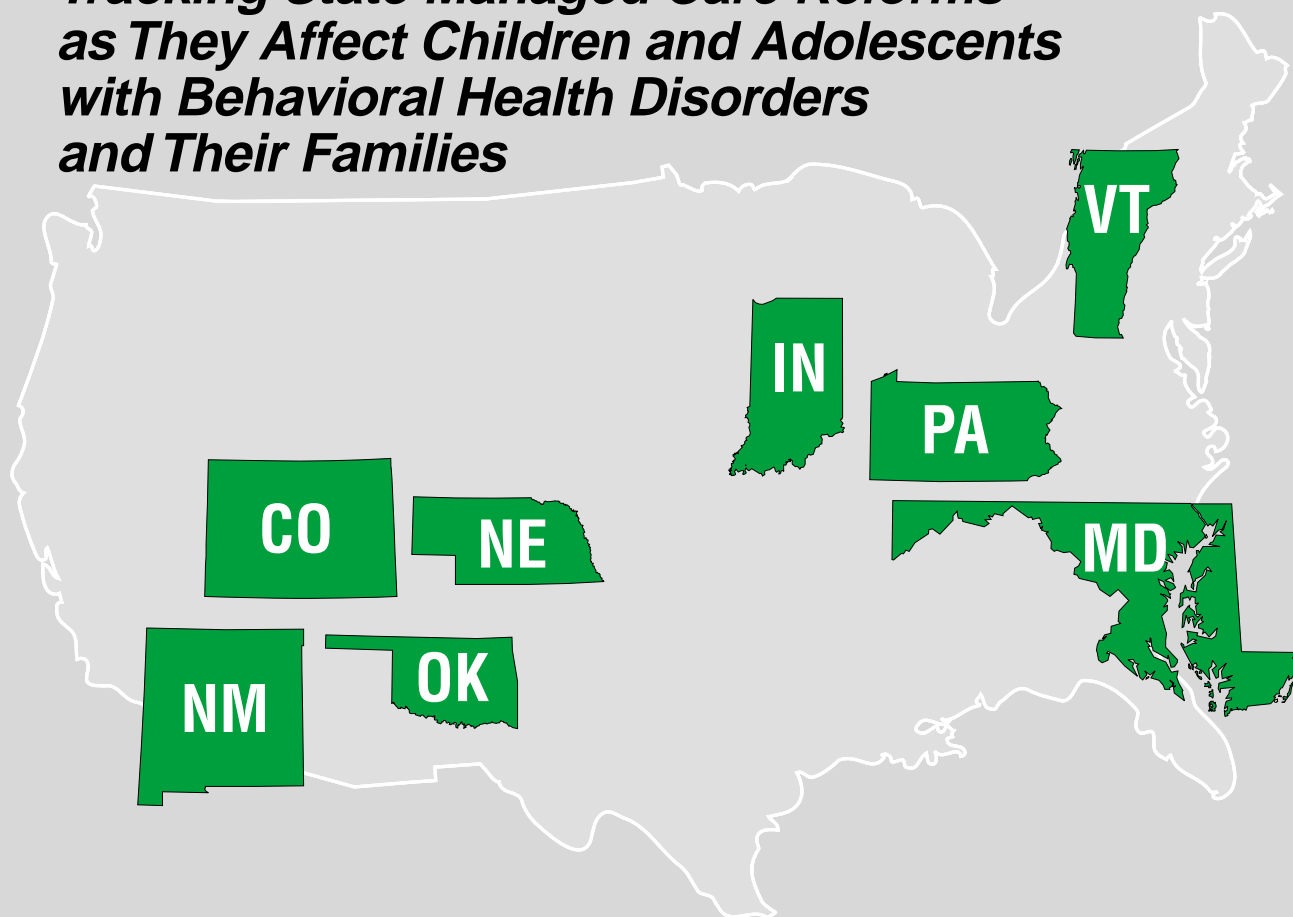


Health Care Reform Tracking Project:

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



1999 Impact Analysis

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South Florida**
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1999 Impact Analysis

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Executive Summary

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

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):

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.

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998) Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with emotional disorders and their families—The 1997 Impact Analysis. 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.

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998) Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with emotional disorders and their families—The 1997 Impact Analysis. 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.

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.

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 **Maturation 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.
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Finding:	Upheld
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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.
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Finding:	Upheld
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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 off-setting 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 10 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 Anaguage 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.

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.

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. ■

Introduction

Health Care Reform Tracking Project

The Health Care Reform Tracking Project was initiated in 1995 for the purpose of tracking and analyzing 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 and adolescents and their families in Medicaid, mental health, substance abuse, child welfare, and State Children's Health Insurance (SCHIP) programs. These public sector managed care reforms are the focus of the Health Care Reform Tracking Project. 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 Tracking Project focuses on children, adolescents and families who rely on public sector agencies 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 health 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 youth and their families depend on multiple state and local systems, including mental health, substance abuse, health, child welfare, juvenile justice, education, Medicaid, and SCHIP systems.

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

The Tracking Project is analyzing whether and how different kinds of managed care approaches and characteristics have differing effects on this population of children, youth, and families. It is examining impact across a broad range of areas associated with effective behavioral health service delivery for children, including: access to and availability of services, family involvement, early identification and intervention, service coordination, provider capacity, cultural competence, financing approaches, quality, outcomes, and cost. The Tracking Project is intended to be useful to public officials, families, providers, advocates and other key stakeholders involved in and affected by public sector managed care.

Methodology of the Tracking Project

The methodology of the Tracking Project has involved 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 **1995 and 1997–98 State Survey** reports identify and 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 1995 State Survey provided a baseline description of state managed care activity, which the 1997–98 State Survey updated by examining changes over time. The **1997 Impact Analysis** report examined the *impact* of this activity in a sample of 10 states with different managed care approaches, as perceived by multiple key stakeholders and as documented quantitatively to the extent data were available.

This current report — The **1999 Impact Analysis** — 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 site visits to a sample of eight new states and examined changes that have occurred in the first 10 states since the 1997 report. The methodology used for the 1999 Impact Analysis is described below.

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):

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.

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998) Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with emotional disorders and their families—The 1997 Impact Analysis. 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.

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998) Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with emotional disorders and their families—The 1997 Impact Analysis. 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.

Methodology of the 1999 Impact Analysis

Maturation Analysis: Update on the 1997 Sample of States

Through telephone interviews with key stakeholders and document review, the Tracking Project analyzed changes that have occurred in the 10 states that were visited for the 1997 Impact Analysis. These 10 states included:

Arizona	North Carolina
Connecticut	Oregon
Delaware	Rhode Island
Iowa	Utah
Massachusetts	Washington

Using semi-structured protocols, experts in children's mental health, child welfare and adolescent substance abuse treatment conducted telephone interviews with key stakeholders in each of the 10 states, including representatives of state children's mental health, child welfare, substance abuse, and Medicaid agencies as well as family members of children with behavioral health disorders. The purpose of the interviews was to identify changes that states have made in their managed care initiatives, reasons for the changes, and known or perceived impact of the changes on children with behavioral health problems and their families. Individual state reports were prepared describing any changes and their effects, and changes were analyzed across the 10 states. The results of the maturational analysis are presented in a special supplement to the 1999 Impact Analysis report, and the results also are incorporated as appropriate into the discussion of findings throughout this report.

Site Visits to a New Sample of States

Eight new states were selected for in-depth site visits similar to those made in 1997 to the 10 states listed above. The eight new states included:

Colorado	Indiana
Maryland	Nebraska
New Mexico	Oklahoma
Pennsylvania	Vermont

Information from the Tracking Project's State Surveys and from the SAMHSA Managed Care Tracking Project conducted by the Lewin Group informed state selection, as did the following factors:

- Differences in managed care approaches and characteristics
- Geographic diversity and variability in state structure (i.e. county-based versus centralized state systems)
- Sufficient experience with managed care so that effects could be discerned

The managed care approaches used by the states selected for the 1999 sample included both *carve out designs*, which are defined by 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 specific managed care initiatives analyzed in each of the states include:

Colorado: Medicaid Mental Health Capitation and Managed Care Program — A capitated mental health carve out that does not include substance abuse; includes a broad benefit design financed by Medicaid dollars; involves nine managed care organizations (MCOs), both nonprofit and commercial; and includes the child welfare population.

Indiana: Hoosier Assurance Plan — A mental health and substance abuse carve out that uses general revenue and block grant funds, not Medicaid, in a case rate arrangement; primarily uses community mental health centers (CMHCs) as managed care entities; and includes the child welfare population.

Maryland: HealthChoices² — Includes both a mental health carve out (referred to throughout this report as *Maryland-MH*) and a physical health/substance abuse integrated system (referred to throughout this report as *Maryland-PH/SA*).

- **Maryland–MH** — A non-capitated mental health carve out that does not include substance abuse; includes a broad benefit design using Medicaid and mental health general revenue funds; uses one statewide for-profit MCO for administrative services only that is not at risk (Administrative Services Organization–ASO); and includes the child welfare population.
- **Maryland–PH/SA** — A capitated physical health reform that includes substance abuse; includes a traditional benefit design financed by Medicaid dollars; uses eight, mainly for-profit, MCOs; and includes the child welfare population.

Nebraska: Options — A capitated Medicaid mental health and substance abuse carve out; includes a broad benefit design financed by Medicaid dollars; uses one statewide, for-profit MCO; and includes child welfare population.

New Mexico: Salud — A capitated, integrated physical health, mental health, and substance abuse reform; includes a broad benefit design using Medicaid dollars; uses for-profit MCOs, which are required to subcontract to specialty behavioral health organizations (BHOs — all for-profits currently) for the management of mental health and substance abuse services, which, in turn, subcontract with regional care coordinating entities (mostly nonprofits currently) to organize provider networks; and includes child welfare population.

² In Maryland, two design types were studied — a mental health carve out and an integrated physical health/substance abuse design. Thus, the number of reforms studied on site for the 1999 Impact Analysis totals nine reforms in eight states.

Oklahoma: SoonerCare Plus — A capitated, integrated physical health, mental health, and substance abuse reform, with an enhanced benefit for individuals with special behavioral health needs, financed by Medicaid dollars; uses both nonprofit and for-profit MCOs, most of which subcontract to BHOs; requires MCOs (or BHOs) to subcontract with CMHCs; and does not include child welfare population.

Pennsylvania: HealthChoices — A capitated mental health and substance abuse carve out with counties having the right of first option to act as their own managed care entities (state contracts on risk basis with counties, and counties can choose to manage care themselves or contract out); includes a broad benefit design financed by Medicaid, mental health and substance abuse general revenue and child welfare general revenue; counties are using a mix of nonprofit, quasi-governmental and for-profit MCOs; and the child welfare population is included.

Vermont: Vermont Health Access Plan — A capitated, integrated physical health, mental health, and substance abuse Medicaid reform; includes a traditional benefit design financed by Medicaid dollars; uses two statewide commercial MCOs; and the child welfare population is included.

Table 1 groups all 18 states — ten from the first cohort and eight from the second — according to the types of managed care designs studied.

Table 1 Type of System Design			
Sample	Carve Out Design	Integrated Design	Integrated with Partial Carve Out
1997 Sample (N=10)	Arizona Iowa Massachusetts North Carolina Oregon Utah Washington	Connecticut Rhode Island	Delaware
1999 Sample (N=9)	Colorado Indiana Maryland–MH Nebraska Pennsylvania	Maryland–PH/SA New Mexico Oklahoma Vermont	

Site Visit Process

As noted earlier, for the 1999 Impact Analysis, site visits were conducted in the eight new states. Prior to the site visits, telephone interviews were conducted with key informants in each state to augment information collected in the state survey and to collect key system documents. Then, site visits were conducted in each state, using a team of four to five trained interviewers. Site visit teams were comprised of individuals knowledgeable

about children's mental health, child welfare, adolescent substance abuse issues, and managed care; each site visit team included a family member with expertise in these areas.

A team leader was designated for each of the eight teams. Prior to the site visits, the team leader prepared a background report to familiarize team members with the managed care reform in the state. Background reports covered such areas as the state structure, status of system of care development, and information about the managed care reform, including stage of implementation, design characteristics, populations covered, financing approach, types of managed care entities used, management mechanisms, and available information on quality and outcome measurement.

