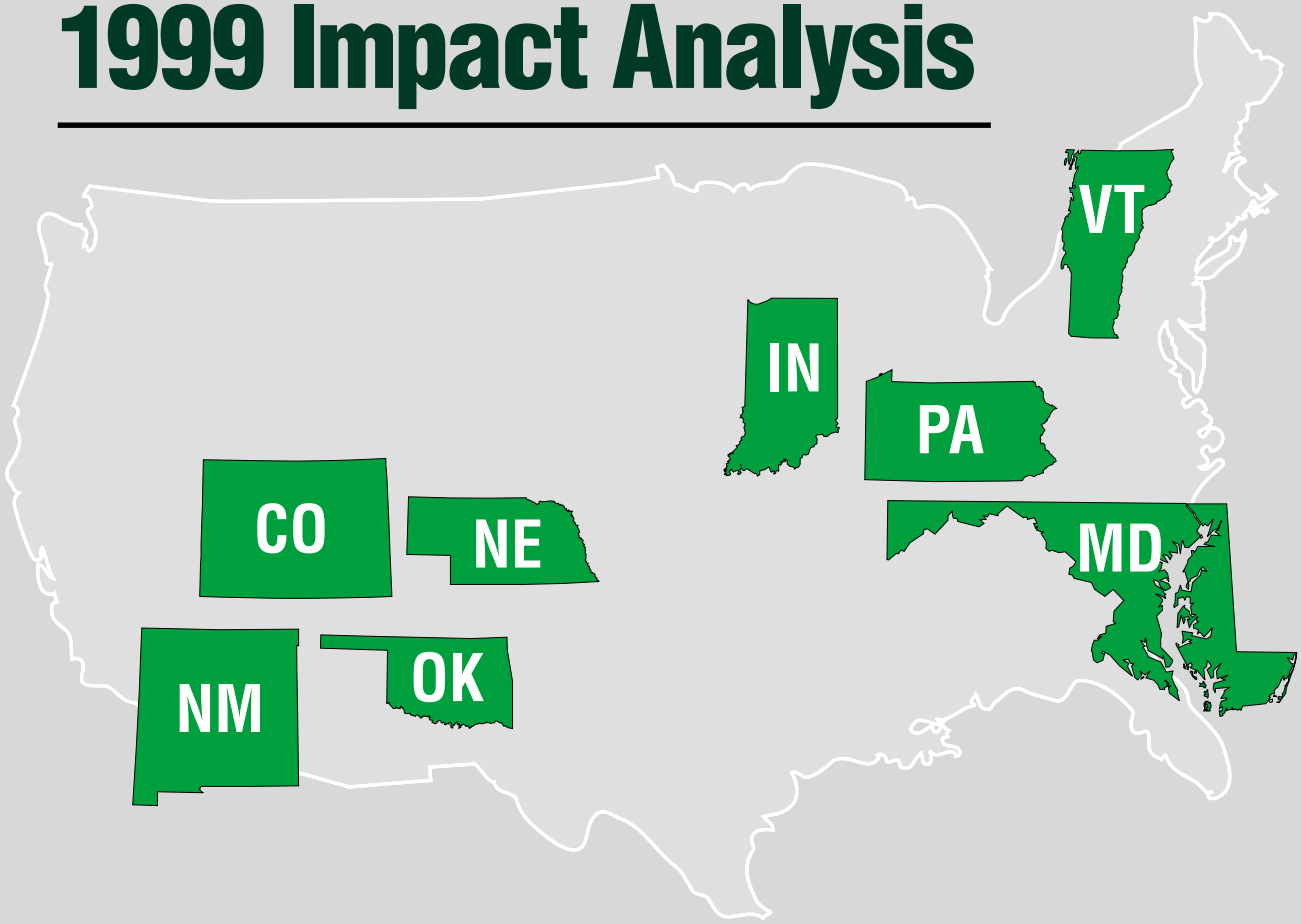
Health Care Reform Tracking Project:

1999 Impact Analysis



Executive Summary

Sheila A. Pires, M.P.A.
Beth A. Stroul, M.Ed.
Mary I. Armstrong, M.S.W., M.B.A.

University of South Florida
USF

Introduction

The Health Care Reform Tracking Project (Tracking Project) was initiated in 1995 to track and analyze state and local managed care 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 initiatives on children and adolescents in the child welfare system. The Tracking 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 Georgetown University.

The Tracking Project is being undertaken during a period of rapid change in public sector health and human service systems. States and, increasingly, local governments are applying managed care technologies to the delivery of mental health and substance abuse services (together referred to as "behavioral health services" in this study) for children, adolescents and their families within Medicaid, mental health, substance abuse, child welfare and State Children's Health Insurance (SCHIP) programs. The Tracking Project is the only national study focusing specifically on the impact of these public sector managed care reforms on children and adolescents with behavioral health disorders and their families.

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.

To date, the Tracking Project has issued three reports:[1]

- Health Care Reform Tracking Project: The 1995 State Survey
- Health Care Reform Tracking Project: The 1997 Impact Analysis
- Health Care Reform Tracking Project: The 1997-98 State Survey.

The all-state surveys describe public sector managed care activity occurring in all 50 states and the District of Columbia that affects children and youth with behavioral health disorders and their families. The 1997 Impact Analysis examines the impact of this activity in a sample of 10 states with different managed care approaches.

[1]All reports are available through the Research and Training Center for Children's Mental Health at the University of South Florida (813) 974-6271. Full citations are provided at the end of this Summary.

Executive Summary

This report presents the findings from the 1999 Impact Analysis, which builds on the previous work of the Tracking Project by examining whether earlier findings continue to be valid. For the 1999 Impact Analysis, the Tracking Project conducted in-depth site visits to a new sample of eight states and, through telephone interviews, examined changes that have occurred in the first sample of 10 states since the 1997 report (referred to as the Maturational Analysis). The states selected for the 1999 Impact Analysis include: Colorado, Indiana, Maryland, Nebraska, New Mexico, Oklahoma, Pennsylvania and Vermont. However, because two reforms were analyzed in Maryland, the 1999 report actually analyzes nine managed care reforms in eight states.

The managed care approaches used by the selected states include both carve out designs, which are defined in this project as arrangements whereby behavioral health services are financed and administered separately from physical health services, and integrated designs, defined as arrangements in which the financing and administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted). The Tracking Project is analyzing whether and how different approaches have differing effects on children and adolescents with behavioral health problems, examining areas such as access, benefit design, service availability, family involvement, cultural competence, quality, and outcomes. The 1999 sample studied five managed care reforms with carve out designs and four managed care reforms with integrated physical/behavioral health designs.

Site visits for the 1999 Impact Analysis were conducted by teams of trained interviewers, including family members and others knowledgeable about children's behavioral health, child welfare, and managed care. Interviews were conducted with a wide variety of stakeholder groups, typically 13-15 groups in each state, including a total of 75-100 interviewees per state. In each state, interviews were conducted with family members, representatives of state and local child mental health, child welfare, juvenile justice, education and substance abuse agencies, state Medicaid agencies, managed care organizations, providers, and advisory and advocacy groups. Quantitative data on the impact of managed care systems were examined, but, because these data were very limited, it is the perceptions and assessments of key stakeholder groups that form the primary data source for the impact analysis.

