VII. FINANCING AND RISK

Use of Capitation or Case Rate Financing

Capitation is a term that refers to "any type of at-risk-contracting arrangement that provides funds on a prospective basis per person in return for the risk of the costs of health care provided to those persons" (McGuirk, et. al., 1995). To illustrate, in one example of a capitated arrangement, a state might make payment up front to an MCO to provide behavioral health services to a total eligible population (for, example, all Medicaid-eligible children), basing the amount of the payment on a pre-set rate per person multiplied by the number of persons in the eligible population. In return, the MCO would assume the risk of providing services to all those in the eligible population within the total payment allotment from the state. Obviously, the capitated rate—how much the state is willing to pay the MCO and how much the MCO is willing to "live within" per person—is a critical decision. A rate that is too low places the MCO at greater risk and may provide an incentive for the MCO to under serve, and may possibly create additional risk for the state if the state remains mandated to serve as the provider of last resort. A rate that is too high places the state in the position of overpaying for services.

Case rates comprise another form of risk-based contracting in which an MCO or provider is paid a fixed fee per actual user of service (as opposed to an eligible user), based typically on the service recipient's meeting a certain service or diagnostic profile. While the MCO is not at risk in this arrangement for the number of persons that use services, the MCO is at risk for the amount and types of services used. Again, setting a case rate too low creates incentives for underservice; setting the rate too high positions the state to overpay for service.

As in 1995, the 1997-98 survey included five basic items related to capitation (adding case rates to the questions):

- Whether the state health care reform involved use of capitation or case rate financing
- The populations capitated (Note: States may capitate and/or provide case rates for several populations within one managed care system. For example, children may be capitated separately from adults; or, children with serious emotional disorders may be capitated separately from adults with serious and persistent mental illness; children with serious disorders may be financed through a case rate, rather than capitation, etc.)
- What the capitation or case rates were
- What the rates were based on
- If capitation or case rates were used for children and adolescents with behavioral health disorders, which agencies contributed to financing the rates

In addition, the 97-98 survey asked states whether rates had been changed based on actual experience, and whether rates in integrated designs specify the percentage to be spent on behavioral health care.

As Table 42 shows, consistent with 1995 findings, the vast majority of reforms are utilizing capitation—92% of reforms in 1997-98, up from 88% reported in 1995. All of the reforms involving an integrated design were reported to use capitation; 80% of carve outs reportedly used capitation financing. A quarter of carve outs also were reported to involve case rates.

Table 42

Percent of Reforms Using Capitation and/or Case Rates

	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Capitation	88%	80%	100%	92%	+4%
Case Rates	NA	25%	7%	16%	NA
Neither	12%	16%	0%	11%	-1%

Changes in Capitation Rates

Table 43 shows the percentage of reforms that were reported to have changed capitation or case rates since initial implementation. The survey sought to identify the extent to which states are making changes in rates and the reasons for those changes. As Table 43 indicates, carve outs are reported to be more likely to make changes in rates than integrated reforms; 61% of the carve outs have reportedly had changes in rates, compared to only 43% of the integrated designs. In almost half (47%) of all reforms, regardless of type, no changes have been made in rates since initial implementation, according to respondents.

Table 43

Percent of Reforms Reporting Changes in Capitation or Case Rates

	1997–98 Carve Out	1997–98 Integrated	1997–98 Total
Yes	61%	43%	53%
No	39%	57%	47%

In some cases, respondents provided reasons as to why rates were changed. The reasons cited for lower rates included ”reduced funding,” “increased MCO competition,” and “lower utilization.” Reasons given for raising rates included “inflation,” “increased costs,” higher than expected enrollment of SSI (Supplemental Security Income) and GA (General Assistance) recipients,” “large State ward population,” and “higher utilization.”