During the site visits, 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. The stakeholders interviewed included representatives from each of the following groups in every state:

- State Children's Mental Health Agency
- State Substance Abuse Agency
- State Child Welfare Agency
- State Medicaid Agency
- Family Members and Representatives from State Family Organizations
- Managed Care Entities
- State Education Agency
- State Juvenile Justice Agency
- Local Substance Abuse Agencies and Substance Abuse Providers
- Local Mental Health Agencies and Mental Health Providers
- Local Child Welfare Agencies and Child Welfare Providers
- Advocacy, Advisory, and Association Groups
- Other Key Players (such as legislative staff, governor's office)

Interviews with each group lasted from one to four hours. Semi-structured interview protocols were developed for each group to guide the interview process and to ensure consistency in areas of inquiry across sites. The protocols explored the impact of managed care reforms related to the following areas:

- Design and Structural Characteristics of the Managed Care System
- Service Array
- Access
- Service Coordination
- Early Identification and Intervention
- Systems of Care
- Providers
- Family and Youth Involvement
- Cultural Competence
- Interagency Relationships

-
- Financing
 - Accountability
 - Child Welfare Population

After each site visit, site team members submitted written notes to team leaders, who prepared summary reports of each state. These reports were reviewed by states for factual accuracy. Reports were then analyzed across states to identify trends, emerging issues, and promising approaches and to synthesize findings. This report details the findings from the cross-state analysis of the eight new states that were visited for the 1999 Impact Analysis (referred to in this report as “**the 1999 sample**”), comparing findings as appropriate with those from the 10 states visited for the 1997 Impact Analysis (referred to in this report as “**the 1997 sample**”). Findings from the maturational analysis of the 1997 sample are included to highlight areas in which these states have made changes in their managed care systems since the time of the original site visits to address areas that have presented problems or challenges. In addition, references are made in this report to relevant findings from the all-state survey conducted in 1997-98, which described and analyzed 43 managed care reform initiatives in 39 states.

How This Report Is Organized

Based on the earlier work of the Tracking Project (two surveys of all 50 states and in-depth study of 10 states), a number of predictions were made about what would be found in the second round of site visits to the eight new states in terms of the impact of public sector managed care on children and youth with behavioral health disorders and their families. These hypotheses provide the organizing framework for the 1999 Impact Analysis report. In most cases, hypotheses based on the early work of the Tracking Project are upheld by findings from the site visits to the 1999 sample. In some instances, however, changes in the landscape of public sector managed care render invalid earlier drawn hypotheses or create a picture that is unclear. Findings are described fully in this report as they relate to the hypotheses, and the discussion notes whether each hypothesis is upheld, not upheld or if results are unclear.

In addition to findings related to the hypotheses, the 1999 Impact Analysis includes the following summaries: Child Welfare Population Issues, Adolescent Substance Abuse Issues, Maturational Analysis Findings, and Family Reflections, a special analysis prepared by family members who participated on the site visit teams. The report also includes a brief description of the next phase of the Tracking Project, which will focus on identifying, studying, and describing *promising approaches and strategies* in public sector managed care systems for effectively financing and providing behavioral health services for children and adolescents and their families. ■

I. Planning and Design of Managed Care Systems

Planning

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

As **Table 2** shows, a larger percentage of the 1999 sample of states involved key children's stakeholder groups in initial planning than did the 1997 group of states, but in neither case did a majority of states do so — with the exception of state children's mental health staff who were involved in initial planning to a greater extent than any other stakeholder group. In both samples of states, stakeholder involvement improved over time, though there was more marked improvement in stakeholder involvement in the earlier sample of states, probably due to there being less initial involvement of stakeholders in that sample.

Table 2 Stakeholder Involvement in System Planning and Refinement				
Stakeholders	1997 Sample N=10		1999 Sample N=9	
	Initial Involvement	Current Involvement	Initial Involvement	Current Involvement
Mental Health Staff	6	10	6	5
Substance Abuse Staff	1	5	3	5
Families	1	9	3	4
Providers	1	5	2	3
Other Child Agencies	2	10	3	4

According to interviewees in both the maturational analysis and the site visits for the 1999 Impact Analysis, stakeholder involvement typically takes the form of participation on advisory committees or in focus groups (most often reported by families), or at regular agency-level meetings. Interviewees in a number of states reported that interagency problem-solving has increased and that monthly interagency meetings have been

instituted to address managed care-related issues. However, stakeholders also reported that many of these meetings tend to address individual cases rather than systemic issues and that they do not include nonagency stakeholder groups. Providers expressed the most concerns about being excluded from planning and redesign processes; state respondents indicated that potential conflict-of-interest issues make them wary of involving providers too closely.

On balance, within both the 1997 and 1999 samples, most stakeholder groups reported growing involvement in managed care policy deliberations. This is especially true with respect to the involvement of stakeholders from child welfare systems, family organizations, and state substance abuse agencies. It reportedly is less true for providers, other child-serving systems, and advocacy groups. Within the 1999 sample, there are several examples of states that are taking proactive steps to involve stakeholders in ongoing, meaningful ways.

- In **Colorado**, families provided written input on the state's request for proposals and on its waiver renewal request, and they participate on the state's Capitation Advisory Committee.
- In **Maryland-MH**, the administrative services organization (ASO) under contract to the state, the state mental health agency, and the state Medicaid agency all have advisory committees that include families of children with behavioral health disorders. Also, families helped to develop the request for proposals and reviewed ASO bids.
- In **New Mexico**, the children's department sits on the quality improvement committee for the managed care reform and is involved in monthly meetings with managed care organizations, behavioral health organizations, and Medicaid.
- In **Pennsylvania**, families participate in the state's readiness review process to determine the readiness of counties for managed care. Families also helped to design the system and the state's request for proposals that serves as a template for counties.

The maturational analysis found several examples of increasing stakeholder involvement among states in the 1997 sample as well.

- In **North Carolina**, the state has created a website to post reports from the system re-design team.
- In **Rhode Island**, Medicaid has created a Leadership Roundtable that includes families and child-serving agencies to address system re-design issues for children with special needs, including children with behavioral health problems, children with chronic physical illnesses, children with developmental disabilities and children involved in child welfare.
- In **Utah**, families reviewed the state's request for proposals, and they participate in on- site monitoring visits.

Attention to Substance Abuse Issues

Hypothesis: In most states, adolescent substance abuse services will be perceived by most stakeholders to receive less attention in managed care planning and design than children's mental health services.

Finding: Unclear

While substance abuse stakeholders were reported to be less involved in initial planning than child mental health stakeholders, as **Table 2** indicates, the involvement of substance abuse stakeholders in the 1999 sample of states reportedly grew over time to equal that of mental health stakeholders. In only three of the seven states with managed care reforms covering substance abuse did stakeholders indicate that substance abuse received less attention than children's mental health. This is in contrast to findings in 1997 in which stakeholders in the majority of states felt that adolescent substance abuse services received far less attention than children's mental health. In many states in the 1999 sample, managed care reportedly is forcing attention to the issue of adolescent substance abuse services because of severe shortages of appropriate services. It should be noted, however, that in the majority of states in the 1999 sample, even though increased attention reportedly is being paid to both adolescent substance abuse and child mental health issues, stakeholders continue to believe, as they did in 1997, that neither child mental health nor adolescent substance abuse treatment is receiving adequate attention nor is there sufficient involvement of stakeholders knowledgeable in these areas. In addition, when their perceptions are considered apart from those of other key stakeholders, substance abuse respondents believe that adolescent substance abuse treatment continues to receive less attention than children's mental health.

Policymaking Authority

As **Table 3** indicates, the state Medicaid agency continues to be the dominant policy authority for state managed care initiatives for the reforms studied in 1999. In most cases, although not all, state behavioral health (BH) agencies have or share policy authority for behavioral health carve outs; they play little role in states with integrated designs. As was also the case in the 1997 sample, there is little shared policymaking for managed care 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.

Table 3 Policy Making Authority		
	1997 Sample N=10	1999 Sample N=9
Policy set by Medicaid alone	4	5
Policy set by BH agency alone	3	2
Policy making shared between Medicaid and BH agency Providers	2	1
Policy making includes other child serving systems	1	1

Several examples of interagency policymaking for managed care systems were identified in the 1999 sample and through the maturational analysis.

In the 1999 sample:

- **Pennsylvania** has a policy board that meets weekly and includes representatives from mental health, substance abuse, mental retardation, Medicaid, and child welfare agencies. In addition, there is a “Kids Managed Care Committee” that includes the major child-serving systems and works on child-specific managed care issues. One of its first tasks, for example, was to develop protocols between the juvenile justice system and the behavioral health managed care organizations.

In the maturational analysis:

- **Massachusetts** has created a cabinet-level group, comprised of the Medicaid, social services and mental health commissioners, that works closely with the head of the managed care organization as a “decision making/planning team.” The group has focused on such areas as the need for step-down services from inpatient, residential treatment, and juvenile justice facilities and the need to enhance community-based services.
- **Oregon** has created a new state agency policy group, called the “Operations” or “Alphabet Soup” group, comprised of child welfare, juvenile services, education, and mental health representatives, which meets monthly to address managed care-related issues, among others.

Process for Problem Solving and Making Refinements

The majority of states in both the 1997 and 1999 samples lack systematic mechanisms or processes for addressing children's behavioral health issues and problems related to managed care. This is particularly (though not solely) true of states with integrated designs. Only a few examples of systematic processes for solving problems and making system refinements were identified in the 1999 sample.

- For its mental health carve out, **Maryland** utilizes a clinical committee, child-specific workgroups and a "De-bugging Committee" created specifically to problem-solve. This latter group has addressed such issues as the payment rate for intensive home-based services. This group also meets monthly with providers and creates working teams to resolve problems—one of the few examples across the 18 states in both the 1997 and 1999 samples of formalized refinement processes that involve providers.
- **Pennsylvania**, which is rolling out managed care over time, developed a learning guide, called a Readiness Assessment Instrument (RAI), based on its experience with the first counties involved in managed care. The state uses the RAI with counties preparing for managed care to assess readiness with respect to the following areas: in-plan services and provider network capacity; service access; care management and utilization management; coordination of care/interagency letters of agreement; member services; member complaint, grievance and appeal system; executive management; quality assurance; consumer and family satisfaction; management information system; provider claims processing; encounter data; performance outcomes; county financial requirements; county solvency requirements; and behavioral health MCO subcontractor financial and solvency requirements. The RAI reinforces the system of care principles and goals articulated in the state's request for proposals (RFP).
- In **Pennsylvania** at the county level, several southeastern counties actively involve families and other key stakeholders in monitoring and refinement processes. For example, in Philadelphia County, the family organization receives funding from the county to develop a report card on the behavioral health MCO's performance. Youth, as well as families, reportedly are involved in monitoring and feedback processes in Delaware County, Pennsylvania.

The maturational analysis suggested a gradual movement toward more systematic trouble shooting, problem solving, and making adjustments than seemed to be the case in 1997. There is, in particular, more systematic problem solving around the child welfare population and interagency issues and between purchasers and managed care entities. The following examples were identified.

- **Connecticut** is an example of a state that uses a legislative oversight body. This group, currently chaired by a parent of a child with special needs, has dealt with the following issues: the problem of excessive paperwork was addressed through required implementation of a consolidated form; complaints about delays in payments to providers was addressed by requiring in contracts penalties for MCOs making late payments; complaints about accountability were addressed by creation of a new \$4 million incentive pool for MCOs, which provides incentives for MCOs that implement effective consumer feedback mechanisms and for MCOs that meet EPSDT screening targets.
- **Delaware** has created two workgroups—one on data and quality improvement and one on the interface between the MCOs and the public child mental health system, with a view toward improving information sharing. The workgroups include representatives from Medicaid and children's mental health agencies and from the MCOs. Also, the children's mental health agency now participates in Medicaid's external review process.
- **North Carolina** has a system redesign team that utilizes "feeder" groups, including the Mental Health Planning Advisory Committee, the Children's Futures Committee, and the Carolina Alternatives Policy Advisory Committee, and publicizes its deliberations through a website.
- In **Rhode Island**, the Medicaid agency has hired a parent to work with MCOs on a case-by-case basis and to advocate for change internally from the family perspective. Also, Medicaid has installed an information line that is used to track complaints and provide feedback for system refinement, holds community meetings, and periodically surveys key stakeholder groups about particular issues. For example, the agency has surveyed foster parents as part of its deliberations as to whether to enroll children in state custody in the managed care system.

Goals of Managed Care

Cost Containment and Other Goals

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 sample typically are trying to achieve both cost containment and a variety of other objectives with their managed care reforms. Cost containment was cited as a goal in virtually all states in both samples. Depending upon the state, other objectives may include: reduction in inpatient and residential treatment utilization, expansion of community-based services, greater accountability, improved quality, improved access, more flexibility in service delivery, greater local control and responsibility for service delivery, and creation of a medical home for Medicaid recipients. As in 1997, stakeholders furthest removed from the state policymaking level—typically, families and local providers—tend to believe that cost reduction is the overriding goal, while state-level representatives cite a variety of non-cost objectives and reference “budget predictability” and “spending stabilization,” rather than cost-cutting, as the cost-related goals. States in which the legislature mandated managed care tend to have clearly stated cost reduction objectives, and often the legislature cut the Medicaid budget with the introduction of managed care.

There are differing perceptions, and approaches to determining, whether states actually have met cost containment goals with managed care. Most respondents in both the 1997 and 1999 samples indicated that states initially were meeting cost containment goals. However, stakeholders in a few states reported that costs are beginning to rise in later implementation as access increases, and interviewees in many states believe that there are large administrative costs associated with the various levels of managed care in states that are not being factored into cost effectiveness equations.

The extent to which states are meeting other objectives with managed care vary widely and are discussed more fully in later sections of this report.