The findings described in the 1999 Impact Analysis report are based on a cross-state analysis of the nine managed care reforms in the eight states that were site visited, the telephone interviews that identified changes that have occurred in the 1997 sample of 10 states (the maturational analysis), and findings from the 1997-98 State Survey, which described 43 managed care reforms in 39 states. The information used for this cross-state analysis reflects areas of general consensus across stakeholder groups; discrepant perceptions of a single interviewee, a single stakeholder group, or a limited number of stakeholders are identified as such in the report.

The 1999 Impact Analysis report is organized around a number of hypotheses that were drawn from the earlier work of the Tracking Project as to the effects of public sector managed care reforms on this population of children, youth and their families. Throughout the report, promising features of states' managed care systems are highlighted. The 1999 Impact Analysis report also includes the following supplemental special analyses: child welfare population issues; adolescent substance abuse issues; maturational analysis findings; and family reflections, prepared by family members who participated on the site visit teams.

Findings

Overview

Overall, findings from the 1999 Impact Analysis suggest a "good news, bad news" scenario in states. Stakeholders and available data indicated that, in their policy decisions and purchasing specifications, when compared to findings in 1997, states are beginning to make choices that would seem to benefit children and adolescents with behavioral health problems and their families. This was reported primarily in states with behavioral health carve out approaches and was evident in such areas as broad benefit designs, broadened definitions of medical necessity criteria, use of child and adolescent-specific level of care and patient placement criteria for behavioral health services, contractual requirements for family involvement and cultural competence, interagency collaboration, and training of managed care organizations on the needs of the population.

However, stakeholders also reported a major disconnect between state policies and contractual requirements and what actually is occurring in implementation, including rigid application of medical necessity and level of care criteria, severe shortages of services, particularly home and community-based services, growing waiting lists, fragmentation of services and cost shifting across children's systems, and limited operationalization of concepts like family involvement and cultural competence.

As they did in 1997, stakeholders in 1999 identified more disadvantages for children with behavioral health disorders in states with integrated physical/behavioral health managed care approaches than in states with behavioral health carve outs. Following are specific key findings from the 1999 report as they relate to the hypotheses.

Key Findings

Stakeholder Involvement in Planning

Hypothesis: In most states, those with knowledge about children's behavioral health services will not be involved in the initial design of the managed care reforms but will become more involved over time in overseeing and refining managed care systems.

Finding: Upheld

Of all stakeholders, state children's mental health staff were involved in initial managed care system planning more than any other stakeholder group and continue to be involved. On balance, in the 1999 state sample and the maturational analysis of the 1997 sample, most other stakeholder groups reported growing involvement in managed care policy deliberations. This is especially true with respect to involvement of stakeholders from child welfare systems, family organizations, and state substance abuse agencies. It is reportedly less true for providers, other child-serving systems, and advocacy groups. Stakeholders attributed this growing involvement to their own increased awareness and to the need for state planners to engage broader constituency groups in addressing implementation problems. In spite of growing involvement, the 1997-98 State Survey found that families and child welfare systems reportedly have involvement characterized as significant in fewer than 40% of reforms nationally, state substance abuse agencies in fewer than 25%, and state child mental health staff in slightly over half of reforms.

State Medicaid agencies continue to be the dominant policy authority for state managed care initiatives for the reforms studied in 1999, as was also the case in the 1997 sample. In most states with behavioral health carve outs, although not all, state behavioral health agencies have or share policy authority with the Medicaid agency; however, they play little role in states with integrated designs. As was also the case in the 1997 sample, there is little shared policy making for managed care systems across child-serving agencies, even though other child systems, such as child welfare, juvenile justice and education, share service and funding responsibility for children with behavioral health needs.

Goals of Managed Care Reforms

Hypothesis: Cost containment will be only one among multiple goals for managed care reforms in most states, with other common goals including expanding access to services and expanding the array of services.

Finding: Upheld

As in 1997, states in the 1999 cohort reported that they are trying to achieve both cost containment and a variety of other objectives with their managed care reforms, such as greater accountability, improved quality and access, more flexibility in service delivery,

greater local control and responsibility for service delivery, and expansion of home and community based services.

Consistency with System of Care Goals

Hypothesis: Goals for managed care reforms will be more consistent with system of care goals in states with carve out designs for behavioral health services than in states with integrated designs that combine the financing and administration of services for physical and behavioral health services.

Finding: Upheld

Particularly in those states with strong histories of system of care development, system of care principles are articulated clearly in managed care system Request for Proposals (RFP) and contract language if the state chose a behavioral health carve out approach–as in Pennsylvania, Colorado, and Maryland, for example. On the other hand, even in states with a long history of system of care development, system of care concepts are not incorporated into managed care systems if the state took an integrated approach–as in Vermont, for example. One of the biggest complaints from stakeholders in states with integrated designs was that managed care is making it more difficult to provide flexible, individualized service planning and treatment, which is a core tenet of the system of care philosophy and approach.

Carve Out and Integrated Design Differences

Hypothesis: For mental health, not for substance abuse, states with carve out or partial carve out designs will cover a broader array of behavioral services, more home and community-based services, and allow greater flexibility in service delivery than states with integrated designs.

Finding: Upheld

Stakeholders attributed the relative advantages of a carve out over an integrated approach with respect to mental health services to a number of factors–specifically, that a carve out allows for protection of the behavioral health dollar and focus, easier blending of Medicaid and non-Medicaid dollars to expand service coverage, greater assurance that savings will be reinvested back into behavioral health, and that typically (although not always) a carve out is designed and monitored by those with expertise in behavioral health, for example, the mental health agency. As was also the case in 1997, stakeholders in 1999 reported that, regardless of managed care design, few substance abuse services are covered in most states.

As was the case in the 1997 sample, states in the 1999 sample that have used integrated designs reported less involvement in planning by stakeholders with expertise in behavioral health and a more traditional benefit design than did states with carve outs. (A traditional benefit design is defined as one typically found in a commercial insurance package, covering a limited number of outpatient visits and a limited number of inpatient days.) In

states with integrated approaches, physical health issues reportedly dominate policy and implementation processes, and there is the perception among stakeholders–though it is difficult to confirm since data are not available–that little of the capitated dollar is allocated to behavioral health. Stakeholders in states with integrated designs also complained about the "multiple layers" created by state contracts with health maintenance organizations (HMOs) or other managed care organizations (MCOs) that then subcontract with behavioral health organizations (BHOs).

Acute and Extended Care Issues

Hypothesis: Most states will focus on including only acute care in their managed care systems, leaving extended care to other systems.

Finding: Not Upheld

The 1997 Impact Analysis found that most of the 10 states in that sample designed their managed care systems to include acute care only, leaving extended care outside of managed care. (This study defines acute care as brief, short term treatment with, in some cases, limited intermediate care provided, and extended care as care extending beyond short-term stabilization, i.e., care required by children with more serious disorders and their families.) In contrast, both the site visits in 1999 and the 1997- 1998 State Survey found that states are moving toward including extended care in managed care systems, as well as including more populations requiring extended care, such as the SSI population and children involved in child welfare systems. This is particularly true of states with carve out designs, but also seems to be occurring to some extent in states with integrated designs. The 1997-98 State Survey found that 60% of reforms nationally reportedly include the child welfare population and 56% include the SSI population.

