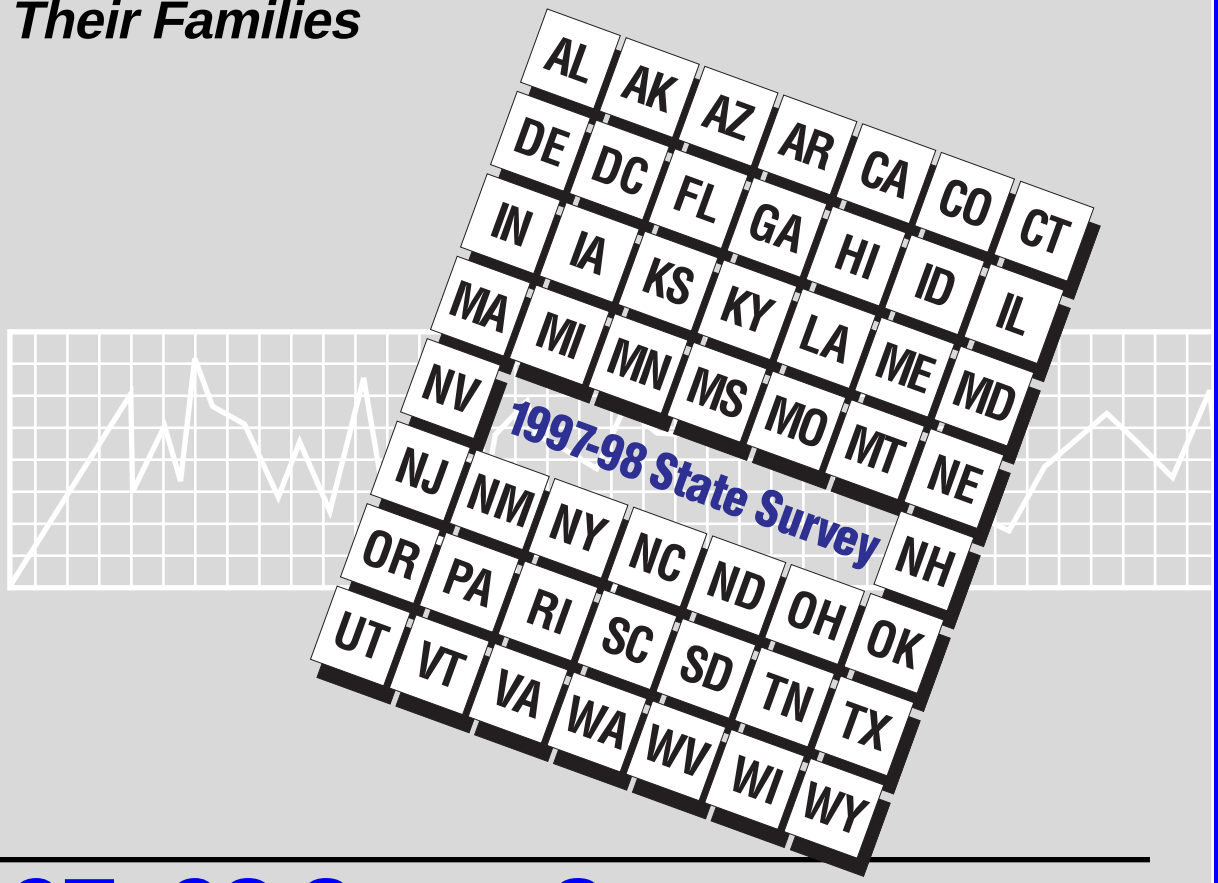
Health Care Reform Tracking Project:

Tracking State Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families



1997–98 State Survey

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EXECUTIVE SUMMARY

The Health Care Reform Tracking Project is a five year project (1995-1999) designed to track and analyze the impact of public sector managed care reforms on children and adolescents with emotional and substance abuse problems and their families. It is co-funded by two federal agencies–the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services and the National Institute on Disability and Rehabilitation Research of the Department of Education with supplemental funding from the David and Lucile Packard Foundation for special analyses related to child welfare. It is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, DC, and the National Technical Assistance Center for Children's Mental Health at Georgetown University.

The Tracking Project is being undertaken at a time of significant changes within public health and human service delivery systems, as states are increasingly applying managed care technologies to the delivery of mental health and substance abuse services (together referred to as "behavioral health" services). Both concerns about and potential benefits of managed care reforms in the public child and adolescent behavioral health arena have been articulated, and the Tracking Project is an important step toward understanding the impact of these reforms on children and adolescents with behavioral health disorders and on the systems of care that serve them. The project is intended to inform state and national policy and to assist states and localities to address the needs of this population of children and adolescents and their families in the managed care reform process.

The methodology of the Tracking Project involves two major components–surveys of all states and impact analyses through in-depth site visits to a select sample of states. An initial baseline survey was conducted in 1995 to identify and describe state health care reforms. The all-state survey was repeated in 1997-98 in order to document changes resulting from the increasing implementation and refinement of managed care reforms since the 1995 survey. This report presents the findings from the 1997-98 State Survey, drawing comparisons to 1995 survey results.

General Information About State Health Care Reform Initiatives

As of late 1997-early 1998 when the data were collected, nearly all states (98%) reported involvement in health care reform activity, increased from 86% in 1995. As in 1995, most reforms are focusing on Medicaid and involve application of managed care approaches. Also consistent with 1995 survey results, most health care reforms involve the use of some type of Medicaid waiver, focus on both physical health services and behavioral health services, and are statewide rather than limited to specific geographical areas. As expected, over half of the reforms were reported to be in advanced stages of implementation in 1997-98, more than a 30% increase since the 1995 survey.

Of the 43 managed care reforms analyzed, nearly two-thirds were characterized as behavioral health carve outs in which the financing and administration of behavioral health services are separate from (that is "carved out" from) the financing and administration of physical health services. One-third of the reforms were characterized as having "integrated" designs in which the financing and administration of physical and behavioral health services are integrated. About two-thirds of the carve outs include both mental health and substance abuse services, while most of the remaining carve outs cover only mental health services. Reforms with integrated designs are more likely to include both mental health and substance abuse services (87% cover both).

In nearly three-quarters of the reforms, state Medicaid agencies were reported to have lead responsibility for planning and oversight, with mental health agencies having or sharing lead responsibility in only half of the reforms. State substance abuse agencies were identified as playing an even less dominant role. Despite the lack of system oversight authority in many states, the involvement of some key stakeholders in planning, implementing, and refining reforms has improved since 1995. For example, state children's mental health staff and families of children with behavioral health disorders are becoming increasingly involved in the initial planning of reforms and even more so in later stages of system refinement, with such involvement more significant in carve outs than in integrated reforms. Still, families reportedly lack *significant* involvement in over 60% of the reforms, and the involvement of state substance abuse staff was characterized as significant in only 23% of the reforms.

Populations Affected by Managed Care Reforms

Although only half of the reforms cover the entire state Medicaid population, nearly all (96%) cover one or more subgroups of the Medicaid population, with the AFDC/TANF, poverty related, and pregnant women and children subgroups covered most frequently. Increases from 1995 to 1997-98 in coverage of all subpopulations suggest the movement of states towards applying managed care throughout their Medicaid programs, including populations characterized by greater risk of being high utilizers of services (such as the SSI and child welfare populations). The vast majority of reforms include both children and adults, and, as in 1995, the few age-based reforms in existence focus on children and adolescents, rather than adults.

Services Covered by Managed Care Reforms

Three-quarters of the reforms reportedly cover both acute and some extended care. Extended care coverage is more likely to be included in reforms with carve out designs; fewer than half of the reforms with integrated designs include extended care. When extended care is not included in managed care systems, the public mental health and substance abuse systems were cited as responsible for providing these services.

For both mental health and substance abuse services, about 40% of the reforms

reportedly cover most or all of the range of services presented in the survey, and reforms with carve out designs were more likely to cover more of the services. Coverage in reforms with integrated designs is more likely to be limited to the traditional 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. Findings further indicated that payment for many services is still provided by other funding streams outside of managed care systems, suggesting continued fragmentation in behavioral health delivery.

More than half of the reforms provide different, typically better, coverage for children—fewer limits, a broader service array, increased flexibility or wraparound service approaches—demonstrating perhaps a growing recognition that children have different treatment and support needs from adults. About one-half of the reforms also include differential coverage for children with serious behavioral health disorders, slightly increased since 1995. An expanded service array and intensive case management are the most commonly used special services for this group of youngsters with serious and complex treatment needs. All of the carve out reforms, but only about half of the integrated reforms, reportedly are building on previous system of care development efforts and incorporating system of care values and principles (such as a broad service array, family involvement, individualized care, interagency treatment planning, and cultural competence) as they develop their managed care systems.

Managed Care Entities

Since the 1995 survey, there has been a growth in states' use of for-profit managed care organizations (MCOs). Nearly half (47%) of all reforms reported using for-profit MCOs in 1997-98, up from one-third in 1995. Some increase in the use of government entities as MCOs was also noted, with carve outs far more likely to use this type of entity than integrated reforms. Community-based nonprofit agencies were less likely to be used as MCOs than either for-profit or government entities; only 13% of the reforms reportedly are using community-based nonprofit entities. Further, states reportedly are not changing the types of MCOs they are using as a result of mid-course corrections or policy changes, with only 15% of reforms reporting that the types of MCOs have been changed since initial implementation.

Carve out reforms were more likely to provide training and orientation to MCOs regarding the needs of children and adolescents with serious emotional disorders, with substance abuse problems, or in the child welfare system as well as training related to the Medicaid population in general. Training is provided most frequently on the Medicaid population in general and on children and adolescents with serious emotional disorders; training related to adolescents with substance abuse problems was the least likely type of training to be provided.

Management Mechanisms

In both 1995 and 1997-98, the range of management mechanisms commonly associated with managed care are employed in states' behavioral health managed care systems. The most commonly used management tools are utilization management and prior authorization, used in 93% and 88% of the reforms respectively.

Case management is used as a management mechanism in 76% of the reforms. Reforms with integrated designs are more likely to provide case management with a fiscal and utilization control focus (45% do so), whereas nearly all carve outs use a case management model that includes service accessing, brokering, coordinating, and advocacy. As in 1995, about half of the reforms reportedly use special management mechanisms for children and adolescents with serious behavioral health disorders (such as interagency service planning and more intensive levels of case management) and about half use special management mechanisms for children in the child welfare system.

Most reforms (86%) reported using medical necessity criteria to guide access to behavioral health services; more than one-third reported making revisions in their medical necessity criteria since initial implementation, most often to broaden them to include psychosocial considerations. Nearly three-quarters of the reforms reported having clinical decision- making criteria specific to children and adolescents (such as level of care or patient placement criteria), with carve outs far more likely to have child-specific criteria than integrated reforms. Nearly all reforms reported having grievance and appeals processes (98%); families and providers were identified as the major sources of appeals.

Financing and Risk

Consistent with 1995 findings, the vast majority of the reforms are using capitation financing (92%), 16% reported using case rates. In about half of reforms, rates have been changed since initial implementation, with carve out reforms more likely to make such changes and more likely to incorporate mechanisms to reassess and readjust rates at specific intervals. States are predominantly using Medicaid dollars to fund children's behavioral health services in managed care reforms. Mental health dollars were included in over half of the reforms, with carve out reforms more likely to include mental health dollars (78% do as compared with 14% of the integrated reforms). Carve outs were also more likely to include child welfare and substance abuse agency dollars.

Fewer than half of the reforms were reported to be using risk adjustment mechanisms, decreased from 61% in 1995, with most examples being risk adjusted rates for certain populations, such as children in state custody or children with serious disorders. In almost two-thirds of the reforms using risk adjustment mechanisms, respondents indicated that risk adjustment was geared primarily to protecting MCOs or providers. The 1997-98 survey results confirm a trend among states to push full risk to MCOs—72% push all risk to MCOs

in 1997-98, compared with only 31% in 1995. Risk at the provider level is less clear, with about two-thirds of the carve outs continuing to reimburse providers on a nonrisk basis and about two-thirds of the integrated reforms reportedly putting providers at risk through subcapitation arrangements. Overall, providers are placed at risk in half of the reforms.

A large majority of carve outs reportedly place limits on MCO profits (75%) and/or administrative costs (80%); few integrated reforms do so. In addition, three-quarters of the carve out reforms require reinvestment of savings in managed care systems into child and adolescent behavioral health care, whereas no integrated reforms were reported to incorporate such requirements. In addition, 68% of the reforms indicated that states are investing in service capacity development, often taking place outside of managed care systems.

Family Involvement at the System Level

Respondents noted that 98% of the reforms currently involve families in some way in managed care system oversight and refinement; *significant* family involvement was reported in only 38% of the reforms. The most frequent mechanisms for family involvement at the system level include involvement as members of various state advisory structures. Nearly half the reforms (45%) reportedly provide funding for family organizations to play a role in managed care systems, again, most frequently to support participation on planning, advisory, and oversight structures related to managed care systems.

Providers

Similar to 1995, almost half of reforms (44%) designate essential providers—providers who are required to be included in provider networks. Community mental health centers were the types of essential providers designated most often. In addition, most reforms (80%) include provisions to address the inclusion of culturally diverse and indigenous providers in provider networks. About one-third of the reforms reportedly include new or revised credentialing requirements for behavioral health providers or programs, with carve outs twice as likely to include new credentialing requirements than integrated reforms.

