VI. MANAGEMENT MECHANISMS

Types of Management Mechanisms

Not surprisingly, respondents reported that a number of the management mechanisms commonly associated with managed care are employed in states' behavioral health care systems. Table 33 shows the percentage of reforms using each type of management mechanism, both in 1995 and in 1997-98.

Table 33

Percent of Reforms Using Various Management Mechanisms

Mechanism	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Screeners	70%	75%	77%	76%	+6%
Case Management	89%	79%	69%	76%	-13%
Prior Authorization	Not Asked	86%	92%	88%	NA
Utilization Management	86%	93%	92%	93%	+7%
Preferred/Exclusive Provider	51%	50%	62%	54%	+3%

In 1997-98 the most commonly used management tools are utilization management (used in 93% of the reforms) and prior authorization of services (used in 88% of the reforms). Few changes were noted between 1995 and 1997-98, with the exception of a slight decline (13%) in the reported use of case management as a management mechanism.

The extensive use of prior authorization by managed care systems requires further examination, given the views on prior authorization expressed by stakeholders interviewed during the 1997 Impact Analysis. Stakeholders in most states complained about prior authorization mechanisms, describing them as cumbersome, time consuming, confusing, and creating barriers to access. There were fewer complaints in areas where MCOs allowed a certain level of services routinely and required authorization only for more extensive care. The 1999 Impact Analysis will provide the opportunity to assess how the new sample of states is using prior authorization and other managed care tools as well as to follow up with the 1997 sample of states to determine what changes in prior authorization process have been incorporated.

Focus of Case Management in Managed Care Reforms

One of the issues addressed by the 1997 Impact Analysis was the extent to which case management in managed behavioral health care systems is consistent with the concept of case management as promoted in public sector systems of care. In community-based systems of care, the functions of children's case management are typically described as accessing, brokering, coordinating, and monitoring services, as well as

advocacy. In managed care systems, case management often is limited to a more fiscal, utilization control, and care authorization focus. In all of the states with carve out designs in the 1997 Impact Analysis sample, the concept of case management in managed care systems was characterized as consistent with that associated with systems of care. In the states with integrated designs, however, case management in managed care systems was characterized as having the more narrow focus of utilization management, care authorization, and oversight of the quality of care.

Findings from the 1997-98 State Survey are consistent with the results of the 1997 Impact Analysis. As shown on Table 34, 61% of the reforms using case management reportedly include both functions as central to their case management approach—service authorization and utilization management as well as service accessing, brokering, coordinating, and advocacy. However, carve out reforms were significantly more likely to include both functions in their case management approach, with nearly 70% reporting that both functions are a primary focus as compared with fewer than half of the integrated reforms (45%) that include both functions. Further, only 7% of the carve out reforms using case management reported a model that focuses exclusively on service authorization and utilization management, whereas 45% of the integrated reforms reported this as their exclusive case management focus. Thus, although over 60% of the reforms reportedly adhere to a broad case management model consistent with the system of care concept, reforms with integrated designs are more likely to limit case management to utilization and fiscal control functions.

Table 34

Percent of Reforms with Various Case Management Functions

Case Management Functions	1997–98 Carve Out	1997–98 Integrated	Total
Utilization Management	7%	45%	18%
Accessing, Brokering, etc.	26%	9%	21%
Both Functions	67%	45%	61%

Special Management Mechanisms for Children with Serious Behavioral Health Disorders

In both 1995 and 1997-98 State Surveys explored whether managed care reforms require additional or special management mechanisms for children with serious emotional or substance abuse disorders because they are a more complex and costly patient population. As Table 35 indicates, in both 1995 and 1997-98, about half of all reforms reportedly incorporated special management mechanisms for children with serious behavioral health problems.

