennsylvania	PA	●	●	●	●	●	●	●		●	●	●	●	○	●	○	○
Tennessee	TN	●○	●○	●○	●○	●○	○	●○			●	○	●	●○	○	●○	●○
Texas (BH)	TX	●	●	●	●	●		●	●	●	●	●	●	●	●	○	○
Utah (N/A)	UT																
Washington	WA	○	○	○	○	○	○	○	○	○	○	○	○		○		○
Wisconsin	WI	●	●	●	●	●		●		○	●	○	●	●	●	●	●
Integrated (n=15)																	
Connecticut	CT	●	●	●	●	●	●	●○	●	○	●	○	●	●	●		●
Hawaii	HI	●○	●○	●○	●○	●○		●	●	○	●	●○	●	●○	●		
Maryland (SA)	MD	●	●	●	●	●		●	●	○	○	○	○	○	●	●	●
Minnesota (N/A)	MN																
Missouri	MO	●	●	●	●	●		●	●	●	●	●		●	●	●	●
Nevada	NV		●	●	●			●	●	●		●		●	●		
New Hampshire	NH	●	●	●	●	●	○	●	●	●	●	●	●	●		●	
New Mexico (N/A)	NM																
North Dakota (N/A)	ND																
Ohio	OH	●	●	●	●	○	○	●	●	●	●	○	●	●	●	○	●
Oklahoma (N/A)	OK																
Oregon (SA)	OR	●○	●○	●○	●○	●○	○		○	○	●	○	●	●	●○	○	
Rhode Island	RI	●○	●○	●○	●○	●○	○	●○	●○	○	●	●○	●	●○	●○	○	
Texas (PH/BH)	TX	●	●	●	●	●		●	●	●	●	●	●	●	●	○	○
Vermont	VT	●	●	●	●	●	○	●	●	●	●	●	●	○			

nearly all of the integrated reforms cover assessment and diagnosis, outpatient psychotherapy, medical management, and inpatient hospital services. Very few of the integrated reforms, however, cover home-based services, respite services, wraparound services, therapeutic foster care, and therapeutic group care—services that are included in the carve outs with much greater frequency.

In the substance abuse arena, the services most likely to be covered in managed care systems include assessment and diagnostic evaluation, intensive outpatient services, outpatient individual counseling, outpatient group counseling, and outpatient family counseling. The substance abuse services that are least likely to be covered include residential treatment, residential detoxification, relapse prevention, case management, and school-based services (which are covered by only 10% of the reforms).

In many cases, services that are not covered under managed care systems are covered by another funding stream, and, in some cases, a service is covered both by the managed care systems and by another financing source. It should be noted that although integrated reforms cover fewer services, most states cover these services through other funding streams. Thus, states with integrated reforms appear more likely than states with carve outs to have left financing streams for behavioral health services outside of their managed care systems.

One of the challenges inherent in child and adolescent behavioral health services is the existence of multiple funding streams across different child serving systems. As respondents pointed out in the 1997 Impact Analysis, multiple funding patterns are one reason for the fragmentation and confusion in children's services. The matrices show that, indeed, multiple funding streams are used by states to support the wide array of behavioral health services needed by children and adolescents.

Individual comments from respondents indicate that the substance abuse service array for adolescents and their families can vary greatly from region to region with a state as well as across states. In order to address this variability, some states are targeting service development to underserved areas, both urban and rural. For example, North Carolina is expanding services in rural areas and increasing attention to children and adolescents with co-occurring substance abuse and mental health disorders.

Differential Coverage for Behavioral Health Services for Children and Adolescents

The 1997-98 survey explored whether managed care systems include services for children and adolescents that are different from the services available for adults. As shown on Table 22, more than half of the reforms (60%) reported including different, typically better, coverage for children and adolescents. For behavioral health carve outs, nearly two-thirds of the reforms (64%) include services for children that are different from the services covered for adults; 53% of the integrated reforms were reported to have differential coverage for children and adolescents. Because the 1997-98 survey inquired about “behavioral health services,” it is unclear whether differential coverage for children and adolescents applies to mental health services, substance abuse services, or both. This is an area that the Tracking Project will explore further.