While states are designing managed care systems to include extended care and extended care populations, stakeholders in these states also noted that the actual provision of extended care is hampered by a number of factors. Specifically, they reported that medical necessity criteria are used to limit duration of care; that lack of a broad service array hampers provision of extended care; and that large amounts of extended care funding are left outside of managed care systems, providing incentives to cost-shift. As they did in 1997, stakeholders in 1999 reported that a split between acute and extended care or across extended care financing streams aggravates the historic fragmentation, duplication, and confusion in children's services.

Use of Commercial MCOs

Hypothesis: Most states will use commercial managed care organizations (MCOs) and behavioral health organizations (BHOs) in their managed care systems.

Finding: Upheld

Both the 1999 Impact Analysis and the 1997-98 State Survey found that states increasingly are contracting with commercial MCOs and BHOs. States with integrated designs are more likely to use only commercial companies, and states with carve outs are more likely to use a mix of both commercial, nonprofit, and governmental entities or to use exclusively nonprofit agencies or government entities as MCOs.

Many of the same advantages of using commercial MCOs that were cited in 1997 were noted by stakeholders in this round of site visits as well, and many of the same disadvantages. The major advantage cited was the commercial companies' expertise with the technical aspects of managed care, such as data management, utilization management, claims handling, and provider profiling. Some stakeholders also believe that commercial companies bring a needed focus on quality improvement and a "culture" change that is needed to shake up long entrenched public systems.

The major disadvantage cited was that the learning curve for commercial companies with respect to serving the public sector-involved population is reportedly higher than for nonprofits or government entities. Stakeholders also were critical of commercial companies' coming into a state without understanding the culture in the state and without building a local presence, and there is widespread concern that for-profit companies will sacrifice service delivery to profit making. The reality of whether MCOs are making profits at the expense of adequate service delivery is difficult to ascertain. Some MCOs complained that the profit margin is so low to serve high-risk populations that it inevitably detracts from the service package. Some states, principally those with carve outs, have put contractual limits on both MCO profits and administrative costs. The 1997-98 all-state survey reported that 75% of states with carve outs limited profits, as compared with only 8% of states with integrated designs.

Familiarity with the Population

Hypothesis: Commercial MCOs will be viewed as unfamiliar with the Medicaid population in general and with children with behavioral health disorders, in particular.

Finding: Upheld

As was the case in 1997, in most of the states using commercial companies in the 1999 sample, stakeholders complained that MCOs lack familiarity with the Medicaid population in general and with children with serious emotional disorders and adolescents with substance abuse disorders, in particular. They noted that commercial companies have to learn about extended care since most come out of an "acute care" model; they have to learn about populations at risk, such as children involved in child welfare and juvenile justice systems; and about interagency collaboration, intensive case management concepts, and the fragmentation of funding streams and delivery systems that exist in the children's arena. Stakeholders also believe that commercial MCOs have to restructure internally to adapt to the public sector. For example, utilization management criteria that are geared only to acute

care have to be adapted to handle acute and extended care across a continuum in those states in which the managed care system includes both.

Stakeholders in several states reported that they have engaged in efforts to orient and train MCOs regarding the needs of the population and about other children's systems.

Use of Multiple MCOs

Hypothesis: The use of multiple MCOs either statewide or within regions, while allowing for greater consumer choice, will create more problems and administrative complexities than offsetting advantages.

Finding: Upheld

As was the case in 1997, stakeholders in all of the states using multiple MCOs either statewide or within regions reported difficulties that were not offset by the notion of choice of MCO. These included administrative complexities for providers, monitoring challenges for states, and navigation difficulties for consumers. The 1997-98 all-state survey found that states with integrated designs almost universally were using multiple MCOs statewide or across regions, while states with carve outs were much less likely to do so.

Consumer Choice

Hypothesis: Choice in providers will be more important to consumers than choice in MCOs.

Finding: Upheld

In all of the states in the 1999 sample, stakeholders, including families, reported that choice of provider was more important to consumers than choice of MCO. This was reported in the 1997 Impact Analysis as well.

Capitation Rates

Hypothesis: In most states, capitation rates will be considered insufficient to guard against underservice and to expand service capacity.

Finding: Upheld

It should be noted that most states are not analyzing the sufficiency of rates for children's behavioral health service delivery in any systematic way and that definitions of "sufficiency" vary across states and among stakeholder groups in any event. For purposes of this study, however, the question asked with both the 1997 and 1999 samples of states was whether rates were considered to be sufficient to guard against underservice, a major concern for children with serious disorders, and to allow for service capacity expansion, which is recognized by virtually all stakeholders as a critical issue. As was the case in 1997,

stakeholders in most of the states in the 1999 sample, and particularly in states with integrated designs, do not believe that capitation rates are sufficient to guard against underservice and to allow for service capacity expansion.

Risk Adjustment Mechanisms

Hypothesis: There will be few instances of risk adjustment mechanisms or risk adjusted rates for children with serious behavioral health disorders, but there will be increased interest on the part of states to develop risk adjusted rates for children involved in the child welfare system.

Finding: Upheld

Both the 1999 Impact Analysis and the 1997-98 State Survey found that states are moving toward developing risk adjusted rates for the child welfare population, but not for children with serious emotional disorders or for adolescent substance abuse treatment. Several states in the current sample also noted that lack of encounter data is hampering their efforts to establish risk-adjusted rates.

Risk Sharing

Hypothesis: In most states, MCOs will be at full risk.

Finding: Upheld

Both the 1999 Impact Analysis and the 1997-98 State Survey found that states increasingly are pushing full risk to MCOs. Both studies also found that, particularly in carve outs, risk is not being pushed down to behavioral health care providers, who continue to be paid on a fee-for-service basis, for the most part.

Provider Reimbursement Rates

Hypothesis: In most states, providers will be receiving the same or higher reimbursement rates through the managed care system than they were under the previous Medicaid fee-for-service system.

Finding: Not Upheld

In the 1997 analysis, seven of the 10 states reported that providers were being paid the same or higher reimbursement rates by MCOs than they had received under the previous Medicaid fee-for-service (FFS) system. That finding basically has reversed itself with the 1999 sample of states. In addition, stakeholders in two states from the 1997 sample reported through the maturational analysis that provider payment rates have been cut since 1997. In states in which rates have been cut, there also were reports of difficulties in attracting and retaining providers, of providers refusing to accept Medicaid clients, of providers discontinuing certain types of services, and of providers going out of business because they

could not survive with the combination of low rates and increased administrative costs associated with managed care systems. A number of states also reported that when rates are higher on the fee-for-service side than in managed care systems, there is incentive on the part of providers to cost-shift to fee-for-service systems.

Prior Authorization Issues

Hypothesis: Complaints about prior authorization management mechanisms will be pervasive, except in states where MCOs have subcapitated providers and/or routinely allow a certain level of service provision.