Quality and Outcome Measurement

All reforms in 1997-98 reportedly incorporate some type of quality measurement system, and the majority (88%) indicated that child-specific quality measures are included. Families were reported to be involved in most quality measurement systems (89% of all reforms), typically by responding to surveys. In addition to serving as a source of information about system quality, some states are beginning to involve families in the design and oversight of quality measurement processes (44% of all reforms). Such involvement is more likely to occur in carve out reforms.

With respect to outcome measurement, the dimension receiving the most attention in 1997-98 is access (90% of the reforms reported measuring this), as well as service utilization and parent satisfaction (each measured by 80%) and cost (measured by 78% of the reforms.) Comparatively less attention is given to clinical and functional outcomes, measured by fewer than two-thirds of the reforms; carve out reforms were much more likely to measure clinical and functional outcomes (82% do as compared with only 23% of the integrated reforms.) Fewer than one-third of the reforms reportedly are measuring the impact of managed care on other child-serving systems, such as child welfare, juvenile justice, and education, and fewer than one-half of the reforms with formal evaluations incorporate a specific focus on children and adolescents.

Child Welfare Managed Care

Supplemental funding from the Packard Foundation has enabled the Tracking Project to include a special focus on child welfare. In addition to assessing the impact of behavioral health managed care reforms on children and adolescents involved in the child welfare system, a special analysis of *managed care reforms in public child welfare systems* has been conducted. This report summarizes the highlights of this special analysis, providing information on 25 state and community child welfare managed care initiatives identified through the 1997-98 State Survey.

Issues for Further Consideration

The following issues emerged from the 1995 and 1997-98 State Surveys, in combination with the 1997 Impact Analysis, as needing additional exploration through the Tracking Project and/or other efforts:

- Differences in design of managed care systems (i.e., carve out, integrated, integrated with partial carve out, and other designs) and their impact.
- The relationship between acute and extended care within managed care systems and with child-serving systems outside managed care systems.
- Changes and refinements made to managed care systems since initial implementation, including the problems they are designed to address, and their impact on ameliorating system issues.
- The systemic separation between mental health and substance abuse services in some managed care systems, and the implications for service delivery and service coordination.
- The extent and nature of more restrictive day and visit limits and more onerous cost-sharing requirements applied to behavioral health in managed care systems and their impact on access to appropriate services and on cost-effectiveness.
- The effect of a limited array of services in managed care systems on children and families, as well as on the cost-effectiveness of services.

- The incorporation of special provisions for children with serious disorders, and the ability of managed care systems to meet the needs of this population.
- The relationship of managed care and system of care reforms, and the impact of managed care reforms on systems of care.
- Both the advantages and problems associated with the use of various types of MCOs.
- The use of prior authorization and other management mechanisms and strategies to make them more efficient and better accepted by providers, consumers, and other child-serving agencies.
- Trends, advantages, and problems related to the use of medical necessity and other clinical decision-making criteria related to behavioral health services for children and adolescents.
- The basis for capitation, the sufficiency of rates, provisions for reassessing the adequacy of rates, and the allocation for behavioral health in integrated systems.
- Trends with respect to pushing risk to the MCO and provider levels, as well as the incorporation of risk adjustment mechanisms to protect MCOs and providers and to prevent underservice.
- The development of approaches to measure clinical and functional outcomes of behavioral health services for children and adolescents and results generated.
- The level of and approaches to involvement of families at the system level in planning, overseeing, and refining managed care systems.
- The level of and approaches to ensuring cultural competence in managed care reforms, particularly the participation of culturally diverse and indigenous providers in managed care provider networks.
- Efforts (and results) of states' attempts to assess the effects of managed care reforms on other child-serving systems, with particular attention to the shifting of children and costs.

Health Care Reform Tracking Project:

Tracking State Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and their Families

1997–98 State Survey

I. INTRODUCTION

Health Care Reform Tracking Project

The Health Care Reform Tracking Project is a five-year project (1995-1999) designed to track and analyze state health care reform initiatives as they affect children and adolescents with emotional and substance abuse disorders and their families. It is co-funded by two federal agencies—the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services and the National Institute on Disability and Rehabilitation Research in the Department of Education. Supplemental funding has been provided by the David and Lucile Packard Foundation for a special analysis of the effects of these reforms on children and adolescents in the child welfare system. The project is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C., and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center.

The Tracking Project is being undertaken at a time of rapid changes within public health and human service delivery systems, as states are implementing reforms that involve the application of managed care technologies to the delivery of mental health and substance abuse services (together referred to as "behavioral health" services) provided through public agencies. *It is these public sector managed care reforms that are the primary focus of the Health Care Reform Tracking Project, with investigation centered specifically on behavioral health services for children and adolescents and their families*.

There has been much speculation as to the potential effects of managed care on the delivery of behavioral health services for children and adolescents and their families. The Health Care Reform Tracking Project is a first step toward understanding the impact of managed care in the public sector on such services. Currently, it is the only national study of public sector managed care focusing on children and adolescents with emotional and substance abuse disorders and their families.

The Tracking Project focuses on children, adolescents, and families who rely on public sector agencies and programs for behavioral health services. These include: Medicaid-eligible, poor and uninsured youngsters and their families; children and adolescents

who have serious behavioral health disorders whose families exhaust their private coverage; and families who turn to the public sector to access a particular type of service that is not available through their private coverage. Often, these children, youth and families depend on multiple state and local systems, including the mental health, substance abuse, health, child welfare, education, and juvenile justice systems.

State managed care activities are occurring against a backdrop of reform efforts in the children's mental health field to develop community-based systems of care, particularly for children with serious disorders, and in the adolescent substance abuse treatment field to develop a broad continuum of treatment options. The Tracking Project is concerned with exploring the impact of state health care reform activity on these reform efforts as well. The specific aims of the Tracking Project are to:

- Identify and describe managed care reforms in the public sector that affect behavioral health service delivery to children and adolescents and their families
- Analyze the effects of these changes on children and adolescents and their families and on the systems of care that serve them
- Identify both problem areas and effective approaches and strategies that will help to inform the activities of states and communities as they develop and refine their managed care systems

The project is intended to inform state and national policy and to assist states and localities to address the needs of this population of children and their families in the health care reform process.

Methodology

The methodology of the Tracking Project involves two major components—surveys of all states and impact analyses through in-depth site visits to a select sample of states.

State Surveys

1995 State Survey

The first activity of the Health Care Reform Tracking Project, which was carried out in the spring of 1995, involved conducting a baseline survey of all states to identify and describe state managed care reforms underway at that time. The 1995 survey, which achieved a 100% response rate, described managed care reform activities underway in 44 states, with seven states reporting no activity at that time. The 1995 State Survey provides a baseline against which to track changes in state managed care activity over time, and 1995 survey results are cited for comparative purposes throughout this report. The 1995 State Survey report is available through the Research and Training Center for Children's Mental Health at the University of South Florida.

1997-98 State Survey

Given the rapid pace of change in state managed care activity, the all-state survey was repeated in late 1997 and early 1998 to update information about state managed care activities affecting this population of children and adolescents and their families. **This**

report presents the results of the 1997-1998 all-state survey. In addition to describing state reforms, this report, as noted, also provides a comparison to state activity at the time of the 1995 baseline survey.

Impact Analyses

In addition to describing state managed care activities through the all-state surveys, the Tracking Project also is analyzing the *impact* of these reforms on youngsters with emotional and substance abuse problems and on the systems of care that serve them. The impact analyses involve in-depth site visits to a select number of states during which interviews are held with multiple, key stakeholders in order to obtain their assessments and perceptions regarding a wide range of areas related to managed care reforms. The first impact analysis took place in 1996-1997 and involved site visits to ten states. The 1997 Impact Analysis report is available through the Research and Training Center for Children's Mental Health at the University of South Florida. Findings from the 1997 Impact Analysis are noted, where appropriate, throughout this report on the 1997-98 State Survey.

A second impact analysis will take place in 1999, with another round of in-depth site visits to a sample of 8 new states and follow-up telephone interviews with the 1997 sample of 10 states. A second impact analysis report will be issued upon completion of the site visits and analysis of findings.

Methodology of 1997-98 State Survey

The 1997-98 State Survey, on which this report is based, captures changes since 1995 in state managed care activity affecting behavioral health service delivery to children and adolescents and their families. During this period, there has been increasing implementation and refinement of managed care reforms in the public sector.

Like the 1995 baseline survey, the 1997-98 State Survey used a written survey instrument (included as Appendix A) that was developed with input from a variety of key stakeholders, including family members, federal officials, state and local officials, advocates, and researchers.

Modifications to the original survey instrument were made for the 1997-98 survey to reflect findings from earlier activities of the Tracking Project. Refinements included adding questions to enable comparisons between state activity in 1995 and 1997-98 and incorporating greater specificity in response options based upon previous findings. Additionally, the survey was revised to incorporate a greater focus on managed care reforms affecting adolescent substance abuse services and to expand the focus on children involved in the child welfare system.

The written survey was sent to state child mental health directors, state substance abuse agency directors, and state substance abuse prevention directors in all 50 states and the District of Columbia in the fall of 1997. Several rounds of follow-up telephone calls were made to those receiving the survey to ensure receipt and understanding of

the survey and to encourage response. Surveys were returned during late 1997 through the summer of 1998. Responses were received from all 50 states and the District of Columbia.

The 1997-98 State Survey captures information across a wide variety of domains. These include:

- General information about managed care reforms
- Populations affected by managed care reforms
- Services covered by managed care systems
- Managed care entities
- Management mechanisms
- Financing and risk
- Family involvement
- Providers
- Quality and outcome measurement
- Child welfare managed care

Each is discussed below, presenting findings from the 1997-98 survey, comparing these findings with 1995 survey results, and noting findings from the 1997 Impact Analysis where relevant and appropriate.

As part of the survey, states also were asked to identify technical assistance materials related to health care reform that might be useful to other states. Many states identified materials, which have been catalogued and are available from the National Technical Assistance Center for Children's Mental Health at Georgetown University (see Appendix B: List of Technical Assistance Materials Available From States Related To Managed Care).

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. 2. Made change to allow for disenrollment of children entering state psychiatric hospital. 3. New requirement that MCOs provide step-down care for child welfare population. 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. (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 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 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 MH carve out	Middle - for integrated PH/SA Early - for MH carve out	No changes reported for integrated PH/SA 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) 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 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 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. 2. Has provided training to MCOs, referral agencies, Medicaid agency and providers related to adolescent substance abuse treatment. 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 BH carve out (pilot)	Late 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 distur-bance — 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 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	
	# States	% States	# States	% States
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 California Colorado Iowa Montana Oregon Utah Washington	Iowa	Arizona Arkansas Delaware District of Columbia Florida Indiana Kentucky Maine Maryland Massachusetts Michigan Nebraska New Jersey New York North Carolina Pennsylvania Tennessee Texas Wisconsin

Integrated Designs (N=15)

Physical Health and Mental Health and Substance Abuse			Physical Health and Substance Abuse
Connecticut Hawaii Minnesota Missouri Nevada	New Hampshire New Mexico North Dakota Ohio Oklahoma	Rhode Island Texas Vermont	Maryland 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.

III. POPULATIONS AFFECTED BY MANAGED CARE REFORMS

Populations Included in Health Care Reforms

Table 17 indicates the types of populations affected by state managed care reforms in 1995 and in 1997-98. The percentage of health care reforms covering the entire state population has remained about the same between 1995 and 1997-98, about 10%. Twenty-one percent of all reforms in 1997-98 include some portion of the uninsured population, representing a slight decrease in coverage of the uninsured from the 1995 survey. It is anticipated, however, that coverage of the uninsured in managed care systems may increase as states implement the State Children's Health Insurance Program, which provides federal support for states to offer coverage to uninsured children. Some states are electing to include uninsured children in their managed care systems.

Table 17

Percent of Reforms Covering Population Types

Population	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Entire State Population	10%	11%	7%	9%	-1%
Uninsured Population	27%	25%	13%	21%	-6%
Total Medicaid Population	59%	68%	13%	49%	-10%

Most managed care reforms are geared toward state Medicaid populations—either the entire Medicaid population or some subset of this group. In 1997-98, 49% of the health care reforms covered the entire Medicaid population, decreased from 59% of the reforms in 1995. The decrease in coverage of the total Medicaid population between 1995 and 1997-98 may be attributable to the reported increase in integrated physical health/behavioral health reforms, which are more likely to cover only a portion of the Medicaid population, typically the Aid to Families with Dependent Children (AFDC) / Temporary Assistance for Needy Families (TANF) population.

Although only half of the reforms cover the entire state's Medicaid population, 96% of the reforms reportedly cover one or more subgroups of the Medicaid population. Table 18 shows that both in 1995 and in 1997-98, the subset of the Medicaid population most likely to be covered by managed care reforms is the AFDC (now TANF) population. In 1997-98, the next most likely populations to be covered are pregnant women and children (covered in 88% of the reforms), poverty related populations (covered in 84% of the reforms), and children in the child welfare system (covered in 60% of the reforms).