Table 35

Percent of Reforms with Special Management Mechanisms for Children with Serious Disorders

Special Management Mechanisms	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Yes	50%	52%	36%	46%	-4%
No	50%	48%	64%	54%	+4%

In 1995, the two types of mechanisms cited most often were interagency service planning and intensive case management. In 1997-98, the responses indicated a use of a wider range of management tools to manage and monitor service delivery to this high-risk, high-utilizer population. Examples of these mechanisms, and some of the states that use them, include:

- Special utilization review mechanisms (Delaware and Florida)
- Prior authorization of higher levels of care (Idaho and Maryland)
- Intensive level of case management (Arkansas, Hawaii, and Maine)
- Interagency service planning mechanisms (Iowa, New Jersey, Kentucky, Pennsylvania, Texas, and Wisconsin)

Interagency service planning mechanisms, often with an interagency focus, were the most frequently cited mechanism used to manage service delivery to the high utilizer population of youngsters with serious and complex disorders. Respondents described approaches such as that used in Texas, where HMOs and BHOs are required to coordinate with community management teams and with local interagency child staffing and resource-sharing groups, called Community Resource Coordination Groups. In New Jersey, MCO care coordinators and individualized service planning teams are required to conduct joint case planning for this population. In Iowa's substance abuse carve out, joint case planning is required for adolescents with serious substance abuse disorders.

Special Management Mechanisms for Children in the Child Welfare System

The 1997-98 survey also explored special management mechanisms employed by reforms to manage services for children in the child welfare system. As shown on Table 36, 49% of the reforms reportedly provide this high-risk population with specialized management and oversight, with few differences reported between the carve out and the integrated reforms.

In their explanations, the most frequent type of special management mechanism cited for the child welfare population involves joint planning and coordination. In Colorado's reform, for example, an interagency child welfare, mental health, and substance abuse group with state and local representation has been formed to resolve problems for this

Table 36

Percent of Reforms with Special Management Mechanisms for Children In the Child Welfare System

Special Management Mechanisms	1997–98 Carve Out	1997–98 Integrated	Total
Yes	50%	46%	49%
No	50%	54%	51%

population. Kentucky's reform includes a regulation requiring the inclusion of child welfare representatives in service planning for high-risk children. Joint planning meetings are held in New Jersey between MCO care coordinators and child welfare staff.

In several managed care systems, expedited procedures for the child welfare population have been adopted. In Maryland, the reform includes provisions for "expedited enrollment" when a precipitous change in placement occurs for any child in state sponsored care, in order to assure continuation of medical treatment. In Pennsylvania's reform, if a service denial is contested for a child in the child welfare system, the process is more rapidly moved to the impartial review level.

Use of Medical Necessity Criteria

In the 1995 survey, 79% of the reforms involved the use of medical necessity criteria to guide access to behavioral health services. By 1997-98, the proportion of reforms using medical necessity criteria increased to 86% (Table 37). Given the widespread use of medical necessity criteria, the issues raised in the 1997 Impact Analysis should be considered. In the Impact Analysis, stakeholders in a number of states noted that medical necessity criteria were the source of problems and complaints. Problems resulted from factors including differing interpretations of criteria among MCOs, narrow definitions of medical necessity, lack of expertise in applying criteria to children and adolescents, and lack of alternatives for services deemed medically unnecessary.

Table 37

Percent of Reforms with Medical Necessity Criteria

Use of Medical Necessity Criteria	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Yes	79%	93%	73%	86%	+7%
No	21%	7%	27%	14%	-7%

In response to these issues, stakeholders in some states included in the 1997 Impact Analysis reported that they were broadening their medical necessity criteria to include psychosocial and environmental considerations in clinical decision making. To determine the extent to which states are considering such revisions, the 1997-98 survey examined whether, and in what way, medical necessity criteria had been changed since the initial implementation of the behavioral health care reform. Table 38 indicates that more than a third (39%) of the reforms have made changes to their medical necessity criteria, with carve out reforms more likely to have made revisions (45%) than integrated reforms (29%).

Table 38

Percent of Reforms with Revisions to Medical Necessity Criteria

Revisions to Medical Necessity Criteria	1997–98 Carve Out	1997–98 Integrated	1997–98 Total
Yes	45%	29%	39%
No	55%	71%	61%

Respondents in five states (Arkansas, Connecticut, Iowa, Michigan, and Oregon) described their revisions as a broadening of medical necessity criteria in order to place greater emphasis on psychosocial issues. Considered along with indications from the 1997 Impact Analysis, a beginning trend toward broadening medical necessity criteria to include psychosocial and environmental considerations in decisions about behavioral health services may be emerging. Other changes in medical necessity criteria described by respondents include:

- In Alaska's reform, the state has defined medical necessity criteria in regulation rather than allowing MCOs to develop their own criteria.
- Texas used a public rule-making process with input from all stakeholders to develop new criteria for medical necessity.
- In Oklahoma, managed care plans may change medical necessity criteria on an individualized basis.
- Pennsylvania includes a definition of medical necessity criteria in its RFP for behavioral health managed care so that bidders know the basis upon which their definitions will be reviewed. For the next RFP, process additions and corrections have been made to the definition.
- In Wisconsin, the use of medical necessity criteria is waived for those children requiring wraparound services.