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

As in 1997, managed care objectives were seen by stakeholders in the 1999 sample of states as more consistent with system of care goals in those states with carve outs than in states with integrated physical health/behavioral health approaches (**Table 4**). Stakeholders in states with carve outs cited the following managed care goals in their states as being consistent with system of care objectives: reduction of inpatient use and expansion of community-based options; creation of single points of entry to care; incorporation of family involvement principles; an emphasis on case management and individualized, flexible service planning; and an emphasis on cultural competence. Particularly in those states with strong histories of system of care development, system of care principles are articulated clearly in RFP language if the state chose a behavioral health carve out approach — Pennsylvania, Colorado, and Maryland-MH, for example. On the other hand, even in states with a long system of care history, if the state took an integrated approach, system of care concepts are not incorporated into managed care, such as in Vermont. One of the biggest complaints from most 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 a system of care approach.

Table 4					
Consistency of Managed Care Goals with System of Care Goals					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Managed care goals are consistent with system of care goals	5	0	0	4	

An example of incorporating system of care goals in managed care was identified in Pennsylvania.

- In **Pennsylvania**, a state with a long history of system of care development through the Child and Adolescent Service System Program (CASSP), system of care principles and values are written into the state's RFP and its Readiness Review Criteria (to gauge county readiness to implement managed care). Also, indicators have been built into the state's performance monitoring system that are tied to system of care principles.

Carve Out and Integrated Designs

Differences in Carve Outs

Hypothesis: 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** (for Mental Health Services, not for Substance Abuse)

As was the case in the first sample of states in 1997, states in the 1999 sample that have taken a behavioral health carve out approach tend to cover a broader array of mental health services, including more home and community-based services, and to create greater flexibility in service delivery than states with an integrated physical/behavioral health design (**Table 5**). Stakeholders in states with carve outs attributed this to a number of factors — specifically, that a carve out allows for protection of the mental 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 mental health, and that typically (although not always) a carve out is designed and monitored by those with expertise in mental health, for example, the mental health agency. Interestingly, in the one state with a carve out in which it was reported that a broader array of services was *not* being covered as a result of managed care, it also was reported that Medicaid alone designed and monitors the system with little involvement by the mental health agency.

Children's stakeholders in states with carve outs expressed some concern that carve outs that include both adult and child behavioral health cause some of the complexities of the children's system to be lost; however, they noted that this would be an even greater concern in an integrated design that included both adult and child physical and behavioral health. Some stakeholders in states with carve outs believe that, in time, an effective integrated design might be possible, but that a carve out is needed initially to determine the dollars that should be allocated for behavioral health and to solidify the behavioral health delivery system so that it does not get "overwhelmed" by physical health issues in an integrated approach.

It should be noted that, while this finding held for mental health services, this was not the case for adolescent substance abuse treatment services. Coverage of adolescent substance abuse treatment services and flexibility in service delivery were reported to be constrained, regardless of type of design.

Table 5 Carve Out Versus Integrated Characteristics						
N=9	Broader Service Array		More Home & Community Based		Greater Flexibility	
	Carve Out	Integrated	Carve Out	Integrated	Carve Out	Integrated
Yes	4	1	4	1	4	0
No	1	3	1	3	1	4

Differences in Integrated Designs

Hypothesis: States with integrated designs will include less involvement in planning by stakeholders with expertise in children's behavioral health services, a more traditional behavioral health benefit, dominance of physical health concerns, and a small percentage of the health dollar allocated to behavioral health.

Finding: Upheld

As was the case in the 1997 sample, states in the 1999 sample that have used integrated designs tend to include less involvement in planning by stakeholders with expertise in behavioral health and a more traditional benefit design than do states with carve outs (**Table 6**). (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 — albeit it difficult to confirm since data are not available — that little of the capitated dollar is allocated to behavioral health. Four of the six states with integrated designs in the 1997 and 1999 samples provided estimates of how much of the capitated dollar is allocated to behavioral health; estimates provided were \$4 per member per month (pmpm), \$5.21 pmpm, \$7 pmpm, and \$9–14 pmpm.

Stakeholders in states with integrated designs also complained about the “multiple layers” created by state contracts with health plans (often Health Maintenance Organizations – HMOs) that then subcontract with BHOs. They reported that the many layers are difficult to monitor for purchasers and difficult to navigate for consumers, that they create administrative complexities for providers, and that they add to the cost of the system.

One state in the sample that ultimately chose a carve out approach reported that their Medicaid and state mental health agencies monitored performance with voluntary HMOs using an integrated approach before deciding what to do with behavioral health in mandatory Medicaid managed care. They reportedly found that the voluntary HMOs “cherry-picked” (i.e., served less difficult populations) and that 85% of them subcontracted to BHOs, reportedly making large profits off the subcontracts and allocating very small dollar amounts for behavioral health. In addition, they found no evidence that the integrated design led to greater coordination between physical and behavioral health care.

Table 6 Integrated Design Characteristics				
N=4	Less Involvement in Planning	Traditional Benefit	Dominance of Physical Health	Small Dollar Allocation to BH
Yes	3	3	4	4
No	1	1	0	0

Managed Care Design for Greater Local Control

A number of states are using managed care as a mechanism to give local jurisdictions greater flexibility and control over dollars and decision making related to behavioral health service delivery. Pennsylvania provides one example of a state that is trying to “localize” service delivery through use of managed care.

- **Pennsylvania** designed a behavioral health carve out that gives counties the option of acting as their own MCOs or of subcontracting with outside entities. Pennsylvania stakeholders described the advantages to greater local control as including: building on and strengthening the existing service delivery infrastructure in localities; better access and less disruption for consumers; less resistance to managed care; greater potential for service delivery to be designed around local needs and priorities; and potential for greater accountability because the design places a population-based responsibility on the counties. Some stakeholders believe that the design also helps to prevent cost-shifting between the states and counties because accountability is clearer, but others pointed out that the state initially did shift some costs to the counties by taking dollars off the top of managed care. In terms of disadvantages, some stakeholders expressed concern over the difficulty of monitoring a locally-run system. They also noted that local county processes, such as procurement, can be archaic and political, and local management infrastructure often is not well developed. Stakeholders noted that the design places greater risk at the county level, which can be problematic for smaller counties that may experience significant cost variations from one year to the next. The state is using a “readiness review process” to gauge county readiness to operate as MCOs or as subcontractors.

Acute and Extended Care

Inclusion of Extended Care

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 states in the sample (six of 10) 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 1997–98 State Survey and site visits to the 1999 sample of states found that states are moving toward including extended care in managed care, 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 (**Table 7**).

Table 7		
Acute and Extended Care		
N=9	Carve Out	Integrated
Design includes acute and extended care	3	3
Design includes acute care only	1	2

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 MCOs, in effect, create arbitrary limits on certain types of care (for example, a 90-day limit on residential treatment); that the lack of a broad service array hampers provision of extended care; and that large amounts of extended care funding are left outside the managed care system, providing incentives to cost-shift. All of the states reporting inclusion of extended care leave significant funding streams for behavioral health care outside of the managed care system for a variety of reasons. These reportedly include funding particular types of services not covered by managed care; creating a safety net for certain populations of children, such as those involved in child welfare; and ensuring access to extended care if medical necessity criteria limit duration of care through the managed care system. As they did in 1997, stakeholders in 1999 reported that the split between acute and extended care or across extended care financing streams aggravates the historic fragmentation, duplication, and confusion in children’s services.

Stakeholders in the 1999 sample of states also noted, as they did in the 1997 sample, that managed care is drawing greater attention to the need for more integrated, or at least coordinated, approaches between managed care and other children's systems. Particularly in states where designs include extended care, MCOs are forced to grapple with the complexities and shortcomings of the multiple extended care systems in the children's arena, specifically, the lack of step-down alternatives to hospitalization, the lack of adolescent substance abuse services, parallel child welfare and juvenile justice delivery systems, and resource and boundary disputes with other children's systems. Stakeholders in states with designs that include both acute and extended care indicated that it is difficult for MCOs to avoid these issues by claiming acute care responsibility only. On the other hand, stakeholders expressed concern over the incentive for MCOs to underserve extended care populations and emphasized the need for adequate monitoring of this by the state and/or county.

An example of a design including both acute and extended care is found in Colorado. Despite the benefits derived from this approach, challenges remain.

- **Colorado** designed its behavioral health carve out to include both acute and extended care, but also left significant treatment dollars — in this case, residential treatment dollars — outside the managed care system. Concerned that managed care would too severely limit length of stay in residential care for its population, the child welfare system successfully negotiated to keep residential dollars outside of managed care. Three years into implementation, many stakeholders expressed concerns that, with this funding stream sitting outside of managed care, cost shifting was occurring from managed care to child welfare and that families not involved in child welfare were having to relinquish custody of their children to access residential treatment. While these stakeholders supported the movement of residential treatment dollars to the managed care system, any effort to do so will be complicated further by the fact that, in some regions, the child welfare system is negotiating preferred provider arrangements with residential treatment providers to create entire continuums of care for children involved in child welfare who have behavioral health treatment needs, negotiations that are separate and apart from the managed behavioral health care system.

Acute Care and Service Fragmentation

Hypothesis: The more acute-care focused the state's design, the more fragmented the service delivery system will be for children with behavioral health disorders and their families.

Finding: Unclear

While states with an “acute-care focus” design must grapple with the additional difficulty of trying to define when acute care ends and extended care starts, states with acute-extended care designs still have to contend with determining responsibility across the multitude of extended care financing streams and systems that continue to hamper integrated service delivery for children with behavioral health needs. Though more states are moving toward inclusion of both acute and extended care, there do not seem to be corresponding reports of diminishing fragmentation in service delivery for children with behavioral health problems and their families. Whether states are using an acute-care only design or including some extended care in their reforms, opportunities for service fragmentation and cost shifting abound, as stakeholders in all of the states confirmed. ■

II. Managed Care Organizations

Type of Managed Care Organizations

Use of Commercial Managed Care Organizations

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

Finding: Upheld

As shown on **Table 8**, all but one of the states in the current sample reportedly are utilizing commercial MCOs and BHOs, although a number of states are using a mix of both nonprofit and commercial organizations. This is consistent with findings in 1997, in which seven of the 10 states in that sample used commercial MCOs, and many employed a mix of entities. The 1997–98 State Survey also found that states increasingly were using commercial MCOs and BHOs in their managed care reforms. The all-state survey also revealed that states with integrated designs were more likely to use only commercial companies, and states with carve outs were more likely to use a mix of both commercial and nonprofit and governmental entities, or to use exclusively nonprofit agencies or government entities as MCOs. Also, states with carve outs were more likely to use MCOs that involved joint ventures between nonprofit or government entities and commercial organizations. Those findings are substantiated with the 1999 sample of states as well, in which three of the four states with integrated designs use commercial companies only, while only one of the states with a carve out uses only a commercial company.

Table 8					
Managed Care Organizations					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Uses commercial MCOs	4	4	1	0	
Commercial MCOs lack familiarity with the population	2	4	2	0	1
Training is provided to MCOs	3	3	0	1	2

Many of the same advantages of using commercial MCOs that were cited in 1997 were noted by stakeholders in this round of site visits to the 1999 sample 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 believed 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 a public sector-dependent population is reportedly higher than for nonprofits or government entities.

MCO Familiarity with the Population

Hypothesis: Commercial, for-profit 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, stakeholders complained that MCOs lack familiarity with the Medicaid population in general and with children with serious emotional disorders and adolescent substance abuse treatment, in particular. (See **Table 9**). 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 multiple 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 managed care includes both. In the one state using a commercial MCO in which stakeholders did not complain about lack of familiarity with the population, the MCO has hired staff with experience in the state system.

Child welfare and juvenile justice stakeholders in most states, regardless of design or type of MCO being used, reported that MCOs needed to be educated about their populations and systems. Stakeholders pointed out that commercial companies tended to be unfamiliar with the issues, policies, and dynamics surrounding children in state custody or with the trauma suffered by these children and their need for additional services. Stakeholders also noted that this was a developmental process in which, over time, MCOs do tend to focus on these systems and children, if only because the challenges of serving these populations and the cross-systems issues are inescapable. (Stakeholders also noted that if this attention were paid at the outset by both state purchasers/planners and MCOs, some of the problems could have been avoided.) There were reports from stakeholders in Colorado and Pennsylvania that formal workgroups were established between MCOs and child welfare/juvenile justice systems at local levels to problem solve and plan that have led to development of specialized treatment programs, such as those addressing sexual abuse issues and programs specializing in attachment disorders.

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 State Survey found that 75% of states with carve outs limited profits, as opposed to only 8% of states with integrated designs.