Several states noted that changes were made in rates due to changes in system design, including the addition of inpatient hospitalization and/or outpatient services to the MCOs' responsibilities when only one or the other was included in the rate previously, and the addition of children and adolescents with serious emotional disorders and adults with serious and persistent mental illness as an option for coverage.

Table 44 shows the percentage of reforms reported to incorporate built-in mechanisms to reassess and readjust rates at specific intervals. Again, carve outs were more likely to include such mechanisms, with 71% reported to incorporate them, compared to 50% of reforms with integrated designs.

Table 44

Percent of Reforms With Mechanisms to Reassess and Readjust Rates at Specific Intervals

	1997–98		
	Carve Out	Integrated	Total
Incorporate Mechanisms	71%	50%	63%
Do Not Incorporate Mechanisms	29%	50%	37%

Agencies Contributing to the Financing of Rates

The survey asked states to identify the agencies that are contributing to the financing of capitation or case rates for child and adolescent behavioral health services. Matrix 4 displays the agencies contributing funding to managed care systems by state.

As shown on the matrix and on Table 45, states predominantly are using Medicaid dollars to fund children's behavioral health services in managed care reforms. Carve outs are more likely than integrated reforms to utilize other agencies' dollars, in particular mental health. Over three quarters (78%) of carve outs reportedly utilize mental health dollars, compared to only 14% of integrated designs. Carve outs also are more likely to use child welfare and substance abuse agency dollars. Thirty-seven percent of carve outs use child welfare dollars, compared to 21% of integrated reforms, and 33% of carve outs use substance abuse agency dollars, compared to 14% of integrated reforms.

The 1997 Impact Analysis found that most of the behavioral health dollars left outside managed care systems were being used to pay for extended care, that is, for care beyond the brief, short-term treatment provided by the managed care system, and for particular types of service, such as residential treatment, that were not covered in the managed care system. While stakeholders indicated that leaving behavioral health dollars outside the managed care system sometimes created a safety net for children, it also aggravated fragmentation, duplication, and confusion in children's services and created incentives to cost shift. Fragmentation was considered by stakeholders to be worse in states with integrated managed care designs than in carve out states.

Matrix 4

Agencies Contributing to Financing Capitation or Case Rates For Behavioral Health Services for Children and Adolescents

		Mental Health	Health	Medicaid	Child Welfare	Education	Juvenile Justice	Substance Abuse	Other
Alaska	AK			●					
Arizona	AZ	●		●	●				
Arkansas	AR	●		●	●				
California	CA	●		●					
Colorado	CO			●					
Connecticut	CT			●					
Delaware	DE	●		●					
District of Columbia	DC	●		●				●	
Florida	FL	●		●	●		●	●	
Hawaii	HI	●		●	●	●	●	●	
Indiana	IN	●		●	●			●	
Iowa–Mental Health	IA			●					
Iowa–Substance Abuse	IA			●				●	
Kentucky	KY			●					
Maine	ME								
Maryland–Mental Health	MD	●	●	●					
Maryland–Substance Abuse	MD			●					
Massachusetts	MA	●		●					
Michigan	MI	●	●	●	●	●	●	●	
Minnesota	MN			●					
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–Mental Health	OR	●		●	●				
Oregon–Substance Abuse	OR		●	●	●			●	
Pennsylvania	PA	●		●				●	
Rhode Island	RI			●					
Tennessee	TN	●	●	●				●	
Texas–(BH)	TX	●		●				●	
Texas–(PH/BH)	TX		●	●					
Utah	UT	●	●	●	●	●	●		●
Vermont	VT			●					
Washington	WA	●		●					
Wisconsin	WI	●		●	●		●		●

Table 45

Percent of Reforms By Agencies Contributing to Funding Pool

	1997–98		
	Carve Out	Integrated	Total
Mental Health	78%	14%	56%
Health	19%	14%	17%
Medicaid	100%	100%	100%
Child Welfare	37%	21%	32%
Education	11%	14%	12%
Juvenile Justice	15%	14%	15%
Substance Abuse	33%	14%	27%
Other	7%	0%	5%

As Table 46 shows, the integrated reforms very rarely include agency funding other than the Medicaid agency's. There appears to be little change in states' use of agency dollars to finance behavioral health services for children and adolescents in managed care reforms since 1995. Table 46 shows that virtually the same percentage of reforms in 1997-98 as in 1995 use Medicaid-only dollars (about 40%), Medicaid and behavioral health-only dollars (20%) and multiple agency financing (about 40%).