Finding: Upheld

The 1997-98 State Survey found that nearly all managed care systems (88% of the reforms analyzed) use prior authorization as a primary mechanism for utilization management. Stakeholders in most states in both the 1997 and 1999 samples complained about prior authorization mechanisms, describing them as cumbersome, time consuming, confusing, and creating barriers to access. Complaints were fewer in systems which routinely allow a certain level of services to be provided and reserve authorization requirements for more intensive and expensive levels of care. Additionally, these complaints were virtually nonexistent in areas in which providers were subcapitated and, therefore, retained control over the types, level, and duration of services provided (in exchange for assuming risk), although instances of subcapitation of providers were relatively rare. Some states in the 1999 sample reportedly are refining their prior authorization processes to address some of these issues, and the maturational analysis also confirmed a trend towards less onerous prior authorization requirements.

Prior Authorization of Substance Abuse Treatment

Hypothesis: In most states, prior authorization and other management mechanisms will create particular barriers to those seeking substance abuse treatment since the motivation to seek care may be diminished.

Finding: Upheld

Respondents in the 1999 sample of states emphasized that the population of youngsters with substance abuse disorders typically is not a population that is motivated to seek treatment and to become engaged in services. According to stakeholders in both 1997 and 1999, being forced to go through the "hoops" of primary care practitioner (PCP) referrals and authorization by MCOs for initial and ongoing substance abuse treatment creates delays and barriers that may discourage many consumers from obtaining services at all. There also were reports in some states that the constraints placed on substance abuse services through prior authorization processes are even more limiting than those placed on mental health care.

Level of Care and Patient Placement Criteria

Hypothesis: Few states will have developed level of care or patient placement criteria specific to adolescent substance abuse treatment, as compared to children's mental health.

Finding: Not Upheld

The 1999 Impact Analysis found that most of the reforms in the sample that included substance abuse were using patient placement criteria for adolescent substance abuse services (as compared to only one reform in the 1997 sample). In contrast, only half of the reforms including mental health services had level of care criteria specific to children's mental health services, a decline as compared with the 1997 sample. Thus, in actuality, clinical decision making criteria of some type were somewhat more likely to be found for adolescent substance abuse than for children's mental health–the opposite of what had been predicted. This may be due to the existence of broadly accepted criteria in the substance abuse field (those developed by the American Society of Addiction Medicine–ASAM), while similar national criteria do not exist in the children's mental health field, leaving to states and MCOs the challenge of developing their own.

Consistency in Clinical Decision Making

Hypothesis: Level of care and patient placement criteria will be perceived as improving consistency in clinical decision making.

Finding: Not Upheld

In contrast with 1997 findings, stakeholders in the 1999 sample of states did not necessarily believe that the use of level of care and patient placement criteria were improving consistency in clinical decision making. Stakeholders in six of the nine reforms in the sample perceived criteria either to be too broad, applied too rigidly by MCOs, or rendered meaningless by a lack of available services.

Medical Necessity Criteria

Hypothesis: In response to problems, medical necessity criteria will be defined broadly or will have been broadened to include psychosocial and environmental considerations in clinical decision making.

Finding: Upheld

As in 1997, medical necessity criteria used in initial implementation of managed care reforms were regarded as problematic by respondents across most states in the 1999 sample. In response to these concerns, a number of states in both the 1997 and 1999 samples have created broad definitions of medical necessity or have broadened their definitions to allow for the inclusion of psychosocial and environmental considerations in clinical decision making. A trend toward broadening medical necessity criteria was also

evident in the 1997-98 State Survey which indicated that the vast majority of managed care systems use medical necessity criteria (86%) and that nearly 40% reportedly had revised their criteria, primarily with a view toward placing greater emphasis on psychosocial issues.

Grievance and Appeals Processes

Hypothesis: Grievance and appeals processes will be problematic for families and providers in most states.

Finding: Upheld

Stakeholders in all states in the 1999 sample expressed concerns about the grievance and appeals processes used in managed care systems, as did stakeholders in all states visited during the 1997 Impact Analysis. The most frequently stated complaint across states is that families do not know about grievance and appeals processes or about how to use them. Families reported feeling intimidated by the process and fearful of potential retaliation or repercussions if they file a grievance or appeal. In addition, complaints centered around the complexities, commitment of time and energy, delays, and difficulties involved in negotiating grievance and appeals processes, both for families and providers.

Range of Covered Mental Health Services

Hypothesis: Managed care reforms will result in coverage of a broader array of children's mental health services in states with carve out designs, but not in states with integrated designs.

Finding: Upheld

As in 1997, managed care reforms were credited by stakeholders in the 1999 sample with expanding the range of mental health services covered in states with carve out designs, but not in those with integrated physical/behavioral health approaches. Stakeholders in states with integrated designs in both the 1997 and 1999 samples tended to feel that the array of covered mental health services was constricted and inadequate.

Across those states in both the 1997 and 1999 samples where service coverage was expanded, the expansion was attributed primarily to filling in the mid-range between outpatient services and hospitalization by adding an array of home and community-based services, such as home-based services, targeted case management, crisis services, respite care, day treatment, intensive outpatient services, family support, wraparound services, and others.

Range of Covered Substance Abuse Services

Hypothesis: Managed care reforms will not result in coverage of an expanded array of substance abuse services for adolescent substance abuse treatment, regardless of design.

Finding: Upheld

The broader array of covered services resulting from managed care reforms has not applied to substance abuse services in most states, according to stakeholders in both the 1997 and 1999 samples. Stakeholders in nearly all states across both the 1997 and 1999 samples noted serious shortages of adolescent substance abuse treatment services, a problem pre-existing managed care. With exceptions in only a few states, the introduction of managed care reportedly has not resulted in improvements.

Coverage of Home and Community-Based and Individualized Services

Hypothesis: Managed care reforms will result in more home and community-based services covered and more flexible, individualized services in states with carve out designs, but not in states with integrated designs.

Finding: Upheld

Confirming 1997 findings, managed care reforms with carve out designs reportedly have resulted in coverage for more home and community-based services and have also resulted in more flexible, individualized services. Conversely, integrated reforms in both the 1997 and 1999 samples did not result in greater coverage of home and community-based service options (with one exception where enhanced services were added to the benefit package), and did not result in greater use of flexible, individualized service approaches. These observations are further substantiated by the results of the 1997-98 State Survey which revealed an expanded array of home and community-based services in most of the carve out reforms (75%) as compared to only 20% of the integrated health/behavioral health reforms. The addition of wraparound services, although defined differently across states, has been credited by respondents as the primary vehicle for providing more flexible, creative, and innovative services.

Service Capacity

Hypothesis: In most states, there will be a perceived need for states to invest in service capacity development for both children's mental health and adolescent substance abuse.

Finding: Upheld

The results of both the 1997 and 1999 Impact Analyses underscored the need to differentiate between coverage of services in managed care systems and the actual availability of these

services. Across states in both samples, stakeholders reported significant gaps in behavioral health services for children and adolescents, regardless of managed care design. Lack of sufficient service capacity is a pre-existing systems issue, but managed care reforms reportedly can aggravate the shortage problem by enrolling and providing initial access for more children than under the previous fee-for-service system without expanding the services available. In the 1999 sample, stakeholders in all nine reforms reported insufficient investment in service capacity development, even though increasing access to behavioral health services is a goal of most of these reforms.

Prevention Services

Hypothesis: In most states, behavioral health prevention services will not be integrated into managed care reforms.