While the learning curve regarding the population to be served reportedly is high for commercial companies, on the other side of the ledger, the learning curve reportedly is high with respect to understanding managed care technologies for nonprofits and government entities that are acting as MCOs. In addition, stakeholders noted that nonprofits that historically have served public sector-dependent populations and government entities tend to be more enmeshed in local politics and bureaucracy than are commercial companies, who reportedly bring greater objectivity. On the other hand, nonprofits and government agencies are said to be more familiar with the needs of the population and engage in greater cross-agency problem-solving and service coordination. Having said that, however, there also were complaints from some stakeholders, including families, in states using CMHCs as MCOs that CMHCs also were not adequately focused on serving children and adolescents and tended to be more adult-oriented.

Stakeholders in six of the nine reforms in the 1999 sample reported that they have engaged in efforts to orient and train MCOs regarding the needs of the population and about other children's systems (also shown on **Table 9**). Efforts reported include regular meetings with MCO clinical directors and case managers, individual case consultation, provision of technical assistance, and training on specific children's system issues, such as issues related to child welfare and juvenile justice. The following examples were among those identified in the 1999 sample.

- In **Maryland-PH/SA**, the state reportedly holds monthly educational forums with MCOs focused on special needs populations, including adolescents with substance abuse treatment needs, and the state has provided training of MCOs on ASAM criteria.
- In **Pennsylvania**, the CASSP Training Institute at Penn State University works with the state to provide training for MCOs on system of care principles, goals, and values. In Bucks County, Pennsylvania, the MCO reportedly is holding biweekly clinical case conferences with the child welfare system to learn and problem-solve.

Number of Managed Care Organizations

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 off-setting 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. **Table 10** shows that five of the states in the 1999 sample (four with integrated designs and one carve out) use multiple MCOs across the state or within regions. Stakeholders in all five complained about the problems that use of multiple MCOs created (**Table 10**). In the other four states (all states with carve outs), two use one MCO statewide, and two use multiple MCOs, but only one per region.

Table 9 Number of MCOs Used		
N=9	Carve Out	Integrated
Uses single statewide MCO	2	0
Uses multiple MCOs but only one per region	2	0
Uses multiple MCOs either statewide or within regions	1	4

Table 10 Use of Multiple MCOs					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Use of multiple MCOs either statewide or within regions is seen as problematic	1	4	0	0	4

These results are consistent with the 1997–98 State Survey which found that states with integrated designs almost universally were using multiple MCOs statewide or within regions, with reportedly none using a single statewide MCO and only 7% nationally using one per region. In contrast, states with carve outs reported use of single statewide MCOs (42% of carve outs nationally), or one per region (31% of carve outs nationally), with only 27% of carve outs using multiple MCOs statewide or within regions.

In states using multiple MCOs statewide or within regions, stakeholders reported inconsistency, fragmentation, and lack of standardization in the system. Stakeholders pointed out that each MCO has developed different procedures for every aspect of system operations, including billing and reimbursement, credentialing, utilization management, service authorization, reporting, and others. According to stakeholders, this creates a host of problems, including:

- Administrative burden for providers in dealing with the different processes (for example, having to be credentialed multiple times)
- Confusion and inconsistency across the state in clinical decision making
- Difficulty for consumers in understanding and navigating the system
- Monitoring challenges for states
- Barriers in small, rural states to tackling problems that should be approached statewide, such as emergency access and crisis intervention services

In spite of the federal Balanced Budget Act of 1997's call for a choice of plans, most respondents felt that the ability to exercise "choice" among MCOs only adds time and obstacles to service delivery, outweighing any benefits. Families reported that it was difficult to switch MCOs in any event, and stakeholders in one of the small, rural states pointed out that even though there are multiple MCOs, they all are using the same providers so there is not really choice. Stakeholders also noted that the use of multiple MCOs creates incentive for adverse selection (that is, MCOs' enrolling healthier populations and trying to avoid more costly populations). The only advantage cited to the use of multiple MCOs came from Medicaid stakeholders in a small, rural state who felt that it strengthened their negotiating position with MCOs to have more than one.

Choice of MCO and Providers

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

Other MCO Issues

Changes in MCOs

Stakeholders in some states in the 1999 sample reported that corporate changes as a result of mergers and buy-outs in the managed care industry caused some level of disruption, instability, and periods of readjustment. This also was reported in states in the 1999 sample that had changed MCOs as a result of rebidding processes. However, most states in the 1999 sample reported either that they had not changed MCOs or that changes had not caused significant problems.

With respect to changes in MCOs identified through the maturational analysis, three of the states in the first sample of 10 reported that they had reduced their number of MCOs, largely due to MCOs' dropping out or choosing not to rebid, and this reduction was viewed positively as reducing complexities in the system.

Subcontracting with BHOs

In states with integrated designs in which physical health MCOs subcontract with behavioral health organizations (BHOs) to manage behavioral health services, stakeholders in the 1999 sample of states expressed concerns about the difficulties of monitoring the BHOs since the state has no direct contractual relationship with them. Also noted were concerns about the additional administrative layers and opportunities for profit making that are added to the system that may detract from service provision. On the other hand, stakeholders also noted the advantage to using BHOs in terms of adding behavioral health expertise to the system that physical health MCOs typically lack. New Mexico provides one example of subcontracting to BHOs.

- In **New Mexico**, the state contracts with MCOs, which are required to subcontract with BHOs. BHOs in turn subcontract with Regional Care Coordinators (RCCs), which in turn contract with providers. While each layer brings its own expertise, skills and technology to the mix, New Mexico also reportedly is struggling with "too many layers, too many players." As a result, the state has hired a consulting firm to conduct an administrative cost audit and is experimenting with different approaches to reducing the complexity. For example, one MCO has proposed to contract directly with the RCC, bypassing the BHO layer. In addition, the state is making an effort reportedly to monitor the various levels. The Medicaid agency reportedly reviews MCO contracts with BHOs and BHO contracts with RCCs. ■

III. Capitation and Risk

Capitation Rates

Sufficiency of 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 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 **Table 11** indicates, in all of the states with integrated designs and in half of the states with carve outs in the 1999 sample, capitation rates were considered to be insufficient to guard against underservice and allow for service capacity expansion. (Maryland's mental health carve out does not use capitation and, therefore, was not included in this analysis.) In only one state—Pennsylvania—did most stakeholders believe that capitation rates were sufficient on both counts.

It should also be noted that some states do not intend to expand service capacity with managed care, but rather to contain growth; indeed, in one state in the sample, the state legislature specifically prohibits the managed care system from expanding service capacity. Obviously, in these states, rates would not be structured in a way to allow for service expansion. Findings from the 1997 sample of states were similar to those from the 1999 sample, with stakeholders in only three of the 10 states in the 1997 sample reporting that capitation rates were sufficient to guard against underservice and expand service capacity.

Table 11					
Capitation Rate Sufficiency					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Rates are too low to guard against underservice	2	4	2	0	1*
Rates are too low to allow for service expansion	2	4	2	0	1*
* Maryland—MH does not use capitation.					

Rate Setting Methods

As was the case in 1997, most states are using prior utilization to determine rates. In states that are shifting responsibility and risk to local levels (for example, Pennsylvania and Colorado), there were complaints about the disparity in rates across regions or counties. Localities that maximized Medicaid spending and built up utilization in the past have higher rates than those that did not. Critics felt that this adversely affects smaller, rural and poorer counties or regions, that the method of basing rates on prior utilization creates a “rich get richer” effect, and that whatever factors kept utilization low in certain areas will continue to prevail. Others pointed out, however, that use of prior utilization data ensures that no area will lose ground. The maturational analysis found efforts in one state to revisit the basis and process for rate setting to create more equitable distribution of funds across the state.

- **Utah** engaged in a process to “equalize” rates across the state with the goal of achieving a more equitable distribution of Medicaid dollars across the state and increasing resources to rural areas to increase service capacity. It grouped its MCOs (i.e., community mental health centers, which previously had each negotiated separate rates with the state) into three groups— rural, urban and metropolitan, with rates established for each. Metro and urban areas suffered budget cuts as a result, while rural areas increased their resources. The process was described by stakeholders as “painful but necessary” to achieve greater equity statewide in resource allocation.

As they did in 1997, many stakeholders noted that prior utilization data at both state and local levels are of poor quality and that for some populations, for example, children involved in child welfare, data on behavioral health utilization may not exist at all. Stakeholders in some states also reported that rate-setting methods relied on outdated (i.e., inadequate) Medicaid fee schedules. They pointed out that as penetration rates increase and MCOs experience “obligation creep” (that is, they are expected to do more and more), rates that were based on prior utilization will prove insufficient.

There were reports from several states in the 1997 sample through the maturational analysis that their number of eligibles had declined even as penetration and utilization rates were increasing, and that the cost of services and of medications had increased—all factors that are causing them to readjust rates upwards or to disenroll certain high-cost populations. In one state, for example, MCOs, concerned about the inadequacy of rates requested, and the state agreed to disenrollment of the SSI population. In another state, the Native American population was disenrolled in response to concerns over the insufficiency of the rate to adequately serve this needier population. On the other hand, in some states, rates based on prior utilization that included heavy inpatient use were reported to be too generous, with MCOs allegedly making large profits as inpatient use was reduced. Some of these states reported that they have hired auditors to examine whether MCOs have been “overpaid” and whether rates should be reduced. Also, as noted earlier, the current trend across states nationally is to enroll higher need/cost eligibles, not disenroll them.

Recognizing the limitations of using prior utilization data to establish rates, half of the states in the current sample indicated that they systematically adjust rates annually based on actual experience; half reported that they do not. Among the changes states are making or considering, the development of risk-adjusted rates for children involved in child welfare is a major one, discussed in greater detail below.

Risk Structuring

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 increased interest on the part of states to develop risk adjusted rates for children involved in the child welfare system.

Finding: Upheld

In the 1997 Impact Analysis sample of 10 states, only one state (OR) had a risk adjusted capitation rate in place for children involved with the child welfare system, and one state (CT) was considering such a move. As shown on **Table 12**, in the 1999 sample of eight states, four (CO, NE, NM, and VT) have put in place risk adjusted rates for the child welfare population; stakeholders in one additional state (PA) indicated that they are considering doing so. Also, the maturational analysis revealed that one of the states from the 1997 sample (DE) reportedly is considering risk adjusted rates for the child welfare population.

Pennsylvania is engaged in a study to determine behavioral health service utilization by the child welfare population to inform its rate-setting. State-level stakeholders in Pennsylvania reported that in physical health managed care, they found that physical health care utilization was running 4-25% higher (depending on the area) for the child welfare population than for the Medicaid child and adolescent population as a whole. Several states indicated that lack of encounter data is hampering their efforts to establish risk-adjusted rates, but there does seem to be growing recognition on the part of states of the higher prevalence of both physical and behavioral health problems in the child welfare population and growing interest in structuring risk to guard against underservice to this population.

Table 12 Use of Risk Adjusted Rates					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Uses risk adjusted rates for children in child welfare	2	2	2	1	2*
Uses risk adjusted rates for children with serious BH disorders	1	2	3	2	1*
*Oklahoma does not include the child welfare population in its managed care system, and Maryland–MH does not use capitation.					

In contrast, about the same proportion of states in the 1999 sample as in the 1997 sample indicated that they have included risk adjusted rates for children with serious disorders. Three states in the current sample (IN, NM, and OK) indicated that they have put in place risk adjusted rates that include children and adolescents with serious behavioral health disorders. Indiana and New Mexico use risk adjusted rates based on SSI eligibility or other determination of disability level. For example, Indiana is adjusting rates based on level of functioning measured by the Child and Adolescent Functional Assessment Scale (CAFAS). Oklahoma has included both an enhanced benefit package and an enhanced rate for individuals with serious behavioral health disorders (adults and children).

- **Oklahoma** has an enhanced benefit package with an enhanced rate for individuals designated as having “Special Behavioral Health Needs” by the Oklahoma Health Care Authority and individuals categorized as aged, blind, or disabled. The enhanced benefit package includes: intensive outpatient services for mental health and substance abuse; psychosocial rehabilitation services; home based services, which may include but not be limited to 24-hour crisis intervention, individual and family counseling, parent education and behavior management training; rehabilitative case management, and therapeutic foster care.

Even with the use of enhanced rates, many stakeholders believe that underservice for the child welfare population and for children with serious disorders is occurring for a variety of reasons, specifically: the use of medical necessity criteria to curtail service; availability of other behavioral health financing streams and services in other children’s systems that creates opportunity to cost-shift; and lack of service capacity. Underservice is not being tracked systematically by states, as noted earlier, so it is impossible to determine to what extent it is actually occurring. Also, it should be noted that underservice of children involved in child welfare and children with serious behavioral health disorders predated managed care. Stakeholders sometimes are unclear as to whether they are comparing service use in managed care to use in the previous fee-for-service system or to what is desirable in an ideal or improved system.

Risk Sharing

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

Finding: **Upheld**

The 1997 Impact Analysis identified a trend among states to push full risk to MCOs, a trend which the 1997-98 State Survey reaffirmed. As **Table 13** indicates, the trend also is reflected among the states in the 1999 sample. Five of the seven states in the sample that are employing capitated managed care approaches have pushed full risk to the MCOs. Only two (OK, VT) have instituted risk sharing arrangements pertinent to children with behavioral health problems. As was the case in 1997, states with integrated physical health/behavioral health designs are more likely to use risk sharing arrangements applied to behavioral health than are states with carve outs. This is not surprising given that the behavioral health care dollars in integrated approaches tend to be especially limited, even though the populations covered include high-cost children, such as those with serious behavioral health disorders and those involved in child welfare.