Table 46

Percent of Reforms By Single or Multiple Agencies Contributing Funding

	1995	1997–98			95–97/98
	Total	Carve Out	Integrated	Total	Change
Medicaid Agency Only Contributing	40%	22%	71%	39%	-1%
Medicaid and Behavioral Health Agencies Both Contributing	20%	30%	0%	20%	0%
Other Agencies (e.g. Child Welfare, Juvenile Justice, Education) Contributing in Addition to Medicaid and Behavioral Health Agencies	40%	48%	29%	41%	+1%

Designating a Percentage of the Capitation for Behavioral Health Care in Integrated Reforms

The survey explored, if capitation or case rates included *both* physical and behavioral health services, whether the state required that a certain percentage be allocated to behavioral health services. There was no reported instance of such a requirement.

The 1997 Impact Analysis reported stakeholder perceptions in states with integrated designs that the percentage of the capitation that is spent on behavioral health services is minimal. None of the states in that sample reported requirements that would specify

a certain percentage of the capitation to be spent on behavioral health care. Estimates as to how much actually was spent on behavioral health care in an integrated system ranged from $.27 per member per month (outpatient services only) to $4 per member per month (outpatient and inpatient) to $7 per member per month (outpatient and inpatient).

Basis for Capitation and Case Rates

As Table 47 indicates, most states are using costs associated with prior utilization of services by the eligible population as the basis for determining capitation and case rates. The 1997 Impact Analysis found there is a certain "trial and error" quality and unease to basing rates on prior utilization. Stakeholders reported that states' utilization data may be of poor quality, incomplete, or simply unavailable for certain populations. Also, they pointed out that the service delivery system that a state envisions for its reformed system may be different from the traditional service system. For example, the traditional system may have relied heavily on the use of inpatient and residential services while the reformed system envisions greater use of community-based alternatives. Historical utilization data might overstate costs in this instance. On the other hand, access to services may have been limited in the traditional system, with the reformed system envisioning greater utilization. In this instance, historical utilization data may understate the costs of services in a system that hopes to serve more people. In reality, in many states, both factors—over reliance on costly "deep-end" services and limited access—may diminish the reliability of prior utilization data as the basis for determining capitation rates for the reformed system. Some states reported trying to account for these types of factors (as well as inflation) by adjusting upwards or downwards costs associated with prior utilization, as Table 47 describes. Others also are trying to build prospective information into the system to allow for future rate adjustments and may be using "floating" capitation rates that are guaranteed to change based on actual data from the reformed system.

Populations Capitated and Rates Used

Table 47 also shows, by state, the populations each state is capitating and the amount of the capitation or case rate for each (where that information was provided). States are developing separate capitation or case rates for a number of distinct populations, including children, children with serious emotional disorders, children in state custody, and adults with serious and persistent mental illness. They also may capitate by Medicaid eligibility category and by nondisabled and disabled categories. While it is possible to identify average statewide rates by capitated population in most cases, rates also tend to vary by geographic region—for example, by county or by rural versus urban areas—and rates may vary by age and gender.