Finding: Upheld

Both the 1997 and 1999 studies indicate that prevention services, with few exceptions, remain outside of managed care systems. Typically, separate state allocations are earmarked to fund mental health and substance abuse prevention activities. Some stakeholders speculated that the typical three-year state contract period is not sufficiently long to create an incentive for MCOs to focus on behavioral health prevention. Others felt that the omission of prevention from behavioral health managed care systems may also be because system participants do not know how to prevent behavioral health problems, do not believe in the potential for such prevention, or do not feel that it is within their statutory or contractual responsibility.

Services in Rural and Frontier Communities

Hypothesis: Pre-existing problems in providing services in rural and frontier areas will not significantly improve under managed care.

Finding: Upheld

As in 1997, pre-existing problems and challenges in providing services in rural and frontier areas were not significantly improved under managed care, according to stakeholders in the 1999 sample. Stakeholders in both the 1997 and 1999 samples suggested that managed care reforms may add complications to providing services in rural areas by adding prior authorization and other utilization management processes. Additionally, managed care reforms may deplete the already inadequate service capacity in some rural areas due to the loss of providers who do not meet credentialing requirements or who choose not to participate due to low rates, administrative burden, difficulty in obtaining service authorizations, and the extensive lag time for payments characteristic of some managed care systems.

Initial Access to Services and Access to Extended Care

Hypothesis: In most states, managed care reforms will increase initial access to services, but aggravate access to extended care services.

Finding: Partially Upheld

In 1997, stakeholders in nearly all of the states studied felt that initial access to behavioral health services was easier as a result of managed care reforms, and nearly all felt that accessing extended care services was more difficult. In 1999, however, while findings were similar with respect to difficult access to extended care, respondents in five of the nine reforms studied (including all of the reforms with integrated designs and one with a carve out design) reported that initial access was being compromised as well. Reasons cited included rigidly applied service authorization and clinical decision making processes and increased demand combined with a lack of available services.

Access to Inpatient and Residential Services

Hypothesis: In most states, inpatient hospital services will be more difficult to access, and there will be concerns about discharging youngsters prematurely from inpatient settings.

Finding: Upheld

Stakeholders in the 1999 Impact Analysis confirmed findings in 1997 that inpatient hospitalization continues to be difficult to access in most states as a result of managed care reforms, and that children reportedly are being discharged prematurely from hospitals without adequate step-down or alternative services in place. The maturational analysis suggests that the problems associated with access to inpatient care perhaps have worsened over time. At least half of the states studied in 1997 reported in the update that it is even more difficult to access inpatient services than at the time of the site visit.

The issues of access to and premature discharge from inpatient care were particular concerns of child welfare and juvenile justice respondents across states. They felt that limits on hospitalization have shifted responsibility for youth with very serious behavioral health problems to child welfare and juvenile justice systems that may be ill-equipped to serve them.

Stakeholders in both the 1997 and 1999 samples also regarded access to residential treatment as problematic. Complaints included fewer residential treatment beds available, onerous and cumbersome approval processes for this level of care, infrequent authorization of residential treatment by MCOs, long waiting lists for residential treatment, difficulty in obtaining longer-term residential treatment even when judged to be clinically appropriate, and lack of appropriate alternatives.

On the other hand, there were increased reports in the 1999 sample of states and in the update on the 1997 sample that alternative levels of care to inpatient and residential treatment are beginning to be developed in states, including crisis stabilization units (referred to in some states as acute residential care, observation and evaluation units, crisis stabilization beds, and the like), therapeutic foster care, day treatment, intensive home-based services, and respite services.

Provisions for Children with Serious Disorders

Hypothesis: Most states will not have a dedicated planning process, differential benefits, or special provisions in their managed care systems for children and adolescents with serious behavioral health disorders.

Finding: Upheld

The 1997-98 State Survey found that half (51%) of reforms nationally do not incorporate a dedicated planning process, special management mechanisms or differential benefits for children with serious behavioral health disorders. The 1999 Impact Analysis confirmed earlier stakeholder reports that most states have neither distinguished the population of children with serious behavioral health problems from the total population of covered children, nor have they included special benefits or other special provisions or management mechanisms to serve this group of high utilizers. These findings apply especially (although not exclusively) to states with integrated designs.

Use of Managed Care Reform as a Strategic Opportunity for System Development

Hypothesis: In most states, managed care reforms will not be used as a strategic opportunity to further the development of local systems of care.

Finding: Upheld

The 1999 Impact Analysis confirmed earlier stakeholder reports that most states have not used their managed care reforms as a strategic opportunity to further the development of local systems of care, even in states with federal grants from the Comprehensive Community Mental Health Services for Children and their Families Program. On the other hand, more than half of the reforms in the 1999 sample reportedly incorporated at least some system of care principles as requirements in their managed care systems through RFPs, contracts, service delivery protocols, and other system documents. Inclusion of system of care principles was more likely in states with carve outs, and the principles most likely to be included were: a broad array of services, community-based care, use of least restrictive service settings, flexible/individualized services, service coordination, family involvement, and cultural competence. The 1999 analysis confirmed earlier study findings that communities are more likely to implement managed care and interpret requirements in a way that is consistent with, and even enhances, systems of care if: 1) the system of care

philosophy, approach, and infrastructure are already well developed in the state or locality, and 2) the design and requirements of the managed care system are structured to allow for and encourage system of care enhancement.

Family Involvement at the System Level

Hypothesis: There will be a trend toward increasing family involvement at the system planning and oversight level.

Finding: Unclear

Findings from previous Tracking Project activities that indicated a trend toward increasing system-level family involvement in managed care systems were not strongly upheld in the 1999 sample. Both the 1997-98 State Survey and the 1999 Impact Analysis found that family involvement at the policy level is increasing, but slowly, and is more likely to occur in states with carve outs than in states with integrated designs. Respondents in the 1999 sample and in the update on the 1997 sample did identify some examples of where family involvement has been institutionalized in the ongoing operation and monitoring of managed care systems, for example by hiring family advocates and including family members in readiness assessments, monitoring, and evaluation activities. However, family involvement, where it is occurring, tends to be characterized most often by participation on advisory boards, rather than in other policy making or operational roles. There was also an increase in the 1999 sample (three out of nine reforms) from the 1997 sample (one out of ten reforms) with respect to the number of reforms that require family involvement in RFPs and contracts; however, actual implementation of family involvement reportedly is variable.

Overall, stakeholders in both the 1997 and the 1999 samples reported that managed care systems offer few supports to family members to facilitate their involvement in system-level planning and oversight activities, although some progress was noted over time through the maturational analysis of the 1997 sample. According to respondents, only one state in the 1999 sample provides training on family involvement for its MCOs and provider networks, results that are similar to findings in the 1997 sample.

Family Involvement at the Service Delivery Level

Hypothesis: Although managed care systems in most states will require family involvement in planning services for their own children, implementation of this requirement will be variable.

Finding: Upheld

Both document reviews and the reports of key stakeholders indicated that there are requirements for family involvement at the service delivery level incorporated in seven managed care reforms (five carve outs and two integrated systems) in the 1999 state cohort. These results are similar to the 1997 sample. However, even in the states where there are

such requirements for family involvement, many respondents reported that the implementation is spotty, that MCOs do not facilitate involvement of families, and that the focus of services is on the identified child rather than taking into consideration related family needs.