Table 22

Percent of Reforms with Differential Coverage for Children

Differential Coverage	1997–98 Carve Out	1997–98 Integrated	1997–98 Total
Yes	64%	53%	60%
No	36%	47%	40%

Reforms in the following states reportedly provide differential coverage for children and adolescents:

Arizona	Maine	North Carolina
Arkansas	Maryland	Oregon
Colorado	Minnesota	Pennsylvania
Connecticut	Missouri	Texas
Delaware	Nebraska	Utah
Florida	New Jersey	Vermont
Hawaii	New Mexico	Washington
Iowa	New York	Wisconsin

One theme noted in the explanatory responses to this item was a built-in allowance for more flexibility in the children's services package. For example, respondents noted that "children's services have no limitations" or are "broader and more flexible." Specific examples of differential coverage noted by respondents include the following:

- Hawaii and Missouri include a limit on the number of inpatient days and outpatient visits per year for adults but not for children.
- In Texas, the managed care system places no limitations on the amount of children's mental health services that can be accessed. For adolescent substance abuse services, the utilization review criteria to determine length of stay in each level of care is more generous than for adults.
- Three reforms specifically noted the value of EPSDT because this mechanism allows for expanded benefits and an unlimited duration of services.
- Reforms in at least three states (Arkansas, Kansas, and Pennsylvania) make available wraparound services for children as part of their benefit package that are more expansive than those for adults.
- Utah's managed care system includes a creative intervention code that is used especially for children and adolescents.
- In Kansas, the managed care reform includes four new services for children—respite care, wraparound facilitation, parental support and training, and independent living skills.
- Colorado's managed care reform includes the availability of home-based services for children and adolescents.

Expansion of Array of Home and Community-Based Services

The 1997-98 survey explored whether managed care reforms have expanded the array of home and community-based services available for children and adolescents. Fifty-six percent of all reforms reportedly have expanded the array of home and community-based services (Table 23). Responses to this question, however, indicate a sharp contrast between the behavioral health carve outs and the integrated reforms. Seventy-five percent of the carve outs have expanded the array of home and community-based services as compared to only 20% of the integrated health/behavioral health reforms. This finding is consistent with stakeholder reports obtained in the 1997 Impact Analysis—a broader array of services, more home and community-based services, and greater flexibility to provide individualized care were reported in states with carve out designs than in states with integrated physical health/behavioral health designs.

Table 23

Percent of Reforms with Expanded Array of Home and Community-Based Services

Expansion of Array	1997–98 Carve Out	1997–98 Integrated	Total
Yes	75%	20%	56%
No	25%	80%	44%

Inclusion of Services for Infants, Toddlers, and Preschoolers and their Families

A new area explored in the 1997-98 State Survey was whether managed care systems include coverage of behavioral health services for young children (infants, toddlers, and preschoolers) and their families. As shown on Table 24, almost all reforms (95%) reportedly include coverage of behavioral health services to infants, toddlers, and preschool children and their families. No differences are evident between the carve-out reforms and the integrated reforms. One issue that the survey cannot address is whether or not behavioral health services are being *delivered* to this population, even if covered in the managed care reform. Respondents in the 1997 Impact Analysis reported that few, if any, behavioral health services were being delivered to this population. Two major barriers were identified by respondents: first, a general lack of expertise about behavioral health problems and intervention strategies for this population of young children, and second, the tendency for managed care entities to focus on the identified patient rather than on the family as a whole.

Inclusion of Early Periodic Screening Diagnostic and Treatment Program (EPSDT)

A related issue is whether managed care reforms incorporate the EPSDT program. According to the 1997-98 survey responses, 93% of reforms, both carve outs and integrated reforms, have incorporated EPSDT (also shown on Table 24). Findings from

the 1997 Impact Analysis indicate that states are most likely to mandate EPSDT screens at the time of first contact with primary health care practitioners and periodically thereafter. However, findings indicated that these screens often do not include a behavioral health needs assessment component. Also, the 1997 Impact Analysis reported that many primary care practitioners do not have the necessary training and skills to detect behavioral health risk indicators in children and adolescents.

Table 24

Percent of Reforms Including Services for Young Children and EPSDT

	Carve Out	1997–98 Integrated	Total
Young Children	96%	93%	95%
EPSDT	93%	93%	93%

Differential Coverage for Individuals with Serious Disorders

An issue identified by many stakeholders in the 1997 Impact Analysis Report is the need for states to develop a broader and more flexible service array for special populations, including children and adolescents with serious behavioral health disorders. The 1997-98 survey investigated whether reforms include differential coverage for children and adolescents with serious behavioral health disorders and/or adults with serious behavioral health disorders.