Table 47

Examples of Capitation or Case Rate Approaches by State

State	Type of Reform	Capitated Populations	Amount of Capitation Rate	Amount of Case Rate	Basis for Rate
Arkansas AR	BH Carve Out	Children and Adolescents–BH Only Children and Adolescents with Serious Emotional Disorders Children and Adolescents in State Custody	$40 pmpm $57 pmpm $360 pmpm		N/A
Arizona AZ	BH Carve Out	Children and Adolescents–BH Only	$15.50 pmpm		Based on Utilization Data
Delaware DE	Integrated with Partial Carve Out	Children and Adolescents with Moderate to Severe Disorders–BH Only Adults and Children and Adolescents–PH and BH Acute Care	$95 pmpm	$4,239 Per Child Per Service Month	N/A
Hawaii HI	Integrated PH and BH	Adults and Children and Adolescents– PH and BH	$150 pmpm		N/A
Iowa IA	MH Carve Out	Children and Adolescents–MH only, non SSI Aduts–MH Only, non SSI Children and Adolescents with Serious Emotional Disorders, SSI Adults with Serious and Persistent Mental Illness, SSI	$14.26 pmpm $11.67 pmpm $92.49 pmpm $66.75 pmpm		Prior Utilization

BH=Behavioral Health MH=Mental Health SA=Substance Abuse PH=Physical Health pmpm=Per Member Per Month

Table 47 Examples of Capitation or Case Rate Approaches by State (Continued)

State	Type of Reform	Capitated Populations	Amount of Capitation Rate	Amount of Case Rate	Basis for Rate
Iowa IA	SA Carve Out	Adults and Adolescents Combined	$3.86 pmpm		N/A
Indiana IN	BH Carve Out	Children and Adolescents with Serious Emotional Disorders Adolescents with Substance Abuse Disorders		$2,000 Annually $2,500 Annually	Actuarial Study and Prior Utilization
Massachusetts MA	BH Carve Out	Adults and Children and Adolescents–SSI	$100.06 pmpm		N/A
Michigan MI	BH Carve Out	Children and Adolescents–BH Only, AFDC under 18 Adults–BH Only, AFDC over 18 Children and Adolescents with Serious Emotional Disorders (disabled, aged, blind) Adults with Serious and Persistent Mental Illness (disabled, aged, blind)	$6.81 pmpm $13.41 pmpm $38.53 pmpm $79.29 pmpm		Prior Utilization
Missouri MO	Integrated PH and BH	Adults–PH and BH Children and Adolescents–PH and BH Children and Adolescents in State Custody	$110.62 pmpm $95.92 pmpm $91.59 pmpm		Trended Historical Data, Adjusted for Several Managed Care Assumptions

BH=Behavioral Health MH=Mental Health SA=Substance Abuse PH=Physical Health pmpm=Per Member Per Month

Table 47 Examples of Capitation or Case Rate Approaches by State (Continued)

State	Type of Reform	Capitated Populations	Amount of Capitation Rate	Amount of Case Rate	Basis for Rate
Oregon OR	MH Carve Out	Adults and Children and Adolescents–MH Only, AFDC Children and Adolescents with Serious Emotional Disorders Adults with Serious and Persistent Mental Illness Children and Adolescents in State Custody	$12.45 pmpm $112.13 pmpm $131.67 pmpm		Prior Utilization
Tennessee TN	BH Carve Out	Adults and Children and Adolescents–BH Only	$22.72 pmpm		N/A
Texas TX	Integrated PH and BH	Adults and Children and Adolescents–PH and BH	$156.61 pmpm		N/A
Wisconsin WI	BH Carve Out	Children and Adolescents with Serious Emotional Disorders		$2,200 Per Child Per Service Month (Dane Co.)	N/A

BH=Behavioral Health MH=Mental Health SA=Substance Abuse PH=Physical Health pmpm=Per Member Per Month

Comparing Rates

For states that are looking to other states' capitation rates for comparative purposes, several cautions are in order. Historical costs vary from state to state and obviously affect the particular rate a state decides to use. In addition, rates employed in a behavioral health carve out will be different from rates employed in an integrated physical and behavioral health reform. State reforms also cover different types of benefits; for example, some rates are being used only for outpatient services and do not include inpatient care. These rates will be lower than rates that cover a full range of services in the benefit design. Also, the populations covered by the reform vary from state to state; some reforms cover only part of the Medicaid population, for example. The point is that, in looking at another state's capitation rate, the full context of the reform in that state must be considered in order to make sense of the rate being used.