Table 13 Risk Structuring			
N=9	Carve Out	Integrated	N/A or No Data
MCOs have full risk	3	2	2*
State and MCOs share risk	0	2	
* Indiana uses case rates, not capitation, and Maryland–MH does not use capitation.			

As noted, only two examples of risk sharing were identified in the 1999 sample. The maturational analysis found that among the states in the 1997 sample, two recently put in place risk sharing arrangements.

In the 1999 sample:

- **Oklahoma** shares risk with MCOs for Special Behavioral Health Needs enrollees whose cost exceeds \$10,000 a year.
- **Vermont** has in place a 30-day per episode (60-day per year) stop-loss with an exposure limit of \$48,000 for Institute for Mental Disorder (IMD) care, which applies to the Brattleboro Retreat for children.

In the maturational analysis:

- **Arizona** instituted a 10% risk corridor allowing the state to adjust capitation rates in either direction mid-year, which reportedly has lowered somewhat the anxiety of the Regional Behavioral Health Authorities (Arizona's MCOs) over risk issues.
- **Connecticut** has instituted risk sharing between the Department of Social Services (DSS) and MCOs for children involved in child welfare who are in inpatient psychiatric hospitalization. Under the arrangement, MCOs pick up 100% of the first 15 days of inpatient care; DSS and the MCOs share the cost of the next 45 days, and DSS assumes the full cost after 60 days. Reportedly, the arrangement has led some of the MCOs and DSS to engage more systematically in joint discharge planning.

It will be interesting to track whether, as states gain experience with managed care and as more high-cost populations are enrolled, states will experiment more with targeted risk sharing mechanisms such as these. At present, this is by no means a trend, raising additional questions as to the potential for underservice.

Provider Payment and Risk

Provider Payment Method

Hypothesis: In most states, most providers will be paid by MCOs on a fee-for-service basis and will not be at risk.

Finding: Upheld

The 1997 Impact Analysis found that most behavioral health providers were being paid by MCOs on a fee-for-service basis in managed care systems. Stakeholders pointed out that this arrangement failed to maximize the potential of managed care to create flexibility at the service delivery level. Many providers expressed willingness to receive a case rate or subcapitation in return for greater flexibility, but many also recognized that providers serving public sector populations typically are unfamiliar with risk-based contracting and also may not have the financial resources to bear risk. Stakeholders in the

1999 sample of states indicated that fee-for-service payment to behavioral health providers remains the norm, regardless of integrated or carve out design. In all nine reforms in the current sample, providers are paid principally on a fee-for-service basis. Also, in tracking changes from the first sample of states through the maturational analysis, only one (AZ) reported that it was experimenting in any significant way with subcapitation arrangements with providers.

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 system. That proportion basically has reversed itself in the 1999 sample of states. As **Table 14** indicates, in most of the reforms in the 1999 sample (six of nine), providers are receiving lower reimbursement rates under managed care. In addition, the maturational analysis found that two of the states in the 1997 sample reportedly have cut rates since the time of the site visits.

Table 14 Provider Reimbursement Rates			
N=9	Carve Out	Integrated	N/A or No Data
Rates are higher or same under managed care	3*	1	
Rates are lower under managed care	3*	3	
*Pennsylvania reported the same or higher rates in the southeastern part of the state and lower rates in the southwestern region.			

In states where rates are reportedly lower under managed care, 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. Selected examples of rate cuts from different states included: case management dropping from \$50/hour to \$30; therapeutic foster care going from \$160/day to \$110; outpatient therapy dropping from \$65/hour to \$41; and residential treatment going from \$270/day to \$220.

Stakeholders in virtually all states in the 1999 sample pointed out that Medicaid reimbursement rates were historically low, so that even in states where rates have remained the same or been increased with managed care, there are still many complaints about low rates. Providers noted that even when rates are the same, the added administrative costs necessitated by managed care render the rates in effect “lower.” Providers complained that rates are too low to enable them to meet quality care standards or state expectations, and that states do not pay sufficient attention to the effect of rates on quality of care. Providers in one state cited as examples the following:

- The rate paid for child outpatient therapy is the same as for adult outpatient therapy, which discourages providers from seeing children, which requires additional collateral work with families and teachers and interagency work.
- There is a disparity between the state’s guidelines for best practice in psychiatry, which providers say would cost \$250/hour to implement well, and the \$75/hour rate paid, and that the low rate discourages psychiatrists from joining networks or from taking Medicaid children if they do, thereby aggravating the supply problem and weakening the role of psychiatry in the system.
- Rates are too low to support better diagnostic work with children.
- Rates are too low to support provision of appropriate clinical training or supervision.

In a number of states, managed care has required a shift for CMHCs and many substance abuse agencies from a “grants to a reimbursement” environment. Even when rates have not been cut from previous Medicaid fee-for-service systems, this shift has been, or has felt like, a payment reduction to these agencies. These stakeholders pointed out that the previous grants mechanism enabled them to cover certain administrative overhead costs, provide training, and subsidize care for non-Medicaid populations, which reimbursement systems under managed care do not.

■ **Maryland’s** mental health carve out meant a shift for community mental health agencies from a grant to a fee-for-service reimbursement system. The state recognized the impact of such a transition and launched an extensive education and training effort to prepare providers, including work with billing personnel to address claims and payment problems, making consultants available to work directly with CMHCs to prepare them for the transition, and allowing for transitional grant funding for those not fully prepared. The state reportedly also has worked with providers to raise certain rates, such as those for child group therapy and family therapy, and is considering augmentation of other rates using base rate funding, such as for intensive in-home services.

A number of states also reported that when rates are higher on the fee-for-service side than in the managed care system, there is an incentive for providers to cost-shift to fee-for-service systems. In one state, for example, rates paid by the child welfare system for behavioral health services are higher than those paid for the same services in the managed care system. As a result, there is an incentive to cost-shift, and child welfare

providers have little incentive to join managed care networks (even though the children they serve are enrolled in managed care). The child welfare agency in this state is considering lowering its rates as a result, but its providers contend that they cannot provide quality care under the lower rates. In another state in the sample, a recent lawsuit may lead to increases in rates on the Medicaid fee-for-service side, but not in the managed care system, again creating the opportunity for cost shifting.

In five of the states in the 1999 sample, providers complained about delays in being paid, a problem which predated managed care, but which stakeholders say is exacerbated by the higher volume under managed care. In one state, providers indicated payment delays were running as long as six months, and in another, a provider indicated that his agency was running a \$20,000 per month shortfall due to late payment. Payment delays to a certain extent seem to be carry-overs from the previous fee-for-service systems and seem to plague managed care systems more in early implementation stages. ■

IV. Clinical Decision Making and Management Mechanisms

Prior Authorization

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. Though the practice is used extensively, in the 1997 Impact Analysis, stakeholders in most states (seven of 10) complained about prior authorization mechanisms, describing them as cumbersome, time consuming, confusing, and creating barriers to access. These results were substantiated in the 1999 Impact Analysis sample—complaints were pervasive in seven of the eight reforms using prior authorization as a management mechanism (prior authorization reportedly is not used in Indiana). In both the 1997 and 1999 samples, complaints about prior authorization 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). Instances of subcapitation of providers were relatively rare, but the practice did appear to result in fewer problems with respect to prior authorization; providers across states expressed a strong preference for assuming risk through subcapitation in return for greater control over clinical decision making.

Table 15 Prior Authorization					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Prior authorization perceived as problematic	3	4	1	0	1

The specific problems cited by stakeholders in the 1999 sample related to prior authorization were very similar to those identified in 1997:

- Authorization is required in some systems for every single service and is seen as unnecessary micromanagement for low-end services.
- Authorization processes are seen as frustrating, time consuming, and cumbersome in some systems, adding extensive paperwork and administrative burden, as well as introducing a “hassle factor” that creates significant roadblocks to providing care.
- Prior authorization processes vary across multiple MCOs, creating confusion and inconsistency for providers and consumers. For example, in one state in the 1999 sample, one MCO allows 10 outpatient visits with no authorization required, while another MCO in the same state requires all outpatient and inpatient care to be pre-authorized.
- Prior authorization processes often create excessive delays in service provision.
- Approval is given for a limited number of service units or a limited time period, making it necessary to seek reauthorization at frequent intervals.
- Providers may offer services based upon perceived need while authorization is pending, and then end up assuming the cost if services ultimately are denied.
- Authorization decisions are dependent upon the competence of the reviewer making the decisions, which varies significantly both within and among MCOs; stakeholders in some states felt that the level of expertise of reviewers often is suspect with respect to children’s services.
- Although actual denials may be kept to a minimum, care often is “negotiated” down to lower levels, even if this is not appropriate.
- Stakeholders from other child-serving systems, especially child welfare, regard prior authorization as a particular barrier and source of conflict with managed care systems due to disagreements as to what constitutes necessary and appropriate services.

Some states in the 1999 sample reportedly are refining their prior authorization processes to address some of these issues.

- In **Colorado**, stakeholders indicated that MCOs have “matured” with respect to their authorization mechanisms, finding that a strong emphasis on utilization management is less useful than identifying and focusing on outliers. One MCO now routinely approves up to 10 outpatient sessions and only reviews requests beyond this level.
 - In **Maryland–MH**, five outpatient visits were routinely allowed without authorization during the initial implementation period; this has been increased to 12 unauthorized visits. The trend reportedly is not to micromanage outpatient services but to focus on managing the use of higher end services.
 - Due to the burden for providers created by having to obtain authorization for each individual service, **Maryland–MH** is moving to authorize units of service within a larger block to reduce administrative burden as well as to authorize services for a longer time period.

The maturational analysis confirmed a trend towards less onerous prior authorization requirements and processes through a combination of routine authorizations for certain amounts of care, authorization of service packages, and greater subcapitation of providers in some states.

- In **Arizona**, there appears to be some movement toward subcapitating provider networks in the regions, thereby delegating the utilization management function to these networks. This is occurring in two regions and may be developing in a third; this gives the provider networks greater responsibility for clinical decision making in return for sharing risk with the MCOs.
- In **Arizona**, some stakeholders noted a greater emphasis on authorizing service packages, with MCOs backing away from the need to authorize service by service, with the intent of simplifying and reducing micromanagement. In two counties, there are five service packages, based upon level of care criteria, that are authorized.
- In **Iowa**, the MCO found that they concurred with service requests for outpatient care in 95% of the cases. The high rates of concurrence led them to move away from prior authorization for outpatient services in the current contract in favor of monitoring service utilization and appropriateness through retrospective reviews and looking at outliers. Inpatient and residential services continue to require authorization.
- In **Massachusetts**, a new Interactive Voice Response System has been implemented for authorization purposes. Providers may ask for a fixed number of units of particular services based upon diagnosis-driven protocols, and these are approved if they are consistent with the clinical guidelines.
- In **Connecticut**, one MCO has set up clinical centers of excellence and allows these centers 10-20 visits without authorization.

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

The hypothesis that prior authorization and other utilization management processes would create particular barriers and problems for substance abuse service delivery was upheld. In the 1999 sample, as shown on **Table 16**, stakeholders in five of the six reforms to which this applied perceived this to be the case (two reforms do not include substance abuse and one does not use prior authorization). Respondents 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. According to stakeholders, being forced to go through the “hoops” of 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. Further, substance abuse services often are initiated during crisis situations in which an immediate response is needed. Stakeholders across states felt that it is imperative for managed care systems to be able to provide a prompt response to identified needs for substance abuse intervention, and that, in many cases, waiting for prior authorization is counterproductive.

Table 16 Prior Authorization of Substance Abuse Treatment					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Prior authorization and other management mechanisms are perceived as particular barriers to those seeking substance abuse treatment	1	4	1	0	3

In some states, stakeholders felt that the constraints placed on substance abuse services through prior authorization processes are even more limiting than those placed on mental health care. For example, in one state, stakeholders alleged that the most intensive substance abuse service typically approved is six hours per week of intensive outpatient care, even in situations warranting more intensive interventions. In another state, stakeholders conveyed the impression that adolescent substance abuse services are virtually unobtainable, that denials for initial service requests for substance abuse treatment often are a “foregone conclusion,” and that providers are forced to argue with MCOs for services in most cases.

Few strategies for addressing this problem were identified either in the 1999 sample or in the maturational analysis.

In the 1999 sample:

- In **Maryland–PH/SA**, a system refinement will allow self-referral for individuals who are not already in substance abuse treatment. They will be able to go to any certified substance abuse provider for an assessment and referral for services.

In the maturational analysis:

- In **Oregon**, referral from a PCP is no longer required for substance abuse services.