Program and Staff Roles for Families and Youth

Hypothesis: In most states, managed care reforms will have no impact on the pre-existing lack of family-run programs or services and use of family members or youth as paid staff.

Finding: Upheld

The perception of stakeholders from all nine reforms included in the 1999 sample is that managed care has had no impact on the availability of family-run programs or services, which, stakeholders noted, did not exist prior to managed care reforms either. Findings are similar regarding the use of family members or youth as paid staff, a practice that was infrequent prior to managed care reforms and continues to be so. These findings are consistent with those of the 1997 sample.

Financial Burden on Families

Hypothesis: In most states, managed care reforms will not increase the financial burden on families.

Finding: Upheld

The findings from the 1999 Impact Analysis support the hypothesis that, in most states, managed care will not increase family financial burden. Several respondents across sites in the 1999 sample observed that financial burden for many families actually has decreased as a result of the changes made in the Balanced Budget Act of 1997 that resulted in Title XXI. These changes include both increases in the family income eligibility levels for Medicaid, making more families eligible for the managed care system, and the creation of the State Children's Health Insurance Program (SCHIP), a new health care program including behavioral health benefits for low-income children above the Medicaid eligibility level.

Relinquishing Custody

Hypothesis: In most states, managed care reforms will exacerbate the problem of families having to relinquish custody of their children in order to obtain needed but expensive treatment.

Finding: Not Upheld

The hypothesis that managed care reforms, in most states, will exacerbate the problem of families having to relinquish custody was not upheld by the 1999 Impact Analysis. While

relinquishment of custody was perceived to be a problem by stakeholders in five of the eight states in the 1999 sample, in only two states did stakeholders believe the issue had been made worse by managed care implementation.

Impact on Early Identification and Intervention

Hypothesis: Managed care reforms will not result in improved early identification and intervention for behavioral health problems, even if the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) is incorporated into the reform.

Finding: Upheld

The 1997-98 State Survey and the 1999 Impact Analysis found that more managed care reforms (93% nationally according to the all-state survey) are incorporating the EPSDT program. However, stakeholders in the 1999 Impact Analysis confirmed earlier reports that managed care reforms are having little impact on the early identification of behavioral health problems, primarily due to lack of financial incentives and lack of training for primary care practitioners.

Services to Young Children and Their Families

Hypothesis: In most states, managed care systems will provide few services to infants, toddlers, and preschoolers and their families.

Finding: Upheld

It was reported that few, if any, behavioral health services are being provided to infants, toddlers, and preschoolers and their families in all nine of the reforms in the 1999 sample, a finding consistent with the 1997 Impact Analysis. In addition, the Early Intervention Program, Part C under the Individuals with Disabilities Education Act (IDEA), which targets young children, was reported to be outside of the managed care system in all reforms in the sample, just as it was outside the managed care system in all reforms in the 1997 cohort. (Part C focuses on infants and toddlers and requires a range of early intervention services needed as a result of developmental delays affecting cognitive development, physical development, language and speech, or psychosocial development.)

Interagency Service Planning at the Child and Family Level and Coordinating Multiple Services

Hypothesis: In most states, managed care reforms will make it more difficult to do interagency service planning at the child and family level.

Finding: Not Upheld

The effect of managed care reforms on interagency service planning appears to be related to the design of the managed care system. All of the reforms in the 1999 sample in which

interagency service planning was reported to be impeded were integrated designs; stakeholders in carve outs, in contrast, did not perceive managed care to be impeding interagency service planning.

Consistent with the findings related to interagency service planning, the effects of managed care reforms on coordinating multiple mental health services are strongly related to the system design, with stakeholders in four of the five carve outs reporting improved coordination, and stakeholders in all four of the integrated reforms reporting that managed care reforms have impeded service coordination.

In both the 1997 and 1999 samples, stakeholders indicated that two major pre-existing issues– coordination between mental health and substance abuse services and coordination between physical and behavioral health care–have not improved as a result of managed care reforms, regardless of design.

Impact on Cultural Competence

Hypothesis: In most states, managed care reforms will not affect the overall level of cultural competence in the system.

Finding: Upheld

The perception of stakeholders in both the 1997 and 1999 samples was that behavioral health care systems lacked cultural competence prior to managed care reforms, and that managed care has had little to no effect in this area. In the 1997-98 State Survey, 80% of reforms reported having provisions that address the inclusion of culturally diverse providers in provider networks. However, respondents in most states in both samples indicated that actual inclusion of culturally diverse providers was a pre-existing problem on which managed care has had no appreciable impact. Only a few states in the 1997 and 1999 samples reported efforts to train MCOs on issues related to cultural competence.

Analysis of the Needs of Culturally Diverse Groups

Hypothesis: In most states, managed care planning will include minimal focus or analysis of the needs of culturally diverse children and families.

Finding: Upheld

In the 1999 sample, few attempts were found to analyze the needs of culturally diverse children and their families and to address these in managed care systems, results similar to those found in 1997. In addition, there were few reported instances in either sample of outreach to culturally diverse children and families involved in managed care systems.

Requirements for Cultural Competence

Hypothesis: Most states will incorporate requirements related to cultural competence in their managed care systems, but these will be limited to linguistically appropriate services.

Finding: Partially Upheld

As in 1997, the majority of reforms in the 1999 sample incorporate requirements related to cultural competence. However, fewer states in the 1999 sample characterized these as focusing primarily on linguistically appropriate services, suggesting that cultural competence requirements (if not realities) are becoming more far-reaching in some states.

Impact on Providers

Hypothesis: In most states, managed care reforms will result in an expanded range of providers, but also will lead to the exclusion of certain types of providers (such as smaller, nontraditional providers and certified substance abuse counselors).

Finding: Upheld

Stakeholders in nearly all of the reforms studied in the 1999 sample reported an expanded array of providers, in comparison to Medicaid fee-for-service systems, as a result of managed care. This represents an increase from the 1997 sample in which only half of the states reported an expanded array of providers. The 1999 Impact Analysis suggests that managed care reforms are, indeed, "opening up" provider networks–a stated goal of many reforms.

Expansion in the array of providers seen in the 1999 sample and in the maturational analysis may be related to the growing inclusion in managed care of more disabled populations who typically require a broader service array. The expansion also may be developmental, with states' recognizing the need for a broader array of providers as they gain more experience with managed care. Some of the expansion also is attributable to greater inclusion of private individual practitioners in provider networks, in comparison to Medicaid fee-for-service systems, reported by stakeholders in both the 1997 and 1999 samples. This development was not always viewed positively, with some stakeholders expressing concern that individual practitioners may lack experience with the public sector population, adequate supervision, training, and peer review mechanisms, in comparison to agency-based providers.

Stakeholders in 1999 also reported greater inclusion in provider networks of traditional child welfare providers, school-based or linked services, and less exclusion of certified addictions counselors than did stakeholders in 1997.

Despite these findings, smaller and nontraditional agencies reportedly struggle to participate in managed care reforms, according to stakeholders in both the 1997 and 1999 samples. The reasons offered by respondents include a lack of administrative infrastructure,

fiscal challenges such as moving from grant-funding to a reimbursement rate structure, the inability to take on financial risk, and the inability to meet credentialing requirements.

