V. MANAGED CARE ENTITIES

Types of Managed Care Entities Used

Table 29 indicates the types of entities states are using to manage their reforms. Many states are using multiple types of entities. The percentages in Table 29 reflect continuation, and, in some instances, strengthening of trends found in the 1995 State Survey. Specifically, there has been a growth in states' use of for-profit MCOs; nearly half (47%) of reforms were reported to use for-profit MCOs in l997-98, up from one-third in 1995. The growth has occurred in both behavioral health carve outs and integrated reforms, but primarily has been driven by the integrated reforms. In the 1997-98 survey, respondents reported that 71% of the integrated reforms utilize for-profit MCOs (compared to 33% of the behavioral health carve outs). Roughly the same percentage of reforms as in 1995, about one-third, were reported to use for-profit behavioral health organizations (BHOs); however, as in 1995, there is probably some use of BHOs (through subcontracts) that has been captured in the "for-profit MCO" category, which would create an underreporting of the use of BHOs.

Table 29

Percent of Reforms by Type of MCO Used

	Carve Out	1997–98 Integrated	Total
For Profit MCO	33%	71%	47%
Non Profit MCO	4%	71%	29%
For Profit BHO	38%	29%	34%
Non Profit BHO	21%	29%	24%
Private Non Profit Agency	17%	7%	13%
Government Entity	42%	7%	29%

Another trend noted in 1995 that has shown some increase is states' use of government entities as MCOs. Twenty-nine percent of all reforms in 1997-98 reportedly use government entities as MCOs, compared to 20% in 1995. As in 1995, behavioral health carve outs are far more likely than integrated designs to use government entities as MCOs. Forty-two percent of the carve outs reportedly use government entities as MCOs—for example, a county mental health authority—compared to only 7% of the integrated designs that use government entities.

Community-based private nonprofit agencies remain the least likely type of entity to be used by reforms as MCOs. Seventeen percent of the carve outs reported use of private nonprofit agencies as MCOs, and only 7% of the integrated designs.

Changes in Type of MCO Used

States reportedly are not changing the types of MCOs they are using. Only 15% of reforms —all carve outs—were reported to have changed the types of MCOs being used (Table 30). These changes were described by respondents as:

- Allowing nonprofit agencies to partner with for-profit MCOs
- Moving to use of for-profit MCOs instead of nonprofits
- Allowing more alliances to be formed at county levels among government entities, nonprofit agencies, and for-profit MCOs

Table 30

Percent of Reforms that have Changed Type of MCO

	1997–98 Carve Out	1997–98 Integrated	Total
Changed Type of MCO	15%	0%	15%

One state also noted that, while it had not changed the *type* of MCO being used, the original managed care contract had been bought out twice by larger MCOs. The 1997 Impact Analysis, while not focusing on changes in types of MCOs being used, did report on stakeholder perceptions about the challenges posed by changes in MCOs caused by changes in awardees as a result of recompetition of bids. The 1997-98 survey, however, explored whether states are changing the *types* of MCOs being used as a result of deliberate policy choices. At present, states, for the most part, appear to be sticking with their original decisions as to the types of MCOs to use.

Use of Multiple MCOs

The 1997 Impact Analysis found that when states use multiple MCOs (as opposed to a single MCO) either statewide or within a single region, significant challenges are created for providers, families, and the states themselves. Providers, families, and child welfare systems complained that the use of multiple MCOs creates confusion, administrative burden and fragmentation because of the differences among them. Each MCO uses different authorization, billing, credentialing and reporting processes, interprets medical necessity criteria differently, and utilizes different provider networks. Particular difficulties were noted for families involved with the child welfare system who may have children enrolled in different MCOs, foster families, for example. While state officials emphasized that use of multiple MCOs was intended to create consumer choice, they also indicated that it was difficult to monitor multiple MCOs. (Consumers interviewed in the 1997 Impact Analysis emphasized that it was more important to them to have choice in providers than in MCOs.)

Given the issues raised in the 1997 Impact Analysis about use of multiple MCOs, an item was added to the 1997-98 survey to determine the prevalence of states' use of multiple MCOs either statewide or within a single region. As Table 31 indicates, half of the reforms are using multiple MCOs statewide or within regions. However, this percentage is skewed by the almost universal use of multiple MCOs by reforms with an integrated physical health/behavioral health design. Ninety-three percent of these reforms use multiple MCOs, while reportedly none use a single MCO statewide and only 7% use one MCO per region. In contrast, carve outs tend to use either a single statewide MCO (42% of carve outs) or a single MCO per region (31%), with only 27% of the carve outs reportedly using multiple MCOs statewide or within regions.

Table 31

Percent of Reforms Using Single Vs. Multiple MCOs

	1997–98		
	Carve Out	Integrated	Total
One MCO Statewide	42%	0%	27%
One MCO Per Region	31%	7%	23%
Multiple MCOs	27%	93%	50%

These findings, and those from the 1997 Impact Analysis, suggest that there are clear distinctions between behavioral health carve outs and integrated managed care reforms in their use of multiple versus single statewide or regional MCOs, and in the preferences of behavioral health policy makers and consumers for using a single MCO statewide or regionally versus using multiple entities.

Training and Orientation for MCOs and Providers

In all of the states using for-profit MCOs that were included in the 1997 Impact Analysis study sample, respondents complained that the MCOs were unfamiliar with the Medicaid population in general, and in particular with children with emotional disorders, adolescents with substance abuse problems, and children involved in the child welfare system. Stakeholders also reported that states had done little orientation or training for either MCOs or providers regarding these populations.

The 1997-98 State Survey asked states to report on training and orientation provided to MCOs and providers regarding the needs of these populations. As Table 32 shows, carve outs were far more likely than integrated reforms to provide training or orientation with respect to any of the populations, according to respondents. Reportedly, 78% of the carve outs provided training to MCOs related to children and adolescents with serious emotional disorders, compared to 21% of the integrated reforms, and 78% of the carve outs provided training related to the Medicaid population in general, compared to 50% of the integrated reforms. Sixty-one percent of the carve outs reportedly provided training related to children involved in the child welfare system, compared to 29% of the integrated reforms, and 35% of the carve outs provided training related to

adolescent substance abuse treatment, compared to only 14% of the integrated reforms. Training related to adolescents with substance abuse problems was the least likely type of training to be provided by managed care systems with either type of design.

Table 32

Percent of Reforms Providing Training or Orientation to MCOs or Providers

	1997–98		
	Carve Out	Integrated	Total
No Training	9%	29%	16%
Taining Related to Children and Adolescents with Serious Emotional Disorders	78%	21%	57%
Training Related to Adolescents with Substance Abuse Problems	35%	14%	27%
Training Related to Children and Adolescents Involved in Child Welfare System	61%	29%	49%
Training Related to Medicaid Population in General	78%	7%	68%