Use and Purpose of Risk Adjustment Mechanisms

As Table 48 indicates, fewer than half the reforms (47%) were reported to be using risk adjustment mechanisms, down from 61% in 1995. Most of the examples provided were of risk adjusted rates for certain populations, such as children in state custody or children with serious disorders. Similar findings were reported in the 1997 Impact Analysis.

Table 48

Percent of Reforms Using Risk Adjustment Mechanisms

	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Using Risk Adjustment Mechanisms	61%	45%	50%	47%	-14%
Not Using Risk Adjustment Mechanisms	39%	55%	50%	53%	+14%

The survey further explored whether the purpose of risk adjustment mechanisms was to guard against underservice to children with serious disorders, protect providers, or both, or some other reason. Table 49 shows that, of those reforms that use risk adjustment, approximately two-thirds, regardless of type, use risk adjustment mechanisms to protect providers or MCOs who are sharing the risk, and roughly a quarter of reforms use risk adjustment to guard against underservice for children and adolescents with serious disorders. This distribution is similar to that found in the 1995 survey.

Table 49

Percent of Reforms By Purpose of Risk Adjustment Mechanisms

	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
To Guard Against Underservice for Children and Adolescents with Serious Disorders	36%	15%	33%	23%	-13%
To Protect Service Providers or MCOs Who are Sharing the Risk	57%	69%	68%	68%	+11%
Other	7%	15%	0%	9%	+2%

Risk Sharing Arrangements

The 1995 State Survey found that over half of the states were sharing risk with MCOs. However, the 1997 Impact Analysis identified a trend among states to push full risk to MCOs. The 1997-98 State Survey reaffirms this trend.

As Table 50 shows, in comparison to 1995 when 56% of reforms reported risk sharing arrangements in which the states and MCOs either shared both risk and benefit (47%) or shared risk only (9%), only 28% of reforms in 1997-98 were reported to include risk sharing arrangements (22% sharing benefit and risk; 6% sharing risk only). States with integrated designs reportedly were twice as likely to share risk with MCOs than states with carve outs.

Table 50

Percent of Reforms by Type of Risk Sharing Arrangement

	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
MCOs Have All the Benefit and All the Risk	31%	65%	50%	59%	+28%
State has All the Benefit and All the Risk	6%	0%	0%	0%	-6%
MCOs and State Share Benefit and Risk	47%	20%	25%	22%	-25%
MCOs and State Share Risk Only	9%	0%	17%	6%	-3%
MCOs and State Share Benefit Only	0%	15%	8%	13%	+13%

In 1995, 31% of reforms reportedly pushed all risk to MCOs. In 1997-98, the percentage climbed to 72% (59% in which MCOs have all of the benefit and all of the risk, and 13% in which states share the benefit but push all of the risk to MCOs). States with carve out designs were more likely than states with integrated reforms to push all of the risk to MCOs.

Pushing Risk to Service Providers

The 1997 Impact Analysis, which had a sample of ten states (eight with carve out designs and two with integrated designs) did not find a trend of MCOs' pushing risk down to service providers through subcapitation arrangements, but found instead that most providers were still being paid on a fee-for-service basis. The results of the 1997-98 State Survey suggest this continues to be the case for states with carve outs, but not for states with integrated designs. As Table 51 indicates, nearly two-thirds (63%) of carve outs continue to reimburse providers on a nonrisk basis, while over two-thirds (69%) of integrated reforms reportedly put providers at risk through subcapitation arrangements. Considered together, all reforms, regardless of type, reportedly are split, 50-50, as to whether or not they put service providers at risk.