Use of Clinical Decision-Making Criteria Specific to Children and Adolescents

The 1997-98 survey investigated the use of clinical decision-making criteria, such as level of care criteria, patient placement criteria, and practice guidelines, that are specific to children and adolescents. Overall 72% of the reforms reportedly use some form of clinical decision-making criteria specific to children and adolescents.

Table 39

Percent of Reforms with Child-Specific Clinical Decision-Making Criteria

Decision-Making Criteria	1997–98 Carve Out	1997–98 Integrated	Total
Level of Care/Patient Placement	81%	38%	67%
Practice Guidelines	58%	8%	41%
No Child-Specific Criteria	12%	62%	28%

Behavioral health carve outs were far more likely to use clinical decision-making criteria specific to children and adolescents—88% as compared with only 38% of the reforms with integrated designs. As shown on Table 39, child-specific level of care or patient placement criteria reportedly are used by 81% of the carve out reforms; practice guidelines are in place for 58% of the reforms. In contrast, only 38% of the integrated reforms use level of care or patient placement criteria for children and adolescents, and only 8% reported child-specific practice guidelines.

This finding is consistent with the 1997 Impact Analysis which found level of care or patient placement criteria specific to children and adolescents only in the states with carve out or partial carve out designs. The perception of stakeholders in the seven states using such criteria was that their appropriate use can improve consistency in clinical decision-making. In managed care systems in which there were no decision-making criteria specific to children, clinical decisions often were viewed as arbitrary and inappropriate for children and adolescents.

Grievance and Appeals Processes

Stakeholders in all states visited during the 1997 Impact Analysis expressed concerns about the grievance and appeals processes used in managed care systems. Families reported that they did not understand the procedures and were concerned about repercussions; providers added that the grievance processes were too lengthy and complicated. Given these widespread concerns, items were added to the 1997-98 survey to explore whether the managed care system includes a grievance and appeals process, and, if so, who is the major source of grievances.

Nearly all (98%) of the reforms reportedly have a grievance and appeals process in place. The survey also sought to determine which groups (families, behavioral health providers, child welfare system, and other systems) comprise the major source of grievances and appeals. Table 40 indicates that the major sources of grievances and appeals are families (identified as a major source by 54% of the reforms) and behavioral health providers (identified as a major source by 50% of the reforms). Families are more likely to be the source of grievances in carve outs; providers are more likely to be the source in integrated designs. Other child-serving systems appear to play a very limited role in initiating grievances and appeals in behavioral health managed care systems; only 4% of the reforms identified the child welfare system as a major source of appeals.

Table 40

Percent of Reforms by Major Source of Grievances and Appeals

Source of Appeals	1997–98 Carve Out	1997–98 Integrated	Total
Families	59%	44%	54%
Providers	41%	67%	50%
Child Welfare Agency	0%	11%	4%
Other Child-Serving Systems	0%	0%	0%

Use of Trouble Shooting Mechanisms

The 1997-98 survey examined the use of trouble shooting mechanisms for consumers and/or providers of behavioral health services. As shown on Table 41, 87% of all reforms employ trouble shooting mechanisms in addition to a grievance and appeals process; 13% do not. A higher proportion of the behavioral health carve outs (92%) than the integrated reforms (77%) reportedly use trouble shooting mechanisms.

Table 41

Percent of Reforms with Trouble Shooting Mechanisms

Trouble Shooting Mechanisms	1997–98 Carve Out	1997–98 Integrated	Total
Yes	92%	77%	87%
No	8%	23%	13%

The types of mechanisms noted by reforms include:

- 800 numbers — Arkansas, Colorado, Florida, Iowa, Michigan, Nebraska, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Washington

• Consumer/Family Advocates	Alaska, Arkansas, Colorado, Pennsylvania, Tennessee, Wisconsin
• Ombudsman	Indiana, Kentucky, Oregon, Vermont, Washington
• Office of Consumer Affairs	District of Columbia, Maryland
• Contact with State Agency	Alaska, Arizona, Delaware