Inclusion of Paraprofessionals, Student Interns, and Family Members as Providers

Hypothesis: The practice of credentialing individual providers rather than entire agencies will exclude or limit the use of paraprofessional staff, student interns, and family members in service delivery.

Finding: Not Upheld

In most of the states visited for the 1999 Impact Analysis, unlike reports in 1997, respondents reported that it was possible to license entire agencies or programs, and, in that way, make it possible to include providers such as paraprofessionals, interns, and family members. However, some stakeholders, particularly in states with integrated designs, indicated that MCOs tend to have a bias for credentialing and referring to individual practitioners, instead of agencies, because of their lower overhead.

Front-Line Practice

Hypothesis: In most states, managed care reforms will result in briefer, more problem-focused approaches to services.

Finding: Upheld

While this finding generally was upheld, reports from the 1999 sample, as well as findings from the maturational analysis, suggest that there may be a gradual trend in some states toward less emphasis on brief short-term therapies. In 1997, respondents in all 10 states in the sample indicated a move toward brief, short-term treatment approaches due to managed care. In contrast, stakeholders in five the of the nine reforms in the 1999 sample, predominantly integrated designs, reported this. This may be related to the increased inclusion of more disabled populations in managed care systems and to MCOs' growing experience with public sector populations who may require extended treatment approaches.

Training for Child and Adolescent Providers

Hypothesis: In most states, managed care reforms will create a need for training providers in brief interventions and in various home and community-based approaches.

Finding: Upheld

Stakeholders across sites in both the 1997 and 1999 samples identified a need for training of providers related to managed care reforms and cited similar training needs, including training on short-term treatment approaches, as well as home and community-based services approaches, such as wraparound, intensive case management, and intensive home-based

services. Other training needs identified by stakeholders across states include working with residential agencies to provide intermediate services, creating partnerships with families, and adolescent substance abuse services. Some stakeholders noted that the lack of appropriate skills and attitudes among providers constitutes a serious obstacle to the successful implementation of managed care.

Administrative Paperwork Requirements

Hypothesis: In most states, managed care reforms will increase the paperwork burden for providers.

Finding: Upheld

Stakeholders in all states in both the 1997 and 1999 samples expressed concerns about the increased paperwork burden on providers as a result of managed care reforms. The administrative and paperwork requirements that providers reportedly find burdensome include credentialing processes for individual practitioners, documentation requirements for service authorization and for frequent utilization reviews, documentation needed to respond to frequent payment denials, and encounter and outcome data reporting (reportedly without much feedback).

Disruption of Families' Relationships with Providers

Hypothesis: In most states, managed care reforms will not disrupt ongoing relationships between therapists and the children and families they were serving.

Finding: Upheld

In the 1999 sample, as in 1997, stakeholders in most states reported that managed care reforms did not result in the disruption of ongoing relationships between children and their therapists to any significant degree.

Interagency Collaboration

Hypothesis: In most states, problems resulting from the implementation of managed care reforms will force agencies to increase collaboration at the system level across child-serving systems.

Finding: Upheld

Stakeholders in most states in both the 1997 and 1999 samples reported that problems related to managed care are forcing child-serving systems to increase collaboration and joint problem-solving at both state and local levels. Stakeholders noted that the implementation of managed care is a developmental process in which, in most states, insufficient attention is paid to cross-systems issues in the design and early implementation stages when establishing managed care processes. By mid-implementation, the cross-

systems issues have created so many challenges, according to stakeholders, that state and local attention to them is inevitable.

Payment Responsibility

Hypothesis: In most states, managed care reforms will exacerbate the issue of who pays/ who is responsible for services across child-serving systems.

Finding: Upheld

As was the case in 1997, stakeholders from a majority of the states in the 1999 sample indicated that managed care is exacerbating the age-old issue of which system is responsible for paying for which services, particularly for children and youth with complex and serious behavioral health disorders. Stakeholders attributed the added difficulty to managed care's strict interpretation of medical necessity criteria and its effect of adding additional players to the financing arena. Stakeholders indicated that arguments over who is responsible for payment are especially problematic with respect to residential treatment and for services related to a child's Individualized Education Plan (IEP). Stakeholders in several states, however, also noted that, historically, neither the state nor local counties have understood fully "who is paying for what" in children's services, and that managed care is focusing needed attention to the issue.

Cost Shifting

Hypothesis: In most states, cost shifting to other child-serving systems (such as child welfare and juvenile justice) will be alleged, particularly of inpatient and residential costs, but states will not be tracking this systematically.

Finding: Upheld

As was the case in 1997, in eight of the nine reforms studied in the 1999 sample, stakeholders claimed that cost-shifting from the managed care system to other child-serving systems was occurring. As was also the case in 1997, there are few data to substantiate or refute these claims, because few states reportedly are tracking cost-shifting. Only one state (CO) in the 1999 sample reported efforts to track cost-shifting.

Many stakeholders noted that states are not accurately portraying the true cost of behavioral health service delivery for children, because tracking of cost shifting is not occurring.

They noted that, as a result, even though a state may claim that managed care is containing costs in the Medicaid or mental health and substance abuse systems, total costs may in fact have increased as a result of increases in behavioral health spending in child welfare, juvenile justice, and/or education systems.

Use of Medicaid

Hypothesis: In most states, managed care reforms will make it easier to use Medicaid as a funding source for behavioral health services to children and adolescents and their families than was the case under Medicaid fee-for-service systems.

Finding: Not Upheld

Whether or not managed care makes it easier to use Medicaid to finance behavioral health services for children appears to be directly related to the type of managed care approach a state is using. In all of the states with integrated physical/behavioral health designs, managed care reportedly has not made it any easier– and in some cases has made it more difficult–to use Medicaid to finance behavioral health services for children than was the case under the previous fee-for-service system. Stakeholders attribute this to a more restrictive benefit plan, less flexibility, and more rigid application of medical necessity criteria. In contrast, in all of the states with carve outs, it is reportedly easier to use Medicaid financing. Managed care reforms in these states have enabled Medicaid to be used more flexibly and to cover a broader array of services than was the case under Medicaid fee-for-service.

Reinvestment Requirements

Hypothesis: Few states will require reinvestment of savings from managed care back into children's behavioral health services.

Finding: Upheld

Both the 1999 Impact Analysis and the 1997-98 State Survey found that few states (and none with integrated designs) require reinvestment of savings back into child and adolescent behavioral health services. Reinvestment was reported to be a critical issue because of severe shortages of services and, in most states in the 1999 sample, stakeholder reports of growing waiting lists for services in spite of access standards.

Management Information Systems (MIS)

Hypothesis: In most states, MIS systems will be considered to be inadequate to meet the demands of managed care systems.

Finding: Upheld

As in 1997, inadequate MIS systems in most states in the 1999 sample were considered to be a major impediment to incorporating effective and useful accountability systems in managed care systems. In general, the MIS systems at the MCO level were judged to be more adequate than those at the state level. However, there also were widespread reports of states being unable to obtain encounter data from MCOs.

In the 1999 sample, four of the five carve outs (and one state with an integrated design) reportedly are tracking children's behavioral health service use. However, the 1999 study

also found that most states are unable to produce data yet on service utilization, outcomes, or quality related to child and adolescent behavioral health care.