Clinical Decision Making Criteria

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 1997-98 State Survey indicated that more than two-thirds of the states are using some type of level of care or patient placement criteria to assist in making clinical decisions regarding level and duration of services in managed care systems. In the 1997 Impact Analysis study, the majority of states (seven of 10) had such care criteria for children's mental health services, but only one had criteria for adolescents with substance abuse disorders, leading to the hypothesis that, in the 1999 sample, few states would have criteria for adolescent substance abuse treatment as compared with children's mental health. This hypothesis was not upheld in the 1999 Impact Analysis sample. In fact, most of the states including substance abuse services in their reforms (five of seven) reported having level of care/patient placement criteria specific to adolescent substance abuse treatment (**Table 17**). 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, clinical decision making criteria of some type were actually somewhat more likely to be found for adolescent substance abuse than for children's mental health (the opposite of what had been predicted).

Table 17					
Level of Care and Patient Placement Criteria					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Level of care criteria exist specific to children's mental health services	2	2	3	1	1
Level of care or patient placement criteria exist specific to adolescent substance abuse services	2	3	1	1	2

The 1999 results suggest that managed care systems have moved rapidly over the past several years to using clinical decision making criteria for adolescent substance abuse treatment, perhaps more easily than for children's mental health services. This may be due to the existence of broadly accepted criteria (those developed by the American Society of Addiction Medicine— ASAM) that could be adopted and readily applied in managed care systems. Stakeholders in all five states reporting the use of criteria for

adolescent substance abuse treatment are using ASAM criteria or a modified version of ASAM criteria in one state. Similar national criteria do not exist in the children's mental health field, leaving to states and MCOs the challenge of developing their own.

For children's mental health services, several states in the 1999 sample have developed their own clinical decision making criteria.

- In **Maryland–MH**, level of care criteria were developed by the state in collaboration with the ASO. Although the criteria are not specific to children and adolescents, the Provider Manual contains child-specific examples (along with adult-specific examples) to demonstrate their application at each level of care. Levels of care with criteria for admission and continued stay are specified for hospitalization, RTCs, mental health residential care, partial hospitalization/day treatment, intensive outpatient treatment, psychiatric rehabilitation services, and outpatient services. Referral and continuing care guidelines are provided for mobile treatment, psychiatric rehabilitation programs, mobile crisis and crisis residential services, and intensive case management.
- In **Colorado**, the Colorado Client Assessment Record (CCAR) is used to determine level of care placement; it includes six levels of care with a package of services and duration identified for each level. Some child-specific items are included on the CCAR, although the CCAR process and levels of care are not specific to children.
- In **Pennsylvania**, Guidelines for Mental Health Medical Necessity Criteria for children and adolescents were developed by the state with stakeholder and family input. These serve as broad admission and level of care criteria for certain services within the benefit package including inpatient, residential treatment, partial hospitalization, outpatient, behavioral health rehabilitation, home and community services, and family-based mental health services.

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 only three states felt that the use of level of care and patient placement criteria were improving consistency in clinical decision making (**Table 18**). The use of ASAM criteria for adolescent substance abuse treatment is perceived to be standardizing and improving the quality of clinical decision making, according to stakeholders in several states. However, problems were still cited with ASAM criteria, as well as with criteria used to guide decision making around children's mental

health services. For example, in one state, level of care criteria are considered by stakeholders to be too broad to provide sufficient distinctions across service components, thus compromising their usefulness. Issues cited by respondents as problematic with respect to level of care criteria include:

- Where there are multiple MCOs, each has developed its own criteria, resulting in significant variation within a state with respect to the type, level, and duration of services that children and adolescents may receive. The use of different sets of criteria and the lack of uniformity is confusing for providers and consumers.
- Even where standard criteria are prescribed by the state, differing interpretations by MCOs and providers compromise consistency and, in some states, make obtaining services a “guessing game” for consumers and providers.
- In some states or MCOs, criteria are applied too rigidly, forcing children to change service levels or modalities too often or impeding the ability to provide flexible, individualized care.
- Insufficient service capacity can render clinical decision making criteria meaningless. For example, criteria may suggest certain services or levels of care as appropriate for a child, but the particular service may not be available or may entail an extensive waiting list. Developing adequate service capacity, according to respondents, is necessary in order to make the application of clinical decision making criteria truly effective.

Table 18 Consistency in Clinical Decision Making					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Level of care criteria are perceived as improving consistency in clinical decision making	2	1	3	3	

The maturational analysis indicated that this is an area of activity among states as their managed care systems continue to evolve.

- In **Oregon**, new rules stipulate broader use of ASAM criteria across substance abuse services.
- In **Utah**, the care criteria developed by one CMHC are being used as a guide for other CMHCs to develop level of care criteria.
- A Children’s Consortium Committee in **Arizona** has developed level of care criteria specific to children and adolescents that are in use within some regions. (The service planning guidelines can be found at www.hs.state.az.us/bhs/home.htm under documents and service planning guidelines.)

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 for mental health, not substance abuse

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 five of nine reforms. Problems related to the initial use of medical necessity criteria were also noted in half of the states (five of 10) in the 1997 sample. Many of the problems related to medical necessity criteria centered around the perception that they were too narrowly defined and based solely on a medical model, failing to take into account the need to link treatment with the social and environmental supports so critical to supporting children and adolescents with behavioral health problems. 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. Five states in the 1999 sample reportedly have done so, suggesting a trend toward broadening medical necessity criteria (**Table 19**). The 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.

Table 19					
Medical Necessity Criteria					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Medical necessity criteria are perceived as problematic	2	3	3	1	
Medical necessity criteria are broad or have been broadened to include psychosocial considerations in clinical decision making	3	2	2	2	

Despite the broadening of criteria in many states, a number of problem areas were raised in the 1999 sample related to the use of medical necessity criteria, many similar to those raised by stakeholders in the 1997 sample:

- Inconsistent interpretation and application of medical necessity criteria by different MCOs and individuals.
- Overly rigid application of medical necessity criteria by some MCOs, creating a major barrier to service delivery by limiting both the types and duration of services for children.
- Dramatically decreased lengths of stay and premature discharges from facilities, based on use of medical necessity criteria, often without the availability of appropriate step-down services. (This presented particular concern for child welfare respondents, many of whom felt that medical necessity judgments might conflict with safety and support needs in decisions around length of stay.)
- Lack of a uniform, statewide definition of medical necessity, leaving each MCO to develop its own definition and creating inconsistency and confusion.
- Concern that medical necessity criteria do not “fit” substance abuse clinical situations and do not account for the chronic and often progressive nature of substance abuse disorders, making it difficult to obtain services, particularly more intensive care.
- Differences of opinion among stakeholders as to what constitutes medically necessary treatment.

Some examples of efforts to address the issue of medical necessity criteria were identified in both the 1999 sample and through the maturational analysis.

In the 1999 sample:

- In **Vermont**, state regulations (Rule 10) were adopted to protect consumers in managed care systems; a fairly broad definition of medically necessary care is included.

In the maturational analysis:

- In **Arizona**, the definition of medical necessity has been clarified and enhanced by adding provisos specifying that services cannot be denied if an individual is not improving at a particular level of care, that services at a particular level of care cannot be denied if a suitable lower level of care is not available, and that individuals cannot be discharged without linking them to other appropriate services.
- In **Iowa**, a system-wide “Keep Kids Safe” policy was implemented which prohibits discharge of a youngster to an unsafe environment, implying that a child in an inpatient setting who is ready for discharge according to the MCO’s continued stay criteria must be maintained in the placement until a safe alternative is arranged.
- In **Connecticut**, the new managed care contract includes a standard definition of medical necessity for statewide use to address the confusion created by different definitions used by the multiple MCOs in the state’s managed care system.

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 (**Table 20**), as did stakeholders in all states visited during the 1997 Impact Analysis.

Table 20					
Grievance and Appeals Processes					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Grievance and appeals processes are perceived as problematic for families and providers	5	4	0	0	

Family and provider stakeholder groups raised many issues and problems related to grievance and appeals processes during the 1999 Impact Analysis site visits. There was little change from 1997 in the types of problems raised by these stakeholders with respect to grievances and appeals. The most frequently stated complaint across states is that families do not know about grievance and appeals processes or about how to use them. Respondents asserted that information about these processes is either not provided or is not provided in an understandable format for families. Focus groups held in one state revealed that consumers and family members had little knowledge of the process. The reported lack of knowledge about grievance and appeals is further complicated by reports that families often are intimidated by the process and fear potential retaliation or repercussions if they file a grievance or appeal.

In addition to lack of knowledge, 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. Providers in several states indicated that they feel overwhelmed and rarely have the time or energy to take on long and frustrating appeals processes. According to stakeholders, these processes often involve multiple layers through which complaints must proceed, and in states with multiple MCOs, each MCO has its own grievance and appeals process, adding additional confusion. In some cases, grievance procedures reportedly take so long to resolve that people just give up. One respondent noted that people “crumble” before they complete the process due to its length and complexity. An additional barrier for providers is that if services are continued during appeals processes and then the appeal is denied, providers must absorb the cost of these services.

Another major issue raised with respect to appeals is that MCOs may avoid providing families and providers written, “official” denials of services, leaving them with no basis for an appeal. MCOs reportedly may attempt to “negotiate” services or may indicate that certain services simply do not exist or are not available. This practice renders the grievance and appeals process inaccessible to those who could potentially have used it in an attempt to obtain services deemed to be needed. There was broad consensus among stakeholders in all states that additional education about grievance and appeals processes is needed.

There were a few examples, however, of efforts in states to improve grievance and appeals processes.

- In **Maryland–MH**, information on the right to appeal and on the process reportedly is given to consumers in a consumer handbook as well as in brochures at service settings, and also is included in each letter of service authorization or denial. Information also is included in the provider manual.
- In **New Mexico**, the state children’s agency has hired two “clinical liaisons” who are dedicated to handling grievances and appeals with the managed care system. These individuals are knowledgeable about the system and are effective at resolving problems with the MCOs in a timely manner.
- In **New Mexico**, a family organization (Parents for Behaviorally Different Children) has a toll free number to assist parents with complaints, grievances, and appeals.
- In **Oklahoma**, each MCO is now required to hire an advocate to walk families and providers through the grievance and appeals process.
- **Pennsylvania** requires in contracts that consumer advisors be available to help consumers to navigate the grievance and appeals process.
- In **Maryland–PH/SA**, an ombudsman program is required to assist enrollees in resolving disputes with MCOs in a timely manner, and assisting enrollees to use the MCOs grievance procedures.

The maturational analysis also found that this is an area that several states are addressing, both with respect to education about appeals processes and making these processes easier to navigate.

- In **Delaware**, a guidebook for families on the entire system, including grievances and appeals, was completed, and families sign to verify that they have received it.
- In **Utah**, considerable attention has been devoted to increasing awareness about grievance and appeals processes. MCOs are being more assertive about providing written materials and verbal information, including brochures, notices posted on bulletin boards, notices in orientation packages, requiring that clinicians review the procedure with families, and routinely providing information about the procedure during the intake process at most CMHCs. In addition, training is provided to partner agencies to review managed care system policies and procedures, with particular emphasis on denials of hospitalization and on the grievance and appeals processes.
- In **Arizona**, an expedited appeals process was added allowing appeals to go directly to Medicaid instead of through the various levels, with services continuing until the decision is rendered. ■

V. Impact on Service Array

Coverage of Behavioral Health Services

Range of 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 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. As shown in **Table 21**, stakeholders in the 1999 sample confirmed coverage for a broader mental health service array in all but one carve out and in only one integrated system. Similarly, in the 1997 sample, stakeholders in nearly all (seven of the eight) states with carve outs reported that managed care is resulting in a broader array of services; in the two states with integrated designs in the 1997 sample, stakeholders reported that the range of mental health services actually decreased. 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, with the one exception of New Mexico where an array of "enhanced services" was incorporated into the benefit design for the managed care system. One stakeholder in a state with an integrated design referred to the system as "insurance without an adequate benefit plan."

Table 21					
Range of Mental Health and Substance Abuse Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Range of mental health services has increased	4	1	1	2	1
Range of adolescent substance abuse services has increased	1	0	2	4	2

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.

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- In **Maryland–MH**, the provider manual lists an extensive array of covered mental health services, including inpatient, residential treatment, partial hospitalization, emergency services, mobile treatment services, supported employment, respite, enhanced support, mental health targeted case management, home health, residential crisis, occupational therapy, psychiatric rehabilitation services (such as after school, in-home, mentor, crisis, and summer camp services), interdisciplinary team planning, community prevention and support, traditional outpatient services, intensive outpatient services, urgent care, psychological testing, and hospital consultation.
 - In **Pennsylvania**, the managed care reform was used as an opportunity to include the full federal list of Medicaid covered services, a broader array of services than had previously been covered under the state’s Medicaid plan. Coverage of the broad service array of behavioral health services is a criterion in the state’s Readiness Assessment Instrument and is a specific outcome area tracked by the state’s performance/outcomes management system.