From 1995 to 1997-98, significant increases in the coverage of all Medicaid eligibility categories has occurred. For example, the percentage of reforms covering the AFDC/ TANF subpopulation increased dramatically from 44% in 1995 to 96% in 1997–98.

Table 18

Percent of Reforms Covering Medicaid Subpopulations

Medicaid Population	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
AFDC/TANF	44%	92%	100%	96%	+52%
Poverty Related	24%	83%	92%	88%	+64%
SSI	20%	92%	23%	56%	+36%
Pregnant Women and Children	34%	75%	92%	84%	+50%
Children in Child Welfare System	37%	67%	54%	60%	+23%
Children in Juvenile Justice System	Not Asked	50%	31%	40%	NA
Other	15%	17%	8%	12%	-3%

Similar dramatic increases are noted for the poverty-related and pregnant women and children subgroups. Coverage of the SSI subpopulation increased as well; the SSI population was covered in only 20% of the reforms in 1995 but reportedly was covered by 56% of the reforms in 1997-98. Another subpopulation for whom coverage has increased is children in the child welfare system; the proportion of reforms covering this population has increased from 37% in 1995 to 60% in 1997-98.

Findings from the 1995 survey suggested that states were phasing in their Medicaid populations, beginning with the AFDC population and moving over time to include other subpopulations which may be expected to use more and costlier services. The increases in inclusion of the SSI and child welfare populations indicate that states are now more willing to cover populations with greater risk of needing more intensive and costly interventions. Overall, the substantial growth in the proportion of reforms covering each Medicaid subpopulation demonstrates the rapid movement of states towards managed care approaches in their Medicaid systems.

The 1997-98 survey also explored whether managed care reforms cover children in the juvenile justice system, an issue that was not examined in 1995. Fifty percent of the carve-outs and 31% of the integrated reforms include children in the juvenile justice system.

Age Groups Included in Health Care Reforms

As shown in Table 19, the majority of reforms (86%) in 1997-98 cover all ages. Only 14% of the reforms involve children and adolescents only. These findings are similar to 1995 when 12% of the reforms included only children and adolescents. As in 1995, if special age-based reforms are underway, they involve children and adolescents; in both 1995 and 1997-98, no reforms covered an adult population exclusively. All of the age-based reforms reported by states are behavioral health carve outs focusing on children and adolescents.

Table 19

Percent of Reforms by Age Groups Covered

Age Group	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
All Ages	88%	79%	100%	86%	-2%
Children/Adolescents	12%	21%	0%	14%	+2%
Adults	0%	0%	0%	0%	0%

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.

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

	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%

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	1997–98 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

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

	Carve Out	1997–98 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%

VIII. FAMILY INVOLVEMENT AT THE SYSTEM LEVEL

The 1997 Impact Analysis found that most managed care reforms have been generally supportive of family involvement in service delivery by requiring family involvement in treatment planning meetings, parents' signing off on treatment plans, and the like. Assessment of family involvement at the system level, however, revealed that family members were involved in the initial planning and implementation of managed care reforms in only one state. In nearly all of the states included in the 1997 Impact Analysis, this picture had begun to change, with families increasingly involved in advisory and oversight structures. To assess family involvement at the system level, items were added to the 1997–98 State Survey addressing the ways in which families are participating in system oversight and refinement, the roles played by family organizations, and funding to support the participation of family organizations in managed care reforms.

Family Involvement in Oversight and Refinement of Managed Care Systems

While respondents noted that 98% of reforms currently involve families in managed care system oversight and refinement in some way, they also reported this involvement as being significant in only 38% of the reforms (see Table 12). The 1997-98 survey also included an open-ended question exploring the ways in which families of children and adolescents with behavioral health disorders are involved at the system level. Consistent with the 1997 Impact Analysis findings, the most common approach to involvement of families at the system level is to involve them as members of various state advisory structures to the managed care system, including steering committees, advisory panels, and governor's advisory councils and legislative committees. Respondents from the following states specified that family members participate in some type of advisory structure at the state level:

Alaska
Arkansas
California
Colorado
Iowa (Mental Health Carve Out)
Kentucky
Maine
Maryland
Massachusetts
Michigan
Montana
Pennsylvania
Texas
Washington
Wisconsin
Connecticut
Hawaii
Minnesota
Missouri
New Hampshire

In addition to parent participation on state-level structures, a number of other approaches to system-level family involvement were cited:

- Involvement of families on advisory committees to MCOs (Connecticut and Nebraska)
- Solicitation of family input into managed care system documents, such as plans and RFPs (Iowa's substance abuse carve out, Michigan, and Wisconsin)
- Use of family input and feedback received through grievance processes, hotline calls, and other processes to make system adjustments (Maryland's substance abuse reform and Oklahoma)
- Inclusion of families as members of quality review teams and site visit monitoring teams (Utah and Washington)

Role of Family Organizations in Managed Care Reforms

As shown on Table 55, 45% of all reforms reportedly provide funding for family organizations to play a role in managed care systems. It is interesting to note that more than half of the states with carve out reforms (52%) fund a family organization, as compared to 31% of states with integrated reforms.

Table 55

Percent of Reforms Providing State Funding for Family Organization Role

Funding for Family Organization	1997–98 Carve Out	1997–98 Integrated	Total
Yes	52%	31%	45%
No	48%	69%	55%

Some respondents provided further information about the role family organizations play in managed care reforms. Again, the most frequently cited role for family organizations involved advisory, oversight, and/or planning functions. In fact, funding for family organizations most often is directed at supporting their participation on planning, advisory, and other oversight structures related to the managed care system. In several cases, family organizations fulfill a broader system advocacy role that includes the managed care system. In several other instances, the role of family organizations was described as involving family education regarding managed care reforms. Three states (Alaska, Kentucky, and New Jersey) are planning to use family organizations in the future to perform quality assurance functions such as conducting independent family satisfaction surveys.

IX. PROVIDERS

A focus of the Tracking Project has been to explore the effects of managed care reforms on providers of behavioral health services to children and adolescents and their families. The 1997 Impact Analysis found that reforms have affected both individual practitioners and behavioral health provider agencies at both organizational and practice levels. The 1997-98 State Survey investigated several issues related to providers' participation in managed care reforms—whether states have mandated that particular types of providers or agencies be included in managed care system provider networks, the inclusion of culturally diverse and indigenous providers, and new credentialing requirements associated with managed care reforms that affect provider participation.

Designation of Essential Providers

Essential providers are providers or provider organizations that are required to be included in provider networks. As shown on Table 56, 44% of all reforms in the 1997-98 survey reportedly designate essential providers; 56% do not. The proportion of health care reforms designating essential providers has remained essentially the same since the 1995 survey and is consistent with the 1997 Impact Analysis, which found that 50% of the states included in the sample mandated the use of essential providers.

Table 56

Percent of Reforms Designating Essential Providers

Use of Essential Providers	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Yes	41%	46%	38%	44%	+3%
No	59%	54%	62%	56%	-3%

The most frequent type of essential provider is community mental health centers, cited by eight of the reforms. The types of essential providers identified by respondents include the following:

- Community mental health centers (Alaska, Indiana, Kentucky, Michigan, Nebraska, Utah, Vermont, and Washington)
- Community behavioral health providers (Oklahoma and Wisconsin)
- Regional behavioral health boards (Arizona and North Carolina)
- County mental health clinics (Wisconsin)
- School-based health centers as essential providers and child guidance clinics and family services agencies as benchmark providers (Connecticut)
- Coalition of community mental health centers, universities, private providers, and hospitals (Kentucky)

- Designated individual providers, including physician, psychiatrist, behavioral developmental pediatricians, Ph.D. psychologists, nurse therapists, certified social workers, and certified professional counselors (Maryland)
- Federally Qualified Health Centers, community health clinics, community health agencies (Minnesota)
- Inpatient programs (Vermont)

Inclusion of Culturally Diverse and Indigenous Providers

As Table 57 indicates, 80% of all reforms reportedly have provisions that address the inclusion of culturally diverse and indigenous providers in provider networks. However, a substantially higher proportion of the carve out reforms (88%) were reported to include mandates for inclusion of culturally diverse providers than integrated reforms (64%).

Table 57

Percent of Reforms with Provisions for Inclusion of Culturally Diverse and Indigenous Providers

Provisions	1997–98 Carve Out	1997–98 Integrated	Total
Yes	88%	64%	80%
No	12%	36%	20%

Although 80% of the reforms include such mandates, the 1997 Impact Analysis found that, in most states, managed care reforms have had no impact on the inclusion of culturally diverse and indigenous providers. Further, in four states, managed care reforms have resulted in decreased availability of culturally diverse and indigenous providers, according to stakeholders, due to more stringent credentialing requirements and to the financial and administrative requirements of participating in managed care systems.

New or Revised Standards or Licensing Requirements

Table 58 shows that 37% of all reforms include new or revised standards or licensing requirements for behavioral health professionals or programs. The proportion of carve out reforms with new or revised credentialing requirements (43%) is almost double the proportion of integrated reforms (23%) with new or revised requirements.

Table 58

Percent of Reforms with New/Revised Credentialing Requirements for Providers

New/Revised Requirements	1997–98 Carve Out	1997–98 Integrated	Total
Yes	43%	23%	37%
No	57%	77%	63%

These findings are consistent with the results of the 1997 Impact Analysis, in which about a third of the states in the sample reported new or revised standards or credentialing requirements. In some reforms, the new requirements reportedly broadened the types of professionals that can be included in provider networks; in other reforms the new requirements were viewed as restrictive and limiting the types of staff, such as family members and substance abuse counselors, that could be included.

X. Quality and Outcome Measurement

The 1997-98 State Survey explored quality and outcome measurement in managed care reforms with respect to a number of issues: whether quality and outcomes measures are specific to children and adolescents, the extent to which families are involved in quality measurement, the types of outcomes that are measured, sources of information for outcome measurement, the existence of mechanisms to track the impact of managed care reforms on other child serving systems, and whether evaluations of managed care reforms include a focus on children and adolescents receiving behavioral health services.

Use of a Quality Measurement System

As shown on Table 59, 100% of the reforms in 1997-98 reportedly incorporate some type of quality measurement system. This finding is consistent with the emphasis in managed care on accountability and performance measurement. Further, the majority of reforms (88%) reportedly incorporate quality measures specific to child and adolescent behavioral health services. It should be noted that 100% of the carve out reforms were reported to have measures specific to children and adolescents, as compared with only 62% of the integrated reforms.

Table 59

Percent of Reforms Incorporating a Quality Measurement System

Quality Measurement System	1997–98 Carve Out	1997–98 Integrated	1997–98 Total
Included	100%	100%	100%
Child-Specific Measures	100%	62%	88%

Involvement of Families in Quality Measurement Systems

The 1997-98 survey gathered information about the ways in which families are involved in quality measurement systems. The survey sought to identify the mechanisms used to obtain information from families about the quality of services (such as participation in focus groups and completing surveys) as well as their participation in the design of the quality measurement system and monitoring of the quality measurement process.

As shown on Table 60, families are typically involved in quality measurement processes for managed care systems by responding to surveys, an approach reportedly used by 77% of all reforms. Participation of families in focus groups was cited less frequently; this approach reportedly is used by 44% of all reforms.

Table 60

Percent of Reforms with Family Roles in Quality Measurement Processes

Role	1997–98 Carve Out	1997–98 Integrated	Total
Not Involved	0%	31%	11%
Focus Groups	58%	15%	44%
Surveys	85%	62%	77%
Design of Process	58%	15%	44%
Monitoring of Process	46%	0%	31%
Other	12%	8%	11%

In addition to serving as a source of information about system quality, some states are beginning to involve families in the design and oversight of quality measurement processes in managed care systems. A significant proportion of managed care systems (44%) reportedly involve families in designing quality measures and/or quality measurement processes. In addition, respondents indicated that families play a role in monitoring the quality measurement process in nearly one-third of the reforms (31%).

In comparing carve outs and integrated reforms, the most striking finding is that 31% of the integrated reforms do not involve family members in any manner in their quality measurement process. In contrast, all the carve out reforms identified one or more roles for families in their quality measurement processes. For each of the family roles explored by the survey, the rate of participation in carve out reforms is notably higher than that in integrated reforms. Also, carve outs reportedly involve families in multiple roles, whereas respondents tended to identify only one way in which families are involved in the quality measurement processes of integrated reforms.

Several respondents identified additional ways in which family members are involved in quality measurement. Oregon's reform requires MCOs to involve families in their own quality measurement systems. In Pennsylvania, the managed care system involves family members in consumer satisfaction teams which review service delivery systems and complaints regarding the managed care system.

Types of Outcomes Used to Measure Children's Behavioral Health Services

Both the 1995 and the 1997-98 surveys revealed that reforms are using a wide array of outcome measures to assess child and adolescent behavioral health services. Across all reforms, the dimension receiving the most attention in 1997-98 was access, with 90% of the reforms indicating that access is measured (Table 61). Service utilization patterns and parent satisfaction also are measured extensively by managed care systems, each is reportedly measured in 80% of the reforms. (It is interesting to note that while parent satisfaction is measured by managed care systems, fewer–63%–were

reported to assess youth satisfaction.) These findings reflect a change from the 1995 State Survey which found that cost was the dimension most often measured by reforms at that time. Cost is still receiving considerable attention; respondents indicated that cost is measured in 78% of the reforms, reflecting only a slight decrease from the 83% reported to track cost in 1995.