Disaggregation of Data on Substance Abuse Services

Hypothesis: In most states, managed care systems will not disaggregate data on adolescent substance abuse treatment utilization from either children's mental health or adult substance abuse service data.

Finding: Upheld

Only one state in the 1999 sample (PA) reported that they are disaggregating substance abuse data on adolescents, similar to findings in 1997.

Quality Measurement

Hypothesis: In most states, quality measurement will focus on process indicators and will not be child and adolescent specific.

Finding: Partially Upheld

Both the 1997 and 1999 impact analyses found some efforts to assess the quality of services in general in managed care systems in most states. While most quality measurement efforts reported in 1997 appeared to center around the process of service delivery, in 1999, there were more reported instances of states' going beyond the process of service delivery in their assessment of quality. On the other hand, only a few states in the 1999 sample, as in 1997, reported having quality indicators specific to child behavioral health.

Measuring Clinical and Functional Outcomes and Family/Youth Satisfaction

Hypothesis: In most states, measurement systems for clinical and functional outcomes for children's behavioral health will be only at an early stage of development.

Finding: Upheld

In the 1999 sample, some progress in the area of developing measurement systems for clinical and functional outcomes is evident, with two states reporting measurement systems in place, in comparison to no states in the 1997 sample. However, efforts to assess clinical and functional outcomes were still characterized by respondents as being at early stages of development. The 1997-98 State Survey also confirmed comparatively less attention to the measurement of clinical and functional outcomes in managed care systems than to domains such as access, cost, service utilization patterns, and satisfaction.

The 1997-98 State Survey showed considerable attention to the measurement of family satisfaction, with 80% of the reforms reporting some efforts in this area; the only other

outcome areas reportedly measured as frequently by managed care systems were access and service utilization patterns. These results were substantiated by the 1999 Impact Analysis sample, in which all of the carve outs and half of the reforms with integrated designs reported efforts to measure family satisfaction. However, only one state in the 1999 sample was able to produce data on family satisfaction at the time of the site visits. Less attention reportedly is paid to measuring youth satisfaction, with only three states in the 1999 sample (all carve outs) reporting activity in this area.

Measuring Cost

Hypothesis: Managed care reforms will not necessarily result in decreased aggregate Medicaid behavioral health costs, but will result in a greater proportion of funds spent on outpatient, home, and community-based services versus hospital services.

Finding: Partially Upheld

The 1999 Impact Analysis found, as did the 1997 analysis, that states are not necessarily reducing Medicaid costs as a result of managed care reforms. In two reforms in the 1999 sample there were reports of decreased aggregate Medicaid behavioral health costs as a result of managed care, and in two others, reports of increased costs. Most of the remaining states in the sample did not provide cost data but reported that they were controlling the rate of growth of Medicaid spending.

Respondents in five of the nine reforms could not provide data to document the relative proportion of funds spent on hospital versus community services. Of those states with data, only two of four (both with carve out designs) reported that the proportion shifted in favor of outpatient, home, and community service options, as compared with 1997 results which found that in seven of 10 states (all with carve outs), the proportion of spending shifted in this direction.

State Child Health Insurance Program (SCHIP)

The Tracking Project has just begun to examine issues related to behavioral health service delivery for children and adolescents in states' implementation of SCHIP. Preliminary information from the 1999 sample of states indicated that, in five of the eight states in the sample, there reportedly is little connection between SCHIP and managed care reforms affecting behavioral health services for children. This is either because SCHIP is being implemented as a separate program from Medicaid or because SCHIP is being integrated with physical health Medicaid managed care and not with behavioral health carve outs. In the majority of states in this sample, behavioral health coverage for SCHIP enrollees reportedly is limited as in an acute care model.

Special Analysis: Child Welfare

The tightened timelines for decision making that have resulted from passage of the Adoption and Safe Families Act in 1997 and from individual state child welfare reforms make it even more important to ensure that appropriate behavioral health services are in place for children and families served by the child welfare system. This special analysis focuses on the perceptions of child welfare stakeholders regarding the key issues and findings addressed in the full report. Also discussed are the child welfare system's involvement in behavioral health managed care initiatives, what it hopes to gain from managed care reforms, and child welfare stakeholders' perspectives on the most positive aspects and most serious problems associated with managed care.

Managed care reforms provide an opportunity to obtain additional Medicaid support for behavioral health services previously supported primarily with child welfare resources. However, for managed care to work for children and families in the child welfare system, child welfare stakeholders agreed that several criteria must be in place. There must be easy access to services; care must be coordinated and continuous, even when children change placements; services must be available for families, as well as the identified child; and the system must be committed to understanding and meeting the needs of children and families in the child welfare system.

Special Analysis: Substance Abuse

This special analysis discusses the findings related to substance abuse services from the 1999 Impact Analysis. Substance abuse services were included in seven of the nine reforms in the 1999 Impact Analysis sample. Although most findings for substance abuse were the same as for mental health, some significant differences were noted. For example, managed care reforms, regardless of design, did not result in the coverage or availability of a broader array of substance abuse services for adolescents, whereas for children's mental health services, respondents reported coverage of a broader service array, particularly in reforms with carve out designs. The array of adolescent substance abuse services was reported to be limited in most states. In addition, managed care systems were more likely to use patient placement criteria for adolescent substance abuse services than to use comparable level of care criteria for children's mental health services. Other issues and findings specific to substance abuse services are reviewed in the special analysis.

Special Analysis: Family Reflections

This special analysis, prepared by the family members who participated on the site visit teams, presents the perspectives of family stakeholders regarding the impact of managed care reforms on families who have children with behavioral health problems. In addition, strategies for increasing the family voice in public sector behavioral health managed care

reforms are offered. Among the major recommendations are the following: state and local governmental agencies should fund family-run organizations that can work to create equal partnerships among family members, policymakers, managed care organizations, and service providers; investments should be made in the development of family and youth leaders who have the skills to negotiate and influence managed care systems; and families and other key stakeholders should be involved in community outreach and involvement efforts. Bringing together, at the community level, all those involved in caring for children with behavioral health problems can lead to managed care reforms that reflect and reinforce systems of care.

Next Steps

Over the next five years, the Tracking Project will continue to conduct all-state surveys to track developments in public sector managed care affecting children and adolescents with behavioral health disorders and their families. In addition, the Project will engage in a study of promising approaches to address the needs of this population within the context of publicly financed managed care, and will convene a Consensus Conference to compare findings from the Tracking Project to findings from related studies, with a view toward developing consensus recommendations about the policy and implementation strategies that most effectively serve this population within the current environment.

Pires, S.A., Stroul, B.A., Roebuck, L., Friedman, R.M.. McDonald, B.B., & Chambers, K.L. (1996). Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with emotional disorders and their families–The 1995 State Survey. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

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Executive Summary

Health Care Reform Tracking Project:

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

1999 Impact Analysis

By: Sheila A. Pires, M.P.A. • Beth A. Stroul, M.Ed.
Mary I. Armstrong, M.S.W., M.B.A.

Produced in Cooperation with:

Research and Training Center for Children's Mental Health
Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida

Human Service Collaborative
Washington, D.C.

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Pires, S. A., & Stroul, B. A., Armstrong, M. I., (2000). *Health care reform tracking project: Tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families – 1999 Impact Analysis.* Tampa, FL: Research and Training Center or Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida.

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