The maturational analysis revealed a continuing trend to broaden the array of covered mental health services under managed care systems. Stakeholders in Rhode Island, for example, related that the behavioral health benefit (previously limited to 15 outpatient visits and 15 inpatient days) was expanded to cover a full array of “unlimited services,” although MCOs reportedly continue to provide primarily traditional outpatient and inpatient care. North Carolina added family interventions to its covered array, making it possible to bill for services provided to family members, and Utah added coverage for specialized services for autism and organic brain disorders.

Range of 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. In the 1999 sample, stakeholders in only one of the seven states including substance abuse in their managed care systems (PA) reported an expanded range of substance abuse services (**Table 21**). Similarly, expansion in the array of substance abuse services was noted in only three of the 10 states in the 1997 sample. Little change was noted from the perceptions expressed by stakeholders in the 1997 Impact Analysis — that the array of covered substance abuse services is not as broad as the array for mental health, and that expansion of the service array related to managed care has been much more significant in the mental health arena.

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- In Pennsylvania, the managed care reform resulted in coverage for a broader array of substance abuse services. Under Health Choices, Medicaid will now cover drug and alcohol targeted case management, drug and alcohol partial hospitalization, nonhospital-based detoxification, and drug and alcohol wraparound services through EPSDT.

Stakeholders in nearly all states across both the 1997 and 1999 samples emphasized that substance abuse services for adolescents are widely unavailable, inadequate to the need, or “virtually nonexistent,” a problem pre-existing managed care. With exceptions in only a few states, the introduction of managed care has not resulted in improvements. One stakeholder called adolescent substance abuse services “the weakest link” in the system. Only a few examples of expansion of the substance abuse service array were noted by respondents in the maturational analysis, most of which do not apply to adolescents. For example, Arizona added a methadone code, and Rhode Island expanded the range of covered substance abuse services for adults. In Delaware, an initiative to serve 30 inner city youth who have substance abuse problems and are on probation was launched, and substance abuse evaluations are now required within 72 hours for adults whose children come to the attention of the child welfare system.

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.
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Finding:	Upheld
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Confirming 1997 findings, managed care reforms with carve out designs reportedly have resulted in coverage for more home and community-based services (found in four of the five carve outs included in the 1999 sample), and has also resulted in more flexible, individualized services (also found in four of the five carve outs studied), as shown on **Table 22**. Conversely, integrated reforms in both the 1997 and 1999 samples did not result in greater coverage of home and community-based service options (with the sole exception of New Mexico where enhanced services were added to the mix), 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.

Table 22 Home and Community-Based and Individualized Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
More home and community-based services are covered	4	1	1	3	
It is easier to provide flexible, individualized services	4	0	1	4	

As noted, the expanded array of mental health services covered in many of the managed care systems with carve out designs include a host of home and community-based service approaches that were not previously covered under previous fee-for-service systems. Nebraska, for example, has added home-based services and community treatment aides, used to support children in their homes and local schools, among other service approaches. In addition, stakeholders in many of the states with carve outs noted that capitation allows greater latitude than was possible under fee-for-service systems to pay for more flexible, individualized services. 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.

In the five states in the 1999 sample where it was characterized as more difficult to provide flexible/individualized services as a result of managed care, stakeholders blamed such factors as rigid authorization processes, the tendency of MCOs to focus on single episodes of discrete services, lack of MCO and provider understanding about how to use flexible approaches, and billing procedures with service codes that impede flexibility. One respondent stated that wraparound remains a “myth,” and that increased flexibility and individualized care remain the “unfulfilled promise of managed care.” Stakeholders in another state described MCOs as “nervous,” both clinically and fiscally, about the use of wraparound approaches, which effectively curtails their use.

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 to children and adolescents in need. Across states in both samples, respondents agreed that although managed care reforms have broadened the array of covered services (at least in states with carve outs) and some service capacity

expansion has resulted, there remain significant gaps in behavioral health services for children and adolescents regardless of managed care design. Lack of sufficient service capacity, a pre-existing systems issue in children's mental health and adolescent substance abuse treatment, remains a daunting problem.

Insufficient service capacity is manifested in several ways, according to stakeholders in the 1999 study sample. Significant regional variation in the availability of services is evident in most states, with rural and frontier areas cited most often as having large gaps in the service array. State mental health agency respondents in one state reported analyzing service capacity on a county by county basis; some counties reportedly had few, if any, children's mental health services available. Insufficient capacity is also seen in waiting lists for behavioral health services, which were reported to be worse in a number of states as a result of managed care reforms (and despite access standards governing waiting times for services that may be included in managed care contracts). 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. Additionally, shortages in particular types of services are pervasive, according to stakeholders. For example, capacity for adolescent substance abuse services was minimal in most states prior to managed care reforms and reportedly has remained a critical problem. Managed care reforms have also underscored pre-existing shortages of child psychiatrists and child psychologists, according to stakeholders in many states.

Stakeholders noted that the participation of providers also plays a significant role in the availability of sufficient service capacity for children's behavioral health services. In some states, individual providers and programs reportedly have stopped participating in the managed care system due to low rates and increased administrative burden, further compromising service capacity. Additionally, stakeholders across states noted that it is difficult for providers to reconfigure to provide new types of home and community-based services; they identified the need for training and technical assistance as well as for start-up resources to encourage service capacity expansion. Providers across states indicated that they do not have the resources to invest in service capacity development and are reluctant to develop and offer certain new types of services if they perceive the payment rates for them to be insufficient or if they perceive overly restrictive authorization practices among MCOs.

In the 1997 sample, seven of 10 states reported insufficient investment in service capacity development for children's behavioral health services. 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 (Table 23). Stakeholders in a number of states in the 1999 sample noted that although inpatient and residential services are harder to access as a result of the managed care reform, there has been little development of service capacity on the home and community-based end of the service spectrum. One respondent stated, "We have cut off the top but haven't grown the bottom." In many states in both the 1997 and 1999 samples, the community-based services that are available reportedly are overwhelmed by the need/demand for services.

Table 23 Service Capacity					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Insufficient investment in service capacity development was reported	5	4	0	0	

The 1997–98 State Survey also asked whether states were investing in service capacity development. Two-thirds of all states (68%) indicated that they were investing in service capacity development, though many noted that these efforts were taking place independent of managed care systems. The 1997 and 1999 Impact Analyses, however, suggest a broad consensus among stakeholders across states that whatever investment in service capacity for children’s behavioral health services is occurring is considered to be inadequate.

Some strategies to address service capacity development were found in the 1999 study sample, although even in these states, investment in service capacity was perceived to be inadequate to keep pace with the need and demand for services.

- In **Maryland–MH**, legislative funding has been obtained for two new initiatives—respite services and services for transition age youth.
- Strong contractual access standards in **Pennsylvania** are leading to the development of some additional service capacity, for example, by requiring that there be a minimum of two providers of each type in provider networks to allow for service choice. In addition, state contracts with counties provide for reinvestment of savings in service capacity development; some counties are investing in children’s services, such as intensive case management, school-based services, therapeutic foster care, and adolescent substance abuse services.

The results of the maturational analysis indicate that, over time, states may be devoting increased attention to the need for greater service capacity for children’s behavioral health services. A number of examples of efforts to develop service capacity were identified.

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- In **Utah**, redeployed resources have been used to expand service capacity in most service areas. Reportedly, savings achieved in reducing adult inpatient use have been diverted to developing community-based services for children (including respite, in-home services, day treatment, case management, and after school programs) supported by a mix of Medicaid and local county funds.
 - In **Arizona**, the state is investing resources to build service capacity to serve individuals with co-occurring mental health and substance abuse disorders.
 - In **Iowa**, the managed care contract requires the MCO to reinvest at least \$1 million per year in service capacity development, resulting in 37 separate projects across the state. The MCO agreed contractually to invest 2.5% of its total contract or more in the development of community-based service capacity.
 - In **Massachusetts**, the state and MCO have focused energy on expanding home-based services through investment as well as rate incentives for providers, and the MCO developed an intensive case management pilot program for children in custody of the child welfare system with the most complex and serious behavioral health needs.
 - In **Delaware**, the fiscal year 2000 budget includes \$800,000 to create therapeutic foster care for multi-agency involved youth who are coming out of more restrictive levels of care, and resources to increase capacity for intensive outpatient services for both mental health and substance abuse services for children and adolescents.

Prevention Services

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

Finding: Upheld

As shown on **Table 24**, behavioral health prevention services were reportedly outside of managed care systems in most of the states in the 1999 sample (seven of nine reforms). This mirrors 1997 results — prevention services were outside of managed care systems in all 10 states in the 1997 sample. Typically, separate state allocations are earmarked to fund mental health and substance abuse prevention activities.

Table 24 Prevention Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Prevention services are primarily outside the managed care system	4	3	1	1	

Both in 1997 and 1999, respondents noted that prevention activities and requirements in managed care systems are far more likely to address physical health concerns such as immunizations, but to ignore prevention in the behavioral health arena. Some speculated that a three-year contract period is not sufficiently long to create 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. Some examples of prevention activities that are incorporated in managed care systems were provided.

- In **Maryland–MH**, the state developed a category of service called “Community Support and Prevention,” which can be used to fund nonbillable activities of clinicians, such as training, making presentations in schools or to community groups, and the like. With approval, providers can obtain payment through the managed care system for these activities.
- In **Colorado**, some MCOs have increased prevention efforts. Examples include parenting groups and “Staying in Bounds with Anger” programs for schools.
- In **Nebraska**, prevention is an area in which reinvestment monies are being used. The MCO created a “Prevention, Education, and Outreach” program that has funded some prevention efforts, primarily involving parent training for Native American and Latino populations.

Respondents in three states from the 1997 sample indicated that some prevention services or activities have been incorporated in their managed care systems since the site visits, indicating some increased attention to this area.

- In **Iowa**, the state’s contract with the MCO calls for the MCO to start a new prevention program every six months.
- School-based prevention programs have been initiated in one region in **Arizona**.
- In **Utah**, an array of prevention groups and services targeting children and adolescents have been incorporated, such as presentations in schools regarding self-esteem, depression, suicide, awareness of mental health issues, and others.

Transportation Services

Hypothesis: In most states, lack of transportation will be cited as a major barrier to accessing services in both rural and urban areas, and managed care reforms will not substantially improve this pre-existing problem.

Finding: Upheld

In 1997, transportation was reported to be a major barrier to accessing services in both rural and urban areas in six of the 10 states studied. Although there was some improvement in the coverage of transportation under managed care systems in some states in comparison to the previous fee-for-service Medicaid systems, significant challenges remained in offering appropriate transportation services, increasing awareness of these services, and streamlining the processes to obtain them. As shown on **Table 25**, the 1999 Impact Analysis also found transportation to be a major barrier to accessing services; managed care reforms reportedly have had little impact on this pre-existing challenge, though they may be making the problem more visible.

Table 25 Transportation Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Lack of transportation is a barrier to service delivery	5	4	0	0	

In some states, transportation services, if offered at all, remain outside of the managed care system. However, some managed care systems reportedly attempt to provide transportation services to assist consumers to access behavioral health services. In New Mexico, for instance, the state has a contract with “Safe Ride” and other companies for transportation services, and MCOs have vans as well. Clients reportedly can call and arrange transportation, though stakeholders noted that few consumers and providers know of the availability of this service, that reservations must be made well in advance, and that it is challenging to make arrangements with MCOs. Transportation is required in the managed care contract in Nebraska, however, providing transportation is difficult for the MCO in rural and frontier areas where transportation options are not readily available. Stakeholders reported that the MCO has attempted to find entrepreneurs in rural areas who will create transportation services in rural areas for consumers and families without cars. A task force in Pennsylvania is exploring how transportation (or lack thereof) affects compliance with access standards for the managed care system. At the very least, it appears that managed care reforms have focused increased attention on this pre-existing problem.

The maturation analysis identified an example in only one state of a strategy to address transportation needs.

- In **Utah**, the capitation was increased and transportation included as a covered service. Mental health centers are providing this through a variety of mechanisms, including vans, taxis, case managers, and others.

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. **Table 26** shows that eight states reported difficulties in serving rural communities (Oklahoma's managed care system is limited to urban areas); in 1997, the majority of states in the sample (eight of 10) reported such difficulties as well.

Table 26 Services in Rural and Frontier Communities					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Problems serving rural and frontier areas were reported	5	3	0	0	1

Difficulties related to serving children and families in rural and frontier communities are not new or unique to managed care systems. Large distances, sparse populations, lack of service capacity, lack of qualified professionals, difficulty in recruiting staff, and high staff turnover rates are just some of the many contributing factors. Stakeholders in both the 1997 and 1999 samples, however, 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 extensive lag time for payments characteristic of some managed care systems.

Some beginning efforts to address this problem were noted by stakeholders and a number of potential strategies were mentioned. For example, in New Mexico, a statewide “access meeting” was organized to develop a plan for improving services in underserved areas, with potential strategies under consideration including:

- Offering a rate differential in rural areas to attract providers
- Using telemedicine for services such as psychiatric consultations
- Building mobile treatment capacity for rural and frontier areas
- Using reinvestment monies to support service development in rural and frontier areas

Few examples of strategies already implemented and having positive effects were noted by stakeholders in either the 1999 sample or through the maturational analysis.