Table 61

Percent of Reforms Measuring Various Types of Outcomes

Outcome	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Cost	83%	82%	69%	78%	-5%
Access	80%	96%	77%	90%	+10%
Service Pattern	77%	89%	62%	80%	+3%
Clinical and Functional Outcomes	51%	82%	23%	63%	+12%
Parent Satisfaction	69%	96%	62%	80%	+11%
Youth Satisfaction	60%	75%	38%	63%	+3%
Other	11%	11%	15%	12%	+1%
None	9%	0%	8%	2%	-7%

Another dimension receiving relatively less attention in managed care systems in 1997-98 is clinical and functional outcomes, reportedly measured in 63% of the total reforms. In 1995, clinical and functional treatment outcomes were also the least likely type of outcomes to be measured by reforms. These findings are consistent with the 1997 Impact Analysis which revealed that the focus of reforms appeared to be on measures related to process or cost, and that measurement of clinical and functional outcomes for behavioral health managed care systems was at an early stage of development, especially for children and adolescents. None of the states in the Impact Analysis sample reported having a well-developed outcome measurement system in place, although stakeholders in six of the ten states reported that the development of outcome measurement systems was in process. The reports that states are working on the development of outcome measurement systems were substantiated by the reported increase from the 1995 survey to 1997-98 survey in the measurement of clinical and functional outcomes—from 51% to 63% of the reforms. The measurement of parent satisfaction also increased by 11 percentage points from 1995 to 1997-98.

In comparing the differences between carve outs and integrated reforms in 1997-98, the most significant finding is that carve outs consistently were more likely to measure each type of outcome than integrated reforms. The pattern is most striking in the domain of clinical and functional outcomes, which is measured by 82% of the carve out reforms and by only 23% of the integrated reforms. Another dimension with a dramatic difference is the area of youth satisfaction, measured by 75% of the carve out reforms but by only 38% of the integrated reforms. Matrix 5 displays the types of outcome information measured by state.

Matrix 5

Types of Outcomes Measured by Managed Care Reforms Related to Child and Adolescent Behavioral Health Services

N/A Not Available

Types of Outcomes		Cost	Access	Service Utilization Patterns	Clinical and Functional Outcomes	Parent Satisfaction	Youth Satisfaction	Other	None
Carve Out (n=28)									
Alaska	AK			●	●	●	●		
Arizona	AZ		●	●	●	●			
Arkansas	AR	●	●		●	●	●		
California	CA	●	●	●	●	●	●		
Colorado	CO	●	●	●	●	●			
Delaware	DE	●	●						
District of Columbia	DC	●	●	●	●	●	●		
Florida	FL	●	●	●	●	●			
Indiana	IN	●	●	●	●	●	●		
Iowa–Mental Health	IA	●	●	●	●	●	●		
Iowa–Substance Abuse	IA	●	●	●	●		●		
Kentucky	KY	●	●	●	●	●	●		
Maine (N/A)	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 (SA)	MD								●
Minnesota	MN							●	
Missouri (N/A)	MO								
Nevada (N/A)	NV								
New Hampshire (N/A)	NH								
New Mexico	NM		●			●	●		
North Dakota (N/A)	ND								
Ohio	OH				●				
Oklahoma (N/A)	OK								
Oregon (SA)	OR	●	●	●	●	●	●		
Rhode Island	RI								●
Texas (PH/BH)	TX	●	●	●	●	●	●	●	
Vermont	VT								●

Sources of Information for Outcome Measurement

As shown on Table 62, in both 1995 and 1997-98, providers and families were identified as the major source of information for the measurement of outcomes by managed care systems. For both groups, there was an increase in the proportion of reforms indicating that they are a source of outcome information—from 73% to 87% for providers and from 68% to 82% for families. Although no information is available from 1995, 53% of all reforms in 1997-98 reportedly use the child welfare system as a source of information for outcome measurement, and about one-third use family organizations as sources.

Table 62

Percent of Reforms with Various Sources of Information for Outcome Measurement

Sources of Information	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Families	68%	93%	55%	82%	+14%
Providers	73%	96%	64%	87%	+14%
Child Welfare	Not Asked	48%	27%	42%	NA
Other Systems	38%	44%	18%	37%	-1%
Family Organizations	Not Asked	44%	0%	32%	NA
Other	24%	19%	27%	21%	-3%
None	6%	4%	9%	5%	-1%

The differences between carve out reforms and integrated health/behavioral health reforms in the sources of information used is striking. For example, in 1997-98, families are used as sources of information by 93% of the carve outs but by only 55% of the integrated reforms. Providers are used as information sources by 96% of the carve outs, but are used by only 64% of the integrated reforms. Family organizations are used by 44% of the carve out reforms as sources of information, but are not used as information sources by any of the integrated reforms. Similarly, the collection of outcome information from child welfare and other child serving systems occurs much more frequently in the carve outs than in the integrated reforms.

Tracking Impact of Reforms on Other Child Serving Systems

As is shown on Table 63, only 31% of all reforms are tracking the impact of managed care on other child serving systems, such as child welfare, juvenile justice, and education. The results from the 1997 Impact Analysis concur with this finding. Stakeholders in only one state involved in the Impact Analysis sample reported efforts to track the effects of managed care reforms on other child-serving systems, particularly with respect to the shifting of children and costs to these systems. Despite the lack of systematic tracking, respondents in eight of the ten states alleged that cost shifting was occurring from the managed care system to other children's systems.

Table 63

Percent of Reforms Tracking Impact on Other Child-Serving Systems

Tracking Impact	1997–98 Carve Out	1997–98 Integrated	Total
Yes	36%	20%	31%
No	64%	80%	69%

A higher proportion of the carve out reforms (36%) reportedly are tracking impact on other systems than of the integrated reforms (20%). Respondents noted that two additional carve out reforms were in the process of developing tracking mechanisms.

Formal Evaluations with a Child and Adolescent Focus

As is shown on Table 64, slightly less than half (47%) of the reforms with formal evaluations of their managed care systems underway indicated that these evaluations have a specific child and adolescent focus. This finding is consistent with the 1997 Impact Analysis which found that of the five reforms with a formal evaluation, two included a specific focus on children and adolescents.

Table 64

Percent of Reforms with Evaluations with a Child and Adolescent Focus

With Child Focus	1997–98 Carve Out	1997–98 Integrated	Total
Yes	62%	18%	47%
No	38%	82%	53%

Again, there is a noteworthy difference between the carve out and integrated reforms in the 1997-98 survey. Nearly two-thirds (62%) of the carve out reforms with evaluations include a specific child and adolescent focus. In contrast, only 18% of the integrated reforms include this focus.

XI. CHILD WELFARE MANAGED CARE REFORM INITIATIVES

In 1996, the David and Lucile Packard Foundation provided additional funding to enable the Health Care Reform Tracking Project to explore more fully: 1) the impact of state managed care reforms on children and families served by the child welfare system who need mental health and substance abuse services, and 2) the impact of managed care reforms in public child welfare systems on children with mental health and substance abuse service needs, and their families. This section addresses the latter, providing information on 25 state and community child welfare managed care initiatives.[1]

Methodology of the Special Child Welfare Managed Care Analysis

The 1997-98 State Survey explored whether the state child welfare system was implementing or planning to implement reforms related to the management, financing, or delivery of child welfare services at the state or county levels, and if these reforms were defined as "managed care." Responses from 36 states indicated that a child welfare system reform defined as managed care was planned or underway, and in early 1998, these sites were contacted to provide information for the study's special child welfare focus. Following these initial contacts, 11 of the 36 sites were excluded from the analysis for several reasons: 1) the key site contact did not believe the initiative could be characterized as "managed care" (i.e., it was not using managed care approaches such as utilization management, capitation or case rates, outcomes measurement, or provider networks); 2) the site did not respond to several requests for an interview; or 3) the initiative was a local multisystem demonstration initiative affecting only a small group of children. This report includes information about multisystem initiatives only if they are *statewide* or affect a large number of children.

An additional source of information about these child welfare managed care initiatives was the Child Welfare League of America's (CWLA) Managed Care and Privatization Child Welfare Tracking Project. The work of the Health Care Reform Tracking Project, especially, the special analytic work related to child welfare, is coordinated with this CWLA project, by continuously sharing information on the frequent changes that are occurring as states and communities implement child welfare managed care reforms.[2]

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[1] *Child welfare managed care*, as described in this document, refers to a type of child welfare reform in which states or communities apply some managed care approaches to the organization, provision, and funding of child welfare services. Child welfare managed care reforms primarily address the use of funds allocated to the child welfare system, and may or may not include some behavioral health services or funds.

[2] CWLA publications are available from the Child Welfare League of America Managed Care Institute at 202/638-2952.

Following site selection, telephone interviews, following a specific interview protocol, were conducted with individuals knowledgeable about the planning, design or implementation of the child welfare reform in each of the 25 sites. Through these interviews, information was collected that described the child welfare managed care initiative itself, the involvement of the child mental health system in the child welfare reform, the effects of managed behavioral health care on children in the child welfare system, coordination of behavioral health and child welfare reforms, and any state or local reforms designed to serve children in multiple systems.

Due to time and resource limitations more qualitative information from front-line child welfare workers or families was not obtained. The 1999 Impact Analysis, which involves three-day site visits to eight states, will explore more fully the experiences and views of others such as front-line child welfare workers, provider agencies, families, and other child-serving systems. Because many sites were still planning or were only beginning to implement their reforms, the results from the 25 phone interviews provide more descriptive information about project design than details about the impact on service delivery or outcomes for children and families served by these reform efforts.

A complete report on analyzing child welfare managed care initiatives has been prepared.[3] The full report includes four sections presenting the wealth of information collected through the telephone interviews and survey instruments:

- Section I describes four major approaches used by states or communities to introduce managed care techniques into their child welfare programs. Key issues examined for each approach include: goals, target population and services, implementation stage, financing strategies, management mechanisms, managed care entities, risk sharing arrangements and capitation or case rates, family involvement, and cultural competence.
- Section II describes the extent and nature of coordination between managed behavioral health care reform and child welfare managed care initiatives and the effects of this coordination on children in both systems who have serious behavioral health problems and their families.

[3]Schulzinger, R., McCarthy, J., Meyers, J., Irvine, M., & Vincent, P. (1998) Health care reform tracking project: Tracking state managed care reforms as they Affect Children and Adolescents with Behavioral Health Disorders and their Families, The 1997-98 state survey. *Special Analysis: Child Welfare Managed Care Initiatives*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. (To obtain a copy of the full analysis, contact the National Technical Assistance Center for Children's Mental Health at 202/687-5000.

- Section III describes how four states use, or plan to use, managed care techniques to implement Title IV-E waivers.
- Section IV presents a summary of positive findings and concerns about these child welfare managed care initiatives, an overview of lessons learned, and recommendations for further study.
- Appendix A includes a list of all sites interviewed and provides detailed summary profiles of each site. The interview protocol also is included as an appendix.

A summary of the key findings from the special analysis of child welfare managed care initiatives follows.

General Trends

Descriptive information from the 25 sites indicates a number of general trends:

- Child welfare managed care tends to be limited to subsets of populations and/or services rather than to be a comprehensive system reform. Many reform initiatives are being conducted first as pilots or in specific geographic areas, rather than as statewide initiatives.
- Few child welfare managed care reforms involve waivers of any type; only one site reported the use of a Medicaid waiver and four reportedly are using IV-E waivers.
- Most initiatives are in the planning or early implementation stage. Only four sites had been in operation more than one year at the time of the interviews.
- State and county public child welfare agencies are not all going down the same track, but instead are experimenting with several different approaches to better serve children and families:
  - A fairly comprehensive managed care approach (13 of 25 sites)
  - Managed care for the provision of mental health services only (4 of 25 sites)
  - Privatization (2 of 25 sites)
  - Multisystem initiatives (7 of 25 sites)
- While respondents recognized that managed care is a way to achieve cost efficiency, other goals that can lead to improved service delivery and outcomes for children and families, such as averting unnecessary out-of-home placement or achieving permanency, also are driving these reform efforts.

Target Populations and Services

The target populations that the reforms tend to focus on are primarily children in out-of-home placements and their families (23 of 25 sites). Most, but not all, of the reforms serve young children, as well as older youth. The majority of the reforms serve children with serious emotional disturbances (15 of 25). Children at risk of placement are served in 19 of the 25 reforms.

Services included in almost all the reforms are placement services, and most incorporate family preservation and support, as well as adoption. The child welfare program that appears to be least affected by the reforms is child protective services (CPS). Although some aspects of CPS assessment and service delivery are included in the reforms, the responsibility for investigation and determination of abuse or neglect is rarely turned over to private agencies. At least some mental health services are covered by most of the reforms.

Management Mechanisms

Most of the child welfare reforms use a variety of management mechanisms that are generally considered part of managed care technology. It appears that the reform efforts are changing how eligibility is determined—many are using teams of workers, rather than a single individual, to decide eligibility and determine the required level of care. The majority of the child welfare managed care reforms create or contract with provider networks and assure comprehensive case management. Many rely on utilization reviews to determine if children are receiving appropriate services. Virtually all reforms intend to track outcome-related data by reviewing expenditures and a variety of additional indicators.