As noted on Table 25, in 1997-98, over half (57%) of the carve-out reforms but only 40% of the integrated reforms reportedly include differential coverage for children and adolescents with serious behavioral disorders. Overall, the proportion of reforms with differential coverage for children with serious disorders has increased slightly from 1995. However, there is a marked difference in findings regarding differential coverage for adults with serious and persistent behavioral health disorders; only 21% of the reforms included different coverage for this group in 1995 as compared with 42% in 1997-98. Whereas differential coverage for children with serious disorders is more frequent in reforms with carve out designs, for adults such differential coverage is reported for both carve outs and integrated reforms. As a result of the growth in differential coverage for adults, the proportion of reforms providing differential coverage for children and adults with serious disorders has equalized.

Table 25

Percent of Reforms with Differential Coverage For Individuals with Serious Disorders

Differential Coverage	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Children with Serious Disorders	44%	57%	33%	49%	+5%
Adults with Serious Disorders	21%	43%	40%	42%	+21%

As noted, 49% of the reforms reportedly provide differential coverage for children with serious behavioral health disorders, representing a slight increase over the 44% of reforms providing differential coverage for this population in 1995. In 1997-98, respondents also indicated which of the following types of special services or provisions have been incorporated into their managed care systems: an expanded service array, intensive case management, interagency treatment planning, wraparound services, family support services, and a higher capitation or case rate.

As shown on Table 26, the two types of special provisions incorporated most frequently are an expanded service array (found in 90% of the reforms with special provisions) and intensive case management (found in 86% of these reforms). The next most frequently incorporated services are wraparound services followed by family support services. Only about 38% of the reforms with special provisions for children with serious disorders include a higher capitation or case rate for these youth; thus, most reforms do not incorporate financial incentives to serve youth with serious disorders.

Table 26

Percent of Reforms with Differential Coverage by Type of Differential Provisions

Special Provision	1997–98 Carve Out	1997–98 Integrated	Total
Expanded Service Array	88%	100%	90%
Intensive Case Management	81%	100%	86%
Interagency Service Planning	56%	60%	57%
Wraparound Services	75%	60%	71%
Family Support Services	63%	80%	67%
Higher Capitation/Case Rate	38%	40%	38%

Building on System of Care Values and Principles

A significant focus of the Health Care Reform Tracking Project is to assess whether states are building on previous efforts to develop community-based systems of care as they develop their managed behavioral health care systems. According to the 1997-98 survey responses, the answer is affirmative—respondents indicated that 85% of the managed care reforms have been built upon previous or ongoing efforts to develop systems of care (Table 27). There is a striking difference between the reforms with

Table 27

Percent of Reforms Building on System of Care Initiatives

Building on System of Care Efforts	1997–98 Carve Out	1997–98 Integrated	Total
Yes	100%	54%	85%
No	0%	46%	15%

carve out and integrated designs in the responses to this item, however. All of the carve out reforms reportedly are building on their previous system of care initiatives as compared with only 54% of the integrated reforms.

The incorporation of system of care values and principles in managed care systems was explored further in the 1997-98 survey by inquiring whether specific system of care values and principles are incorporated into the managed care systems' requests for proposals, contracts with MCOs, and service delivery protocols. As shown on Table 28, there are striking differences between behavioral carve out and integrated reforms in the extent to which system of care values and principles are included in their documents and, thus, incorporated into managed care systems. The behavioral health carve outs have a much higher rate of inclusion, over 90% for most principles. For the integrated reforms, specific system of care values and principles are incorporated about half of the time, with the highest rate of inclusion (67%) reported for case management and the lowest rate of inclusion (40%) reported for requiring a broad array of services.

Table 28

Percent of Reforms Incorporating System of Care Values and Principles

Principle	1997–98 Carve Out	1997–98 Integrated	Total
Broad Service Array	89%	40%	72%
Family Involvement	96%	46%	79%
Individualized Care	93%	53%	79%
Interagency Treatment Planning	93%	46%	77%
Case Management	96%	67%	86%
Cultural Competence	93%	60%	81%

These findings represent a departure from the 1997 Impact Analysis which found that only half of the states in the sample incorporated system of care principles. The discrepancy may be due, in part, to the fact that the 1997 Impact Analysis reflected the perceptions of a broader group of stakeholders.