In the 1999 sample:

- In **Maryland–MH**, the state has kept regional offices in rural areas, each with an adult and child staff person, to assist in developing the provider network in these areas. There have also been efforts to provide mental health services in the schools in these areas.

In the maturational analysis:

- **Utah** has increased outreach and outstationing of staff as an approach to better serve rural and frontier areas. For adults, staff are placed at the Department of Workforce Services, for children, staff are placed at the Department of Child and Family Services. Special efforts have been made to formalize relationships with school districts to provide school-based behavioral health services.
- In **Utah**, a new federal grant from the Comprehensive Community Mental Health Services for Children and their Families Program was obtained to develop service capacity in a three-county frontier area, and a new rate structure was developed to encourage service capacity development in rural and frontier areas.
- **Arizona** has expanded telemedicine approaches in rural areas. ■

VI. Impact on Access

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 (nine of 10) felt that initial access to behavioral health services was easier as a result of managed care reforms, but there was a widespread perception in seven of the states studied that it was more difficult to obtain care beyond a certain basic level and that accessing extended care services was more difficult. As shown on **Table 27**, 1997 findings with respect to initial access were not upheld in the 1999 sample. In 1999, respondents in only four states (all with carve out designs) reported easier initial access; in five states (four with integrated designs) initial access was judged by most stakeholders to be compromised by managed care reforms. The one exception among stakeholder groups was substance abuse respondents, who felt that initial access to substance abuse outpatient services was made easier by managed care reforms. However, as in 1997, extended care was widely perceived as more difficult to obtain under managed care systems as compared with previous fee-for-service Medicaid systems in the majority of states, with stakeholders in eight of the nine reforms reporting this to be the case. Thus, it appears that managed care may no longer be increasing initial access to services, even as it continues to aggravate access to extended care.

Table 27 Access					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
It is easier to initially access a basic level of behavioral health services	4	0	1	4	
Penetration rates have increased	3	1	1	1	3
It is perceived to be more difficult to obtain extended care services	4	4	1	0	

Where initial access to behavioral health services was deemed easier, this was attributed to such factors as expanding eligibility to cover more children, expanding the provider pool to make more providers available, adopting access standards governing timeliness of service delivery, and providing access mechanisms such as toll free telephone lines. In Pennsylvania, for example, contractual access standards require services to be provided within one hour for emergencies, within 24 hours for urgent care,

and within seven days for routine care. In Maryland–MH, respondents reported a dramatic increase in access with the managed care reform, attributed to more providers participating in the system, allowing 12 pre-approved unmanaged outpatient visits, and allowing multiple routes for accessing services (a toll free line to the ASO for referrals or direct access through providers).

Increased penetration rates in four states were cited as verifying improved initial access to care. In Nebraska, for instance, penetration rates were reported to have increased from 3/1000 to 7.5/1000 as a result of the managed care reform. (Of particular note is the fact that three states could not provide data on penetration rates, making it difficult for them to assess their stated goal of increasing access to care. Also, states with data on penetration rates cannot always disaggregate child and adolescent rates from those of adults.)

In the other five states where initial access was judged by stakeholders to be more difficult, a number of aspects of managed care systems were cited:

- The need to get a referral from a PCP in order to obtain behavioral health services.
- Prior authorization and other utilization management requirements that were not in force previously and that require substantial time and effort.
- Fewer providers in the system where providers have dropped out or declined to participate based on low rates, administrative burden, failure to meet credentialing requirements, and the like.
- Ineffective toll free access lines with callers often placed on hold for extended periods of time. (One respondent called the toll free number “1-800-Drop Dead.”)
- Increased level of severity of problems needed in order to be eligible for behavioral health services.
- Delays in obtaining appointments and often extensive wait lists for services, despite access standards.

In five states in the 1999 sample, stakeholders specifically mentioned that access to substance abuse services has suffered under managed care systems. In one state, the reform has resulted in a reduced number of substance abuse providers. In another state, stakeholders felt that the inexperience of PCPs and MCOs with substance abuse disorders and services created difficulties in obtaining appropriate and timely referrals for treatment, and unwieldy prior authorization processes have added much complexity. In this state, delays in obtaining appointments, assessments, and approval for substance abuse treatment reportedly are excessive. In a third state, stakeholders expressed concern that penetration rates for adolescent substance abuse services may be declining because of severe shortages of services for this population coupled with a lack of knowledge about substance abuse issues on the part of MCOs.

As in 1997, most stakeholders across states in the 1999 sample agreed that it is more difficult to obtain extended care services due to such factors as authorization processes and tighter controls on admission and length of stay in hospitals, residential treatment centers, and other services. In addition, the typical emphasis in managed care systems on short-term treatment was identified by many stakeholders as a major problem; some asserted that managed care systems often do not sufficiently consider or serve children needing more than brief treatment. In managed care systems, with lengths of stay in most

of the higher end services decreasing (such as in inpatient, residential, and even therapeutic foster care settings in some states), children with higher acuity reportedly are in lower levels of care that may not be equipped to handle them. Further, stakeholders noted that underdeveloped service capacities for home and community-based services mean that appropriate levels of care often are not available for youngsters, and wait lists for intensive community-based services may be extensive. It was also noted that limited reauthorization periods in some systems make it difficult to plan for extended care treatment needs and to treat individuals with serious and complex behavioral health disorders.

In line with findings from the 1999 sample, in some of the states included in the maturational analysis, stakeholders indicated that access has become even more difficult over the past several years, due to increased demand for services and inadequate service capacity, particularly for the more intensive service approaches. Some strategies to address access were described.

- In **Massachusetts**, a 1-800 Interactive Voice Response System was implemented that providers can call to get service plans approved. Plans are approved if they conform to diagnosis-driven protocols.
- In **Arizona**, timelines have been changed in a new contract to require that access be more timely, and access has been streamlined allowing clients to use the toll free line to request services and be linked with an appropriate provider or a member can go directly to a contracted provider to initiate services, eliminating the step of intake at the MCO level.

Access for Non-Medicaid Children and Other Subpopulations

Access for Non-Medicaid Children

An issue reported in four of 10 states in 1997 and three states in the 1999 sample (shown on **Table 28**) is dwindling resources to serve non-Medicaid children and adolescents. In these states, for youngsters whose family income is just above the eligibility cut-offs for Medicaid or SCHIP, or for those who have exhausted their insurance benefits, services reportedly are more difficult to obtain. As in 1997, respondents in these three states in the 1999 sample noted that increasing amounts of their state behavioral health budgets are needed to match dollars for the Medicaid population, to fund services for Medicaid recipients that are not covered in the managed care system, or, in some cases, to pay for services not considered to be medically necessary. As a result, fewer resources are left to support services to the non-Medicaid population. This was not reported as an issue in six of the nine reforms, however.

Table 28 Access to Behavioral Health Service for Non-Medicaid Children					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There are fewer resources to serve non-Medicaid children	3	0	2	4	

Among states identifying this as an issue, stakeholders in one state noted that access for non-Medicaid children is worse under managed care because dollars were diverted to the managed care system, leaving fewer resources available. Further, some families with commercial insurance felt that their insurance often fails to cover extended care or a particular type of service that is needed. Their perception is that the non-Medicaid children get “bumped to the end of the list” because of the state’s emphasis on and allocation of most of its resources to serving Medicaid-eligible children. Stakeholders in another state related that lower reimbursements to provider agencies under the managed care system precludes these agencies from subsidizing care for the uninsured and underinsured as they were able to under the previous system; they felt that the payment rates devised for the managed care system did not adequately account for the provider agencies’ overhead rates and for the degree to which they subsidize care to non-Medicaid eligible children.

In those states which did not report this problem, respondents generally pointed out that Medicaid eligibility levels were expanded to include many more children in the Medicaid program and that the State Child Health Insurance Program (SCHIP) has provided at least some behavioral health coverage for an additional population of children. This has reduced the population with no coverage for behavioral health care to some degree.

The maturational analysis confirmed that the SCHIP program is seen as a primary vehicle for addressing at least some of the needs of non-Medicaid children. When interviewed for the maturational analysis, stakeholders in at least six states in the 1997 sample stated that access for non-Medicaid children has increased somewhat due to the implementation of SCHIP, even though behavioral health benefits under SCHIP programs may not be as comprehensive as those provided through the Medicaid managed care system. In one state, for instance, the SCHIP mental health benefit is based on the public employees’ health plan and is a limited benefit more akin to a private insurance model. Similarly, the behavioral health benefit in another of these states includes limits on behavioral health services (such as 30 inpatient days, 30 outpatient visits, plus unlimited case management, and medication management). The implementation of SCHIP, while helpful, has not eliminated the problem of serving children who do not qualify for either Medicaid or SCHIP. In one state, the legislature allocated a substantial amount of behavioral health general revenue funds to SCHIP, leaving even fewer resources to serve children who do not qualify for either Medicaid or the SCHIP program. Thus, serving uninsured children and those who exhaust their commercial insurance has become even more difficult according to stakeholders in several states.

Examples of strategies used by states in the 1999 sample to address the needs of non-Medicaid (and non-SCHIP) children include the following.

- In **Colorado**, funds have been given to the CMHCs specifically to serve this population. Until recently, CMHCs were responsible for serving this population without any funding earmarked for this purpose.
- In **Maryland–MH**, non-Medicaid children receive services as part of the so-called “grey zone” population that is included in the mental health managed care system. Grey zone consumers extend beyond the Medicaid and SCHIP populations and are defined in documents as individuals who “because of severity of mental illness and financial need, the cost of medically necessary services will be subsidized” by the state.

Access for Other Sub-Populations

Access to behavioral health services for particular subpopulations of youth tended to be consistent with observations about access in general in each particular state. However, in discussing access issues, stakeholders across states (both in the 1997 and 1999 samples) tended to single out the child welfare and juvenile justice populations as experiencing proportionately greater challenges in obtaining needed care. There are some indications that access for the child welfare population has improved to some degree across sites. For example, children in the child welfare system are prioritized for services, automatically rising to the top of the list in several states.

In a number of states, service denials for youth with conduct disorder diagnoses were reported by stakeholders to be a significant problem, based on interpretation of medical necessity criteria by MCOs. Rigidity with respect to conduct disorder diagnoses disproportionately affects youth involved in the juvenile justice system. In addition, court-ordered services present a daunting challenge to managed care systems; services ordered by judges may not be considered by MCOs to meet medical necessity and/or level of care criteria in the behavioral health managed care system and cannot be guaranteed for pre-established durations. In one state, respondents noted that it is more difficult to get youth out of detention due to the difficulty in accessing appropriate services through the managed care system, thus compromising a primary avenue of help and diversion from more serious involvement in the juvenile justice system. In this particular state, judges reportedly are perceived to be more likely to commit youth to the juvenile justice system due to the difficulty in obtaining adequate treatment through the managed care system.

Fledgling efforts to address access problems related to youth in the juvenile justice system were identified in two states.

In the 1999 sample:

- In **Colorado**, contracts with the MCOs require that they have memoranda of understanding with youth corrections, specifying how they will serve this population and formalizing their responsibilities.

In the maturational analysis:

- Increased access for youth with conduct disorder diagnoses was reported in **Oregon**. Previously, the conduct disorder diagnosis was split into two categories (mild and severe), and the severe category was below the priority line for services, eliminating services for a large segment of the juvenile justice population. Under the latest iteration of priorities, all conduct disorders are under a single category that is above the priority line, leading to better access for youth in the juvenile justice system.

Access to Inpatient and Residential Services

Inpatient 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

Consistent with 1997 findings, and shown on **Table 29**, stakeholders in most states in the 1999 sample reported that inpatient services are more difficult to access as a result of managed care reforms (seven of nine reforms). Further, concerns about discharging youngsters prematurely from inpatient settings were expressed by respondents in nearly all (eight of nine) managed care systems studied in 1999. In both cases, more stringent admission and continuing stay authorization processes were seen as severely curtailing access and length of stay in inpatient settings.

Table 29 Access to Inpatient and Residential Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Inpatient hospital services are more difficult to access	3	4	2	0	
Children are discharged from hospitals prematurely	5	3	0	0	1
Increased recidivism rates were reported	2	2	3	1	1
Increased use of residential treatment was reported	3	0	2	3	1

Some respondents regarded the decreased use of hospitals (both admissions and length of stay) to be a positive change in service systems which, in their opinions, used inpatient services too routinely and where lengths of stay were regarded as excessive. The reduction in historic overutilization of inpatient services was seen as correcting a long-standing systemic problem. However, most stakeholders across states expressed concern that the shift away from inpatient care has become too dramatic, that inpatient services have become far too difficult to access, and that stays have become dangerously brief. Stories of two-day authorizations for hospital care were related by family members and providers in one state, for example.

Concerns about access to inpatient care applied to substance abuse treatment as well as to mental health. Stakeholders in several states noted that it is extremely difficult to access inpatient substance abuse services through the managed care system, which also was attributed