Managed Care Entities

Public child welfare agencies frequently retain responsibility for serving as the managed care organization (MCO) (8 of 25 sites), rather than contracting that function to a private organization. Organizations outside of the public child welfare system that do serve as MCOs are usually not-for-profit or local collaboratives. Only one site reported contracting with a for-profit organization to serve as the MCO. Three reported using for-profits as administrative service organizations (ASOs). At the time of the interviews, 7 of the 25 sites had not yet determined what type of entity would serve as the MCO.

Funding

Child welfare funds are used in all 25 of the initiatives, with many also including Medicaid (16 sites) and mental health (12 sites) funding sources. Other child-serving agencies contribute less to the child welfare reforms. More than half of the sites interviewed are relying on case rates to provide flexibility and, in some instances, to share risk with lead agencies or a managed care entity. Only 3 of the reform efforts cited the use of capitation financing. Most of these involved states offering a capitated budget to counties and shifting the risk (or part of it) for costs above the capitated budget to the county.

Family Involvement and Cultural Competence

Although respondents identified family involvement in planning many of the child welfare reform initiatives, this involvement tended to be peripheral (focus groups, public meetings) rather than placing families as partners in decision making. Respondents in

9 of the 25 sites believed that the historical practice of parents having to relinquish custody to obtain treatment services for their children would be reduced as a result of the child welfare managed care reform. Respondents also indicated that most of the reform initiatives have provisions to address the inclusion of culturally diverse and indigenous providers.

Behavioral Health Services

The public mental health system is usually primarily responsible for the provision of *acute* behavioral health care services for children in the child welfare system (16 of 25 sites). However, the child welfare system is involved in almost one-third of the sites, with either primary responsibility for acute care services (in 2 sites) or sharing it with the mental health agency (in 6 sites). For *extended* behavioral health care, the public mental health system is not as involved, according to child welfare respondents, characterized as primarily responsible in less than half of the sites (10 of 25). In 11 of the sites, the child welfare and mental health systems shared responsibility for extended care services, and in 3 sites the child welfare agency assumed primary responsibility for extended behavioral health care.

Coordination of Child Welfare and Behavioral Health Reforms

There is some coordination between child welfare and behavioral health managed care initiatives in many of the 25 sites, however, very few are totally integrated. Respondents indicated that lack of coordination between the two can lead to numerous problems, such as duplication, service gaps, cost shifting, disagreements about payment responsibilities, confusion for families, and inconsistent rates and policies for providers who contract with both systems.

Respondents indicated that most behavioral health care reform initiatives in their states and communities include and provide at least some services for children in the child welfare system (22 of 25 sites).[4] However, 19 of the 25 respondents also said that Medicaid funds—separate from and outside of the behavioral health managed care initiative—remain available to fund mental health services for children and youth in the child welfare system.

It appears that in about half of the sites, each system (child welfare and behavioral health) was involved in planning the other system's reform initiative. However, neither appears to be adequately tracking the impact of managed care on other child-serving systems.

[4] In the 1997-98 State Survey, of the 43 state behavioral health managed care reforms analyzed, 26 reforms (60%) reportedly included children in state custody.

Title IV-E Waiver Demonstrations

Title IV-E waiver demonstrations are being used as a vehicle for testing a managed care approach in 4 of the 25 sites. Respondents cited numerous positive anticipated outcomes from these demonstrations. Most of these four sites employing managed care strategies in implementation of their IV-E waivers are basing their efforts on system of care values and principles and have incorporated a wraparound philosophy and process in the delivery of services. They support flexibility in service delivery that is community based, centered on the needs of each individual child, and family focused.

In the July 10, 1998 Federal Register, at least five of the 17 new state IV-E waiver requests include managed care approaches in their implementation plans.

Findings and Lessons Learned

Initial positive findings as well as concerns are evident from the findings of this study; however, they reflect expectations more than actual outcomes as many respondents felt it was “just too early to tell”.

Initial positive findings suggest that managed care reforms in child welfare systems:

- Secure greater flexibility for child welfare systems and opportunities to leverage child welfare funds in new ways
- Promote greater concern about accountability to the public and decision makers
- Increase attention to achieving more concrete outcomes for child welfare systems and the children and families they serve
- Promote a more efficient service delivery system and influence providers to offer a greater array of home and community-based services
- Provide opportunities for child welfare agencies to work in partnership with a broader group of child-serving agencies, promoting a greater sense of shared responsibility among agencies to serve children and their families
- Increase access to services for children and families
- May reduce the practice of relinquishing custody of children in order to obtain services
- Reduce reliance on out-of-home care

Initial concerns about child welfare managed care initiatives include the following:

- Insufficient tracking mechanisms to determine outcomes and possible cost shifting among child welfare and mental health agencies
- Insufficient family involvement in design, planning, and program implementation
- Insufficient current data to make decisions about setting case or capitation rates
- Concern that case rates may be too low

- No special (higher) case rates for children with serious behavioral problems
- Loss of control in decision-making
- Changing role for child welfare staff from service provider/manager to monitor
- Fear of accepting or sharing risk

Respondents were eager to share lessons learned and ideas about how to plan and implement child welfare reforms so that others could benefit from their experience. Foremost in their suggestions was the need to allow adequate planning time and to build partnerships with all stakeholders. Other advice included: set realistic, clear, common goals and objectives; collect adequate data to make informed decisions; avoid risk arrangements until two years of data are available; implement the reform in stages, allowing time to incorporate changes as needed; learn from criticisms and difficulties; focus the reform on assisting the family, rather than on an individual child; practice "managing care" rather than "managed care" in the traditional sense; clearly define the new responsibilities of child welfare and other involved agencies; build strong relationships with providers; set outcome measures with all stakeholders and monitor the impact of the reform.

XII. HIGHLIGHTS AND ISSUES FOR FURTHER CONSIDERATION

This section highlights the major findings of the 1997-98 State Survey, presenting them according to: 1) changes that have occurred since the 1995 survey, 2) areas that have remained constant since 1995, and 3) differences between reforms with carve out and integrated designs. In addition, issues needing further consideration are identified, based upon results of the 1995 and 1997-98 surveys as well as the 1997 Impact Analysis.

Changes Since the 1995 State Survey

The 1997-98 State Survey found the following changes to have occurred in state managed care activity since the 1995 baseline state survey:

State Involvement in Managed Care

- A 12% larger majority of states reported involvement in managed care reforms in 1997-98 than in 1995. Ninety-eight percent of states (all but one) reported involvement in managed care activity affecting behavioral health service delivery to children and adolescents and their families in 1997-98, compared to 86% (all but seven states) in 1995.
- States are developing greater experience with managed care, with over half of the states (52%) reporting that they are in mid to late stage implementation of their managed care reforms, compared to 1995, in which only 21% of states reported being that far along.

Involvement of Key Stakeholders in System Planning and Refinement

- While families are more involved in the planning and implementation of managed care reforms in 1997-98 than they were in 1995, they reportedly still lack *significant* involvement in 60% of managed care reforms.
- Child welfare systems also have increased their role in planning and implementation of reforms since 1995, but, like families, reportedly still lack significant involvement in over 60% of reforms.
- State substance abuse agency staff were the least likely stakeholder group to have increased their involvement in the planning and implementation of managed care reforms, with a reported lack of significant involvement in 80% of reforms.
- While state child mental health staff were the most likely stakeholder group to increase their involvement in the planning and implementation of managed care reforms since 1995, they reportedly continue to lack significant involvement in nearly half (47%) of reforms.

Types of Managed Care Organizations (MCOs) Used

- There has been a reported increase in the states' use of for-profit managed care companies since 1995, with 47% of reforms utilizing commercial companies in 1997-98, compared to 33% of reforms in 1995.

- There has been an increase in the use of government entities as managed care organizations since 1995, with 29% of reforms utilizing government entities as MCOs in 1997-98, compared to 20% of reforms in 1995.

Differential Coverage for Children and Adolescents with Serious Disorders

- There has been a slight (5%) growth in incorporation in managed care reforms of differential coverage for children and adolescents with serious disorders since 1995. There has been an even larger growth (31%) in differential coverage for adults with serious and persistent mental illness.
- There has been a 36% increase since 1995 in reforms including the SSI (Supplemental Security Income) population in managed care systems.

Risk Structuring

- States report a small increase in the use of risk-based financing since 1995, with 92% of reforms in 1997-98 reportedly using capitation or case rate financing, compared to 88% of reforms in 1995.
- There has been a reported reduction in the percentage of reforms using risk adjustment mechanisms for children and adolescents with serious disorders, with 47% of reforms reportedly utilizing risk adjustment mechanisms in 1997-98, compared to 61% in 1995.
- There has been greater movement since 1995 in states' pushing full risk to managed care organizations, with MCOs having full risk in 72% of reforms in 1997-98, compared to 31% of reforms in 1995.

Outcomes Monitoring

- There has been a reported 14% increase since 1995 in the percentage of reforms that are using families of children and adolescents with behavioral health problems and providers as sources of information in outcomes monitoring.

Findings Remaining Constant Since the 1995 State Survey

The 1997-98 State Survey found the following to have remained unchanged since 1995:

Statewide Reforms, Not Demonstrations

- As in 1995, most state managed care reforms (77%) were reported to be statewide, rather than demonstration projects.

Inclusion of Substance Abuse

- As in 1995, substance abuse services were more likely to be included in integrated physical health/behavioral health reforms (93%) than in behavioral health carve outs (71%).

Planning and Oversight Authority

- As in 1995, state Medicaid agencies play the dominant role in planning and overseeing most managed care reforms, with Medicaid reportedly having or sharing lead responsibility in nearly three-quarters of reforms, compared to state mental health agencies' having or sharing the lead in slightly over half of reforms and state substance abuse agencies having or sharing a lead role in about one quarter of reforms.

Financing and Risk Structuring

- States reported little change since 1995 in the types of dollars used to finance managed care reforms, with 100% of reforms involving Medicaid dollars, 56% involving mental health dollars, 32% involving child welfare monies, and 27% using substance abuse dollars.
- There was no reported instance in 1997-98 of states with integrated designs requiring that a certain percentage of the capitation be allocated to behavioral health services.
- Half of reforms reportedly push risk down to the service provider level.

Comparison between Reforms with Carve Out and Integrated Designs

In addition to reporting on the current status and changes in state managed care activity, the 1997-98 State Survey allowed for comparisons between states with behavioral health carve outs (defined as reforms in which behavioral health financing and administration are separate from the financing and administration of physical health services) and states with integrated physical health/behavioral health designs (in which the financing and administration of physical and behavioral health are integrated). Among the differences between carve outs and integrated reforms reported by stakeholders in the 1997-98 state survey are the following.

Planning, Orientation and Training

- Families were three times as likely to be involved in planning carve outs than in planning integrated reforms.
- Planning for integrated reforms was less likely to include a discrete planning focus on any of the following special populations of children and adolescents: children with serious emotional disorders (20% of integrated reforms included this focus, compared to 78% of carve outs); children involved in the child welfare system (33% of integrated reforms, compared to 56% of carve outs); adolescents with substance abuse problems (20% of integrated reforms, compared to 26% of carve outs); culturally diverse children and adolescents (7% of integrated reforms, compared to 26% of carve outs).
- Integrated reforms were twice as likely *not* to provide training and orientation related to the goals and operations of managed care reforms for stakeholder groups, such as families, providers and child welfare systems, than carve outs.

- Carve outs were two to three times as likely to provide training and orientation for MCOs and providers related to adolescent substance abuse treatment, children with serious emotional disorders or child welfare system issues.

Design Issues

- Nearly two-thirds of carve outs (64%) incorporate differential coverage for children in general, compared to 53% of integrated reforms, and over half of carve outs (57%) provide differential coverage for children with serious disorders, compared to one-third (33%) of integrated reforms.
- Most carve outs (89%) were reported to provide both acute care (i.e., brief, short-term treatment) and some level of extended care, compared to fewer than half (47%) of integrated reforms that provide both acute and some extended care.
- Carve outs are more likely to incorporate system of care values and principles in managed care policy documents and contract requirements than integrated reforms, with 89-96% of carve outs reportedly incorporating system of care goals, compared to 40-67% of integrated reforms.
- Over half (52%) of carve outs include special management mechanisms for children with serious disorders, compared to 36% of integrated reforms.
- Virtually all integrated reforms (96%) utilize multiple statewide MCOs, in comparison to only 27% of carve outs that do so. (The Tracking Project's 1997 Impact Analysis found that use of multiple MCOs creates problems for families, providers and child welfare systems in that each MCO uses different authorization, billing, credentialing and reporting processes, interprets medical necessity differently and utilizes different provider networks.)

Service Delivery

- Three-quarters of carve outs reportedly expand home and community-based services for children and adolescents with behavioral health problems, compared to only 20% of integrated reforms.
- Carve outs were nearly twice as likely as integrated reforms (100% versus 54%) to build on existing systems of care in their managed care service delivery systems.
- Carve outs were more likely than integrated reforms (67% versus 45%) to have case management systems that include traditional public sector functions of advocacy, brokering and linkage to services, in addition to traditional managed care case management functions of utilization management.
- Carve outs were more likely than integrated reforms (45% versus 29%) to have made changes in medical necessity definitions to reflect psychosocial necessity criteria.