Table 51

Percent of Reforms Pushing Risk to Service Provider Level

	Carve Out	1997–98 Integrated	Total
Pushes Risk to Service Providers	37%	69%	50%
Does Not Push Risk to Service Providers	63%	31%	50%

Integrated systems, which include both physical and behavioral health service providers, may be more likely to put providers at risk for a variety of reasons. Integrated reforms in many states are "older" than behavioral health carve outs, giving everyone involved in the reform more time to understand risk issues and opportunities. Also, providers in integrated design networks, who often are individual practitioners, group practices, or hospitals, may have more experience with managed care in the commercial sector and thus more willingness to assume risk than providers in carve out arrangements, which may include more community-based, nonprofit agencies that traditionally have served noncommercial, public sector service recipients. The 1997 Impact Analysis, however, did note that many of these providers expressed interest in assuming risk in exchange for the greater flexibility in providing services and clinical decision making that capitation allows. This issue, including differences between states with carve outs and those with integrated designs, will continue to be explored in the 1999 Impact Analysis.

Limits on MCO Profits and Administrative Costs

Table 52 indicates the percentage of reforms that place limits on MCO profits or administrative costs. Less than half of reforms (48%) limit profits; slightly more than half (58%) limit administrative costs. However, there are significant differences between states with carve outs and states with integrated reforms. A large majority of carve outs reportedly limit MCO profits (75%) and/or administrative costs (80%). In comparison, only 8% of integrated designs were reported to place limits on MCO profits, and 23% were reported to place limits on administrative costs.

Table 52

Percent of Reforms With Limits Placed on MCO Profits and Administrative Costs

	Carve Out	1997–98 Integrated	Total
Limits MCO Profits	75%	8%	48%
Limits MCO Administrative Costs	80%	23%	58%

Reinvestment of Savings

The survey examined whether the reform required reinvestment of any savings back into the behavioral health system for children and adolescents, and if so, how savings were reinvested. As Table 53 indicates, there are major differences between states with carve outs and states with integrated designs as to whether they require reinvestment of savings into child and adolescent behavioral health care.

Table 53

Percent of Reforms Requiring Reinvestment of Savings and Purpose of Reinvestment

	Carve Out	1997–98 Integrated	Total
Requiring Reinvestment	76%	0%	48%
Not Requiring Reinvestment	23%	100%	52%
How Savings are Reinvested			
Creating New or More Services	57%		
Serving More Children and Adolescents	43%		
Other	24%		

None of the states with integrated reforms reported requirements for reinvestment of savings into child and adolescent behavioral health care. This is consistent with observations made in the 1997 Impact Analysis that in states with integrated designs, physical health issues and concerns tended to take precedence over behavioral health concerns. In contrast, in states with carve outs, 76% reported requirements regarding reinvestment of savings. Savings reportedly were reinvested in the creation of new or more services (57% of carve outs that required reinvestment) and/or in serving more children and adolescents (43% of reforms requiring reinvestment). The 1997-98 State Survey found significantly higher percentages of carve outs incorporating requirements for reinvestment of savings than did the 1997 Impact Analysis, which found only 40% of states requiring reinvestment. This will be an area for further exploration in the 1999 Impact Analysis.

Investment in Service Capacity Development

The 1997 Impact Analysis observed that shifting to managed care does not, in itself, resolve the lack of service capacity for child and adolescent mental health and substance abuse services that exists in most states. The 1997-98 State Survey asked states, besides requiring reinvestment of savings from managed care reforms, whether states were investing in service capacity development. Two-thirds of the states (68%, Table 54) indicated they were investing in service capacity development, often noting that these efforts were taking place independent of managed care systems. The extent to which these investments are benefitting managed care systems remains unclear and will be explored further by the Tracking Project.

Table 54

Percent of States Investing in Service Capacity Development

	1997–98
Investing in Service Capacity Development	68%
Not Investing in Service Capacity Development	32%