- Carve outs were over twice as likely to have level of care criteria in place for children with serious disorders than integrated reforms (81% versus 38%), and over seven times as likely to have practice guidelines for adolescent substance abuse treatment (58% versus 7%).
- Eighty-eight percent of carve outs reportedly include provisions to ensure the inclusion of culturally diverse and indigenous providers in service delivery networks, compared to 64% of integrated reforms.

Financing

- Carve outs reportedly were over nine times as likely to place limits on MCO profits as integrated reforms (75% versus 8%), and over three times as likely to place limits on MCO administrative costs (80% versus 23%).
- There was no reported instance of an integrated reform's requiring reinvestment of savings back into child and adolescent behavioral health services, while 76% of carve outs reportedly have such requirements.
- Integrated reforms were less likely than carve outs to blend funds from across systems to finance managed care, relying mainly on Medicaid dollars.
- Carve outs were more likely than integrated reforms (61% versus 43%) to have changed capitation rates based on actual experience with managed care.
- Nearly three-quarters of carve outs (71%) reportedly have built in mechanisms to adjust rates based on actual experience with managed care, compared to half (50%) of integrated reforms.
- Over half of carve outs (52%) reportedly are financing family organizations to play some formal role in implementation and/or monitoring of managed care, compared to 31% of integrated reforms.

Monitoring

- There was no reported instance of carve outs' not involving families of children and adolescents with behavioral health problems in some way in quality assurance processes, while nearly a third (31%) of integrated reforms reportedly do not include these families in quality assurance processes, even though all of these reforms are providing behavioral health services.
- One hundred percent of carve outs reportedly include a quality assurance focus on children and adolescents with behavioral health services, compared to 62% of integrated reforms.
- Eighty-two percent of carve outs reportedly monitor clinical outcomes for children and adolescents with behavioral health problems, compared to fewer than a quarter (23%) of integrated reforms.
- Virtually all carve outs (96%) reportedly measure satisfaction of families who have children and adolescents with behavioral health problems, compared to only 62% of integrated reforms.

- Three-quarters of carve outs (75%) reportedly measure youth satisfaction, compared to only 38% of integrated reforms.
- Virtually all carve outs (93%) reportedly use families of children and adolescents with behavioral health problems as sources of information for outcomes monitoring, compared to 55% of integrated reforms.
- Forty-four percent of carve outs reportedly utilize family organizations (i.e., families of children and adolescents with behavioral health disorders) in formal ways to monitor outcomes, compared to none of the integrated reforms.
- Carve outs reportedly are almost twice as likely than integrated reforms (48% versus 27%) to use child welfare systems as sources of information for monitoring outcomes.

Issues for Further Consideration

- Comparisons between reforms with carve out and integrated designs corroborate findings from the Tracking Project's 1997 Impact Analysis that states with carve out designs tend to incorporate planning, design, service delivery, financing, and monitoring approaches that are more favorable to children and adolescents with behavioral health disorders than do states with integrated designs. The many differences in implications for children and adolescents with behavioral health disorders and their families between carve outs and integrated reforms found in both the 1997 Impact Analysis and the 1997-98 State Survey do not necessarily mean that there are *inherent* problems with an integrated design. However, they do suggest that states with carve outs engage in planning and implementation processes that more clearly focus on this population, and this focus leads to more favorable system characteristics. Additional attention to design differences and their impact is needed to further assess these observations.
- Reforms continue to be widespread and are implemented as statewide reforms rather than as demonstrations. However, states are further along in the reform process, and, as a result, there is a significantly larger experience base with managed care than there was in 1995. Since initial implementation, many states have made changes and refinements to their managed care systems based upon this experience. There is much to be learned from the nature of these system refinements, the problems they are designed to address, and their impact on ameliorating system issues. These changes, the basis for them, and their effects are the focus of a "maturational" analysis to be included as part of the 1999 Impact Analysis.
- Over a quarter of all reforms continue to manage mental health and substance abuse services separately. As noted in 1995, the separation of the management of mental health and substance abuse services raises concerns, given the known

co-morbidity of mental health and substance abuse disorders. It appears that the need for greater coordination and integration of mental health and substance abuse services within managed care systems remains in many states.

- In a significant proportion (40%) of all reforms, parity between behavioral health and physical health services has not been achieved, with behavioral health services subject to limits and co-payments that are not applied to physical health services. Concern during the national health care reform debate and more recently in state legislatures has focused on the parity issue. As noted in the 1995 State Survey report, arbitrary limits on behavioral health service delivery may result in greater use of hospitals instead of appropriate alternatives and, therefore, may not be as cost-effective as they appear. The same concerns about more restrictive day and visit limits and more onerous cost-sharing requirements for behavioral health remain given the results of the 1997-98 survey. Specific attention to these differential benefits for behavioral health is needed to assess their impact on access to appropriate services and on cost-effectiveness.
- The involvement of key stakeholders in planning and refining managed care systems has improved since the 1995 survey. However, when only involvement characterized as "significant" is considered, there is still a great deal of room for improvement with respect to all stakeholder groups—families, state children's mental health staff, state substance abuse staff, and state child welfare staff. Although these stakeholders may be at the table, they do not necessarily have a significant influence in managed care planning and implementation processes. Without the significant participation of these stakeholders, the likelihood of reforms being attuned to the special needs of children is diminished. Stakeholder involvement and its effect on the design and features of managed care systems will continue to be an important focus of the Tracking Project.
- Although most reforms were reported to cover both acute and extended care services, Tracking Project findings suggest that significant behavioral health treatment dollars remain outside managed care systems to pay for extended care and services not covered by managed care systems. The fragmentation and discontinuity potentially created by the separation of acute and extended care is an issue needing further study, particularly with respect to the ability to serve children and adolescents whose treatment needs extend beyond limited, acute care. When extended care is not included in managed care systems, the need to create rational mechanisms for managing the boundaries between acute and extended care services, without compromising continuity of care, becomes paramount. Further study should be directed at the relationship between acute and extended care within managed care systems and with child-serving systems outside managed care systems.
- Many reforms, particularly those with integrated designs, limit coverage to the more traditional services typically covered by commercial insurance plans. Few of these reforms cover home-based services, respite services, wraparound

services, and other home and community-based services; carve out reforms are more likely to do so. Given widespread acceptance of the need for a wide array of home and community-based services for children and adolescents with behavioral health disorders, the effect of a limited array on children and families, as well as on the cost-effectiveness of services, is an area needing additional exploration through the impact analysis process.

- It appears that there is some recognition in the managed care planning process of the special behavioral health service needs of children. About 60% of the reforms reportedly provide differential coverage for children and adolescents, including such provisions as fewer limits, a broader service array, and increased flexibility or wraparound services. Somewhat fewer (49%) provide differential coverage or special provisions for children with serious behavioral health disorders, increased only slightly since 1995, and even fewer include special management mechanisms for this population. While some progress in attending to the needs of children in general, and to those with serious and complex problems in particular is evident, many reforms still have yet to address these needs. The incorporation of special provisions for children with serious disorders, and the effects of managed care on this population, are important areas for continued study.
- The interface between managed care reforms and previous efforts to develop community-based systems of care for children and adolescents with serious emotional disorders and their families remains murky. Findings from the 1997-98 survey indicate that managed care reforms have, to a significant extent, been built upon previous system of care development efforts and that system of care principles have been incorporated into managed care systems. These findings conflict with the results of the 1997 Impact Analysis in which stakeholders in only half of the states in the sample felt that this was the case. This relationship, and the impact of managed care reforms on systems of care, needs further exploration.
- The 1997-98 survey confirmed a trend noted in 1995 toward the use of for-profit MCOs and BHOs to manage behavioral health service delivery. This is significant given the pervasive viewpoint of stakeholders in the 1997 Impact Analysis that for-profit MCOs are accountable to shareholders, have little investment in the community, and that profits divert resources from services. Although they are seen as bringing expertise in information systems and in the technologies of managed care, they are also seen as lacking knowledge and understanding of the populations to be served—particularly children with serious behavioral health disorders. Further exploration of both the advantages and problems associated with the use of various types of MCOs is needed.
- Prior authorization is one of the most frequently used management mechanisms, according to the 1997-98 survey. Again, stakeholders interviewed in the 1997 Impact Analysis complained about these mechanisms in most states, describing

them as cumbersome, time consuming, confusing, and creating barriers to access. Providers and respondents from other child-serving systems expressed particular concerns, feeling that they caused unwarranted delays and intrusions into clinical decision-making. Some strategies were noted that reduced complaints, such as allowing a certain level of services routinely or requiring authorization only for higher levels of care. Additional investigation of strategies to make prior authorization and other management mechanisms more efficient and better accepted is needed.

- Some movement toward broadening medical necessity criteria to include consideration of psychosocial and environmental factors was noted in the 1997-98 survey, a need identified in the 1997 Impact Analysis. Also consistent with the Impact Analysis is the finding that most states (72%) reportedly use some type of clinical decision-making criteria (level of care or patient placement criteria and practice guidelines) specific to children and adolescents. Stakeholders in the Impact Analysis felt that such criteria can improve the consistency in clinical decision-making and can be beneficial, so long as they are not applied with excessive rigidity. The impact of such criteria on the ability to access appropriate levels of care also requires additional attention.
- Managed care reforms reportedly involve extensive use of capitation financing (92% of reforms); case rates are used in comparatively few reforms. Concerns about the use of prior utilization data as the basis for deriving capitation and case rates were raised in 1995 and again in the 1997 Impact Analysis. In addition, questions were raised in the 1997 Impact Analysis about the sufficiency of capitation rates to guard against underservice and to expand service capacity. Although almost two-thirds of states incorporate mechanisms to reassess and adjust rates on a regular basis, fewer than half of the reforms reported changes in rates since initial implementation. Another issue in integrated reforms is that states typically do not require that a certain percentage of the capitation be allocated to behavioral health services, often resulting in a very small amount spent on behavioral health. The 1997-98 survey revealed no instance of such a requirement. The basis for capitation, the sufficiency of rates, provisions for reassessing the adequacy of rates, and the allocation for behavioral health are among the issues needing consideration.
- The 1997 Impact Analysis identified a trend toward putting MCOs at full risk, a trend confirmed by the 1997-98 survey. Since risk adjustment mechanisms were reported in fewer than half of the reforms, the resulting incentives and effects on service delivery should be studied. In particular, the impact on service delivery to high utilizer populations, such as children with serious disorders and children in the child welfare system, should be investigated further. In the Impact Analysis sample, most reforms did not push reform down to the provider level; this is reportedly occurring in half of the reforms analyzed for the 1997-98 State Survey. Providers interviewed in the Impact Analysis were receptive to assuming risk in exchange for greater flexibility in service delivery and decision making, but most

behavioral health providers have little experience in bearing risk. Continuing trends and effects with respect to risk management should be followed.

- Families appear to be increasingly involved in managed care system oversight and refinement, according to results of the 1997-98 survey. Individual family members and family organizations typically are involved by including them on state-level advisory, oversight, and planning structures in some cases with funding to support their participation. However, while most reforms reportedly involve families in some way, "significant" involvement of families occurs in only 38% of all reforms. Although family involvement is increasing, managed care systems have yet to embrace the principle of involving families as full partners.
- While most reforms (80%) reportedly include provisions to address the inclusion of culturally diverse and indigenous providers in provider networks, the 1997 Impact Analysis found that culturally diverse and indigenous providers often are unable to participate due to the lack of infrastructure or new credentialing requirements. Further exploration of the impact of managed care on culturally diverse and indigenous providers, and their participation in provider networks, is warranted, as well as elucidation of other strategies to ensure cultural competence in managed care systems.
- Quality measurement systems were reported for all reforms; the 1997 Impact Analysis suggested that such quality measurement focuses primarily on process measures. The majority of reforms reported having process measures specific to children and adolescents, suggesting some improvement from reports received during the 1997 Impact Analysis. Access, service utilization, parent satisfaction, and cost were the most frequently measured outcomes. Similar to 1995, clinical and functional outcomes are receiving comparatively less attention. The 1997 Impact Analysis also revealed that measurement approaches for assessing clinical and functional outcomes among children and adolescents were in early stages of development. Both approaches to measuring clinical and functional outcomes in behavioral health systems, and any emerging results, are critical areas for further study.
- The impact of managed care reforms on other child-serving systems is being measured in fewer than one-third of all reforms, according to the 1997-98 survey. The 1997 Impact Analysis revealed only one beginning attempt to systematically examine this area, although cost shifting to other child-serving systems was alleged by stakeholders in most states. Given the pervasive feelings among other child-serving systems that they are feeling the effects (and costs) of more "controlled" behavioral health service delivery, more reliable information about the shifting of children and costs is essential.

1997-98 SURVEY OF STATE HEALTH CARE REFORM INITIATIVES AFFECTING BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS AND THEIR FAMILIES

State: _____ **Respondent:** _____

Date: _____ **Title:** _____

Phone: _____

Check the types of health care reform in which your state is engaged. (Check all that apply.)

_____ **None**
_____ **Medicaid reform for physical health only (no behavioral health)**
_____ **Medicaid reform for behavioral health only (includes mental health only or mental health and substance abuse)**
_____ **Medicaid reform for physical health and behavioral health services**
_____ **Insurance reform**
_____ **Comprehensive health care reform for entire state population**
_____ **Other, Specify** _____

Please duplicate this form and complete a separate survey form for each type of reform, if your state is engaged in more than one type.

GENERAL INFORMATION ABOUT STATE HEALTH CARE REFORM

(If necessary, feel free to add a brief explanation to any of your responses.)

1. Which of the following types of health care reform are you describing on this survey form? (Check only one.)

_____ Medicaid reform for physical health only (no behavioral health)
_____ Medicaid reform for behavioral health only (includes mental health only or mental health and substance abuse)
_____ Medicaid reform for physical health and behavioral health services
_____ Insurance reform
_____ Comprehensive health care reform for entire state population
_____ Other, Specify _____

2. What are the stated goals of this reform? (Check all that apply.)

_____ Cost containment
_____ Increase access
_____ Expand service array
_____ Improve quality
_____ Improve accountability
_____ Other, Specify _____

Return completed survey to: Mary Ann Kershaw
Research & Training Center for Children's Mental Health
13301 Bruce B. Downs Blvd. Tampa, FL 33612

3. Briefly describe this reform.

4. Is this reform a statewide reform or limited to certain geographic areas? (Check only one.)

_____ Statewide reform
_____ Limited geographic areas with intent to phase in statewide
_____ Limited geographic areas

If statewide, did it begin in limited geographic areas?

Yes _____ No _____

5. Does this reform involve the use of a Medicaid waiver?

Yes _____ No _____

If yes, specify type of waiver _____

6. Does this reform include substance abuse services?

_____ Yes _____ No

7. If this reform includes both physical health and behavioral health services, is there parity between physical and behavioral health services?

_____ Yes _____ No

If no, check all of the following choices that apply.

_____ Mental health services are subject to higher co-payments and deductibles
_____ Substance abuse services are subject to higher co-payments and deductibles
_____ There are lifetime limits on mental health services
_____ There are lifetime limits on substance abuse services
_____ There are day and/or visit limits on mental health services
_____ There are day and/or visit limits on substance abuse services

8. At what stage of implementation is the state with respect to this reform? (Check only one.)

_____ Proposal
_____ Proposal approved, planning underway
_____ Early implementation (less than one year)
_____ Middle implementation (one to three years)
_____ Late implementation (more than three years)

Specify the start date of the implementation of the reform:
_____

9. Who at the state level has the lead responsibility for planning and overseeing implementation of behavioral health services for this reform? (Check all that apply.)

_____ Governor's office
_____ State health agency
_____ State Medicaid agency
_____ State mental health agency
_____ State substance abuse agency
_____ Other, Specify _____

10. In your judgment, to what extent were each of the following involved in the initial planning and implementation of this reform?

	Not Involved	Some Involvement	Significant Involvement
Families			
State child mental health staff			
State substance abuse staff			
State child welfare staff			
Other child-serving agencies			

11. In your judgment, to what extent are each of the following involved in current refinements and implementation of this reform?

	Not Involved	Some Involvement	Significant Involvement
Families			
State child mental health staff			
State substance abuse staff			
State child welfare staff			
Other child-serving agencies			

12. Briefly describe how families of children and adolescents with emotional and substance abuse disorders are currently involved in refinements and implementation of the reform.

13. Is the state funding a family organization to play some role in the reform?

Yes _____ No _____

If yes, specify role.

14. For which of the following populations has the reform included a discrete planning process?

_____ Adolescents with substance abuse disorders
_____ Children and adolescents with serious emotional disorders
_____ Children and adolescents involved with the child welfare system
_____ Culturally diverse children and adolescents

15. Briefly describe the major changes, if any, the state has made in its reform since initial implementation that affect children and adolescents with emotional and substance abuse disorders and their families?

POPULATION AND SERVICES

1. What is the population affected by this reform? (Check all that apply.)

_____ Entire state population
_____ Uninsured
_____ Total Medicaid population
_____ Portion of Medicaid population

If the total Medicaid population is not covered, which of the following subgroups are covered? (Check all that apply.)
_____ AFDC population
_____ Poverty related population
_____ Aged, blind, and disabled population (SSI)
_____ Pregnant women and children
_____ Children and adolescents in the child welfare system
_____ Children and adolescents in the juvenile justice system
_____ Other, Specify _____

2. What age group is affected by this reform?

_____ All ages
_____ Children and adolescents only
_____ Adults only

3. Does the reform include coverage for behavioral health services for children and adolescents that is different from behavioral health coverage for adults?

_____ Yes _____ No

Explain

4. For each type of service, indicate how the service is covered. (Check all that apply.)

Service	Covered Under Reform	Covered By Another Funding Source	Not Covered By the State Through any Source
MENTAL HEALTH SERVICES			
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			
Other, Specify			

Service	Covered Under Reform	Covered By Another Funding Source	Not Covered By the State Through any Source
SUBSTANCE ABUSE SERVICES			
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			

5. Does the reform expand the array of home and community-based services for children and adolescents with emotional and substance abuse disorders that are covered?

   _____ Yes _____ No

6. Does the reform include coverage for both acute (i.e., episodic, short-term) and extended (long-term) behavioral health care services?

   _____ Acute care only
   _____ Acute and extended care

7. If the reform covers acute care only, who is primarily responsible for providing extended behavioral health care services to children and adolescents? (Check all that apply.)

_____ Public child mental health system
_____ Public child welfare system
_____ Other public child-serving systems
_____ Public substance abuse system
_____ Other, Specify _____

8. Does the reform include behavioral health services to infants, toddlers, and preschool children and their families?

_____ Yes _____ No

9. Does the reform incorporate EPSDT requirements?

_____ Yes _____ No

10. Does the reform include differential coverage for behavioral health services for children and adolescents with serious behavioral health disorders and/or adults with serious and persistent behavioral health disorders? (Check all that apply.)

_____ Behavioral health coverage is different for children and adolescents with serious behavioral health disorders
_____ Behavioral health coverage is different for adults with serious and persistent behavioral health disorders

11. If there is differential coverage for children and adolescents with serious behavioral health disorders, what does it involve? (Check all that apply.)

_____ Expanded service array
_____ Intensive case management
_____ Interagency treatment and service planning
_____ Wraparound services or flexible service dollars
_____ Family support services
_____ Higher capitation or case rate
_____ Other, Specify _____

12. Does the reform build on previous or ongoing efforts to develop community-based systems of care for children and adolescents with serious and complex disorders and their families?

_____ Yes _____ No

13. From the following list, check the system of care values and principles that are incorporated into the reform's RFPs, contracts, and service delivery protocols.

_____ Broad array of community-based services
_____ Family involvement
_____ Individualized, flexible care
_____ Interagency treatment and service planning
_____ Case management
_____ Cultural competence

DESIGN AND MANAGEMENT

1. Which of the following best characterizes the design of this reform? (Check only one.)

_____ Integrated design (i.e., administration and financing of physical health and behavioral health are integrated, including instances where physical health plans subcontract with behavioral health plans)
_____ "Divided" design (i.e., some behavioral health services are integrated with the physical health system while splitting out others for separate management and financing)
_____ Behavioral health carve out (i.e., behavioral health financing and administration are separate from physical health financing and administration)

2. If you checked "behavioral health carve out," how are the administration and financing of substance abuse services handled?

_____ There is a separate substance abuse carve out
_____ The behavioral health carve out includes mental health and substance abuse
_____ Substance abuse is integrated with physical health
_____ Substance abuse remains fee for service

3. What types of entities are used as managed care organizations (MCOs) for behavioral health services under the reform? (Check all that apply.)

_____ For-profit managed health care organizations
_____ Nonprofit managed health care organizations
_____ For-profit behavioral health managed care organizations
_____ Nonprofit behavioral health managed care organizations
_____ Private, nonprofit agencies
_____ Government entities, Specify _____
_____ Other, Specify _____

4. Has the type of MCO been changed since the initial implementation of the reform?

_____ Yes _____ No

Explain

5. How many MCOs are used in the reform to manage behavioral health services?

_____ One MCO statewide
_____ One MCO per region
_____ Multiple MCOs

6. In conjunction with the reform, has training and orientation been provided to MCOs and providers related to serving the following populations? (Check all that apply.)

_____ No training
_____ Training related to children and adolescents with serious emotional disorders
_____ Training related to adolescents with substance abuse disorders
_____ Training related to children and adolescents involved with the child welfare system
_____ Training related to the Medicaid population in general

7. In conjunction with the reform, has training and orientation about the goals and operation of the managed care system been provided to any of the following groups? (Check all that apply.)

_____ No training
_____ Families
_____ Providers
_____ Public child welfare system
_____ Other child-serving systems
_____ Other, Specify _____

8. Which management mechanisms, if any, are utilized in the delivery of behavioral health services under this reform? (Check all that apply.)

_____ Screeners/gatekeepers
_____ Case management
_____ Prior authorization
_____ Utilization management
_____ Preferred and/or exclusive provider arrangements
_____ Other, Specify _____

9. If case management is utilized in the reform, is the primary focus service authorization and utilization management or accessing, brokering, coordinating, and advocacy?

_____ Primary focus on service authorization and utilization management
_____ Primary focus on service accessing, brokering, coordinating, and advocacy
_____ Both

10. Are there additional or special management mechanisms that this reform requires for children and adolescents with serious behavioral health disorders because they are a more complex and costly patient population?

_____ Yes _____ No

If yes, specify type of mechanisms.

11. Are there additional or special management mechanisms that this reform requires for children and adolescents involved with the child welfare system?

_____ Yes _____ No

If yes, specify type of mechanisms.

12. Does this reform involve the designation of essential providers for behavioral health service delivery?

_____ Yes _____ No

If yes, specify the types of agencies designated as essential providers.

13. Does the reform incorporate provisions to ensure the inclusion of culturally diverse and indigenous providers in provider networks?

_____ Yes _____ No

14. Has this reform involved the use of criteria for determining “medical necessity” or “clinical necessity” for accessing behavioral health services?

Yes _____ No _____

15. Have medical necessity criteria been changed since initial implementation of the reform?

Yes _____ No _____

If yes, explain how and why.

16. Does the reform incorporate clinical decision making criteria specific to behavioral health care services for children and adolescents?

_____ Level of care criteria/patient placement criteria
_____ Practice guidelines
_____ No criteria specific to children and adolescents

17. Does this reform involve the use of a grievance and appeals process?

Yes _____ No _____

If yes, which of the following groups is the major source of grievance and appeals? (Check only one.)

_____ Families
_____ Behavioral health care providers
_____ Child welfare system
_____ Other child-serving systems

18. Does this reform involve the use of some type of trouble-shooting system or mechanism (e.g., 800 #, ombudsman, etc.) for consumers and/or providers of behavioral health services?

Yes _____ No _____

If yes, specify type of mechanism.

19. Does the reform incorporate new or revised standards, licensure or credentialing requirements for behavioral health professionals or programs?

Yes _____ No _____

FINANCING AND RISK

1. Does this reform involve use of capitation or case rate financing?

_____ Capitation
_____ Case rates
_____ Neither

2. Have the capitation or case rates changed since initial implementation of the reform?

_____ Yes _____ No

If yes, explain how and why.

3. Does the reform incorporate built-in mechanisms to reassess and adjust capitation and case rates at specific intervals?

_____ Yes _____ No

4. Which of the following agencies contribute to the financing of behavioral health services for children and adolescents in the reform? (Check all that apply.)

_____ Mental health
_____ Health
_____ Medicaid
_____ Child Welfare
_____ Education
_____ Juvenile Justice
_____ Substance Abuse
_____ Other, Specify _____

5. If capitation or case rates are used, please complete the following matrix as applicable.

Population	Amount of Capitation Rate (Specify if annual or monthly)	Amount of Case Rate (Specify if annual or monthly)	Basis for Rate (e.g. prior utilization, etc.)
Adults and children and adolescents-physical and behavioral health			
Children and adolescents – physical and behavioral health			
Adults and children and adolescents – behavioral health only			
Children and adolescents – behavioral health only			
Adults – behavioral health only			
Children and adolescents with serious emotional disorders			
Adults with serious and persistent mental illnesses			
Adolescents with substance abuse disorders			
Children and adolescents in state custody (i.e., child welfare)			
Other, Specify			

6. If capitation or case rates include both physical and behavioral health, does the state require that a specified percentage of the rate be allocated to behavioral health care?

_____ Yes _____ No

If yes, specify percentage _____

7. Does this reform involve use of a risk adjustment mechanism?

_____ Yes _____ No

If yes, specify the risk adjustment mechanisms used.

8. If risk adjustment is used, what is the purpose of the risk adjustment? (Check all that apply.)

_____ To guard against underservice for children and adolescents with serious disorders
_____ To protect service providers who are sharing the risk
_____ Other, Specify _____

9. In what way do the state and MCOs share the financial risks and benefits?

_____ MCOs have all the benefit and all the risk
_____ State has all the benefit and all the risk
_____ MCOs and state share risk and share benefit
_____ MCO and state share risk only
_____ MCO and state share benefit only

10. Do MCOs push risk down to providers?

_____ Yes _____ No

11. Does the state put a limit on MCO profits?

_____ Yes _____ No

12. Does the state put a limit on MCO administrative costs?

_____ Yes _____ No

13. Does the state require reinvestment of savings back into the behavioral health system for children and adolescents?

_____ Yes _____ No

If yes, how are savings reinvested? (Check all that apply.)

_____ Creating new or more services
_____ Serving more children and adolescents
_____ Other, Specify _____

14. Besides reinvestment of savings, is the state investing in service capacity development for behavioral health services for children and adolescents and their families?

_____ Yes _____ No

QUALITY AND OUTCOME MEASUREMENT

1. Does this reform incorporate a quality measurement system?

Yes _____ No _____

If yes, does it include measures specific to behavioral health services for children and adolescents and their families?

Yes _____ No _____

2. How are families involved in the quality measurement process?

_____ Not involved
_____ Focus groups
_____ Surveys
_____ Involved in the design of the quality measures and/or process
_____ Involved in monitoring the quality measurement process
_____ Other, Specify _____

3. What types of outcomes does this reform measure specific to behavioral health services for children and adolescents and their families? (Check all that apply.)

_____ Cost
_____ Access
_____ Service utilization patterns
_____ Clinical and functional outcomes
_____ Parent satisfaction
_____ Youth satisfaction
_____ Other, Specify _____
_____ None

4. What sources of information are used to measure behavioral health outcomes for children and adolescents and their families under the reform? (Check all that apply.)

_____ Families
_____ Providers
_____ Child welfare system
_____ Major child-serving systems
_____ Family organizations
_____ Other, Specify _____
_____ None

5. Are there mechanisms to track the impact of the reform on other child-serving systems (e.g., cost shifting)?

Yes _____ No _____

6. If there is a formal evaluation of the reform, does it include a focus on children and adolescents with emotional and substance abuse disorders and their families?

Yes _____ No _____

CHILD WELFARE MANAGED CARE

1. In your state, is the child welfare system implementing or planning to implement reform related to the management, financing, or delivery of child welfare services at the state or county levels?

Yes _____ No _____

Is this reform initiative defined as “managed care?”

Yes _____ No _____

2. Is this reform initiative coordinated with the state health care reform (i.e., Medicaid managed care)?

Yes _____ No _____

3. Briefly describe any child welfare reform initiative that is defined as managed care.

4. Contact person for information about the child welfare managed care initiative.

Name: _____ Phone: _____

Title: _____ Fax: _____

Agency: _____

TECHNICAL ASSISTANCE MATERIALS/INFORMATION

On the list below, please indicate the types of material/information related to behavioral health service delivery for children and adolescents that you have in your state that may be useful to other states undertaking health care reforms.

_____ Requests for proposals
_____ Medical/clinical necessity criteria
_____ Standards for professionals
_____ Standards for programs
_____ Level of care criteria
_____ Quality measurement criteria
_____ Grievance and appeals procedures
_____ Capitation or case rate setting methods

_____ Risk adjustment methods
_____ Contracts with managed care entities
_____ Health care reform legislation
_____ Outcome measures for children and adolescents with emotional and substance abuse disorders and their families
_____ Outcome "report card"
_____ Medicaid waiver applications

PLEASE INCLUDE WITH YOUR RESPONSE ANY OF THE ABOVE ITEMS THAT YOU HAVE CHECKED AND WOULD BE WILLING TO SHARE WITH OTHER STATES

Appendix A

1997–98 Survey of State Health Care Reform Initiatives Affecting Behavioral Health Services for Children and Adolescents and their Families

Technical Assistance Materials Available from States Related to Managed Care

Type of Material	Available From	Mental Health Contact Person	Substance Abuse Contact Person
Request for Proposal	Arkansas	Anne Wells 501-689-9166	
	Delaware		Julian Taplin 302-633-2600
	Florida	David Fairbanks 850-487-2920	
	Iowa	Candi Nardini 515-242-6021	Janet Zwick 515-281-4417
	Minnesota	Bill Novak 612-296-1725	
	Nebraska	Mark DeKraai 402-479-5512	
	New Jersey	Lucy Keatings 609-777-0740	
	New York	Marcia Fazio 578-473-6902	
	Oregon		Barbara Cinaglio 503-945-5763
	Pennsylvania	Michael Tichner 717-772-7950	
	Texas		Karen Petagrue 512-349-6615
Medical/Clinical Necessity Criteria	California	Teri Barthels 916-654-5691	
	Connecticut	Karen Anderson 860-550-6683	
	Delaware		Julian Taplin 302-633-2600
	Iowa	Candi Nardini 515-242-6021	Janet Zwick 515-281-4417
	Missouri	Ed Morris 573-751-8028	
	Nebraska	Mark DeKraai 402-479-5512	
	New Jersey	Lucy Keatings 609-777-0740	
	New York	Marcia Fazio 578-473-6902	
	North Carolina	Tara Larson 919-733-0597	Stuart Berde, 919-733-0596

Type of Material	Available From	Mental Health Contact Person	Substance Abuse Contact Person
Medical/Clinical Necessity Criteria (Continued)	Oregon		Barbara Cinaglio 503-945-5763
	Pennsylvania	Michael Tichner 717-772-7950	
	South Carolina	Dave Mahrer 803-898-8576	
	South Dakota		Barry Pillen 605-773-3123
	Vermont		Denis Barton 802-651-1564
	Wisconsin	Eleanor McLean 608-266-6838	
Standards for Professionals	District of Columbia		Donna Folkemer 202-645-5064
	New Jersey	Lucy Keatings 609-777-0740	
	North Carolina	Tara Larson 919-733-0597	
	Oregon		Barbara Cinaglio 503-945-5763
	South Carolina	Dave Mahrer 803-898-8576	
	South Dakota		Barry Pillen 605-773-3123
	Wisconsin	Eleanor McLean 608-266-6838	
Standards for Programs	Delaware		Julian Taplin 302-633-2600
	District of Columbia		Donna Folkemer 202-645-5064
	Iowa		Janet Zwick 515-281-4417
	New Jersey	Lucy Keatings 609-777-0740	
	North Carolina	Tara Larson 919-733-0597	
	Oregon		Barbara Cinaglio 503-945-5763
	Texas		Karen Petagrue 512-349-6615
	South Dakota		Barry Pillen 605-773-3123
	Wisconsin	Eleanor McLean 608-266-6838	

Type of Material	Available From	Mental Health Contact Person	Substance Abuse Contact Person
Level of Care Criteria	Delaware		Julian Taplin 302-633-2600
	Illinois		Lillian Pickup 312-814-2436
	Iowa		Janet Zwick 515-281-4417
	New Jersey	Lucy Keatings 609-777-0740	
	Missouri	Ed Morris 573-751-8028	
	North Carolina	Tara Larson 919-733-0597	Stuart Berde 919-733-0596
	South Dakota		Barry Pillen 605-773-3123
	Texas		Karen Petagrue 512-349-6615
	Wisconsin	Eleanor McLean 608-266-6838	
Quality Measurement Criteria	Delaware		Julian Taplin 302-633-2600
	Iowa	Candi Nardini 515-242-6021	
	Michigan	Jim Wotring 517-335-9101	
	New Jersey	Lucy Keatings 609-777-0740	
	Oregon		Barbara Cinaglio 503-945-5763
	Pennsylvania	Michael Tichner 717-772-7950	
	South Carolina	Dave Mahrer 803-898-8576	
	North Carolina		Stuart Berde 919-733-0596
	Texas		Karen Petagrue 512-349-6615
	Utah	Mary Ann Williams 801-538-4268	
	Vermont		Denis Barton 802-651-1564
Grievance & Appeals Procedures	Delaware		Julian Taplin 302-633-2600
	District of Columbia		Donna Folkemer 202-645-5064

Type of Material	Available From	Mental Health Contact Person	Substance Abuse Contact Person
Grievance & Appeals Procedures (Continued)	Arkansas	Anne Wells 501-689-9166	
	California	Teri Barthels 916-654-5691	
	Connecticut	Karen Anderson 860-550-6683	
	Indiana		Robert Tyburski 317-232-7883
	Minnesota	Bill Novak 612-296-1725	
	Missouri	Ed Morris 573-751-8028	
	New Jersey	Lucy Keatings 609-777-0740	
	North Carolina	Tara Larson 919-733-0597	Stuart Berde 919-733-0596
	Pennsylvania	Michael Tichner 717-772-7950	
	Rhode Island		
	South Carolina	Dave Mahrer 803-898-8576	
	Tennessee		Frazier Beverly 615-741-4498
	Texas		Karen Petagrue 512-349-6615
	Wisconsin	Eleanor Mc Lean 608-266-6838	
Capitation/Case Rate Setting Methods	District of Columbia		Donna Folkemer 202-645-5064
	Indiania	Jim Phillips 317-232-7934	Robert Tyburski 317-232-7883
	Iowa		Janet Zwick 515-281-4417
	Missouri	Ed Morris 573-751-8028	
	New Jersey	Lucy Keatings 609-777-0740	
	North Carolina	Tara Larson 919-733-0597	Stuart Berde 919-733-0596
	Oklahoma	Beverly Smallwood 918-581-2865	
	Vermont		Denis Barton 802-651-1564

Type of Material	Available From	Mental Health Contact Person	Substance Abuse Contact Person
Capitation/Case Rate Setting Methods (Continued)	Wisconsin	Eleanor McLean 608-266-6838	
Risk Adjustment Methods	District of Columbia		Donna Folkemer 202-645-5064
	Missouri	Ed Morris 573-751-8028	
	New Jersey	Lucy Keatings 609-777-0740	
	North Carolina	Tara Larson 919-733-0597	
	Oklahoma	Beverly Smallwood 918-581-2865	
	Vermont		Denis Barton 802-651-1564
Contracts with Managed Care Entities	District of Columbia		Donna Folkemer 202-645-5064
	California	Teri Barthels 916-654-5691	
	Indiania	Jim Phillips 317-232-7934	Robert Tyburski 317-232-7883
	Iowa	Candi Nardini 515-242-6021	Janet Zwick 515-281-4417
	Nebraska	Mark DeKraai 402-479-5512	
	New Jersey	Lucy Keatings 609-777-0740	
	North Carolina	Tara Larson 919-733-0597	Stuart Berde 919-733-0596
	Vermont		Denis Barton 802-651-1564
	Wisconsin	Eleanor McLean 608-266-6838	
Health Care Reform Legislation	Missouri	Ed Morris 573-751-8028	
	Nebraska	Mark DeKraai 402-479-5512	
	New Jersey	Lucy Keatings 609-777-0740	
	New York	Marcia Fazio, 578-473-6902	
	North Carolina	Tara Larson 919-733-0597	

Type of Material	Available From	Mental Health Contact Person	Substance Abuse Contact Person
Health Care Reform Legislation (Continued)	Oregon		Barbara Cinaglio 503-945-5763
Outcome Measures for Children & Adolescents with Emotional & Substance Abuse Disorders (Continued)	California	Teri Barthels 916-654-5691	
	Florida	David Fairbanks 850-487-2920	
	Idaho	Anna Sever 208-334-5706	
	Iowa		Janet Zwick 515-281-4417
	Michigan	Jim Wotring 517-335-9101	
	Missouri	Ed Morris 573-751-8028	
	New Jersey	Lucy Keatings 609-777-0740	
	North Carolina		Stuart Berde 919-733-0596
	Oregon		Barbara Cinaglio 503-945-5763
	South Carolina	Dave Mahrer 803-898-8576	
	Texas		Karen Petagrue 512-349-6615
	Virginia	Molly Brunk 804-225-2967	
	Vermont		Denis Barton 802-651-1564
	Wisconsin	Eleanor McLean 608-266-6838	
Outcome "Report Card"	Indiania	Jim Phillips 317-232-7934	Robert Tyburski 317-232-7883
	Iowa		Janet Zwick 515-281-4417
	Missouri	Ed Morris 573-751-8028	
	New Jersey	Lucy Keatings 609-777-0740	
	Oregon		Barbara Cinaglio 503-945-5763
	Virginia	Molly Brunk 804-225-2967	

Type of Material	Available From	Mental Health Contact Person	Substance Abuse Contact Person
Outcome "Report Card" (Continued)	Wisconsin	Eleanor McLean 608-266-6838	
Practice Guidelines	South Dakota		Barry Pillen 605-773-3123
Medicaid Waiver Procedures	District of Columbia		Donna Folkemer 202-645-5064
	California	Teri Barthels 916-654-5691	
	Delaware		Julian Taplin 302-633-2600
	Indiania	Jim Phillips 317-232-7934	
	Iowa	Candi Nardini 515-242-6021	Janet Zwick 515-281-4417
	Michigan	Jim Wotring 517-335-9101	
	Missouri	Ed Morris 573-751-8028	
	New Jersey	Lucy Keatings 609-777-0740	
	New York	Marcia Fazio 578-473-6902	
	North Carolina	Tara Larson 919-733-0597	Stuart Berde 919-733-0596
	Oregon		Barbara Cinaglio 503-945-5763
	Pennsylvania	Michael Tichner 717-772-7950	
	South Dakota		Barry Pillen 605-773-3123

Appendix B

Technical Assistance Materials Available from States Related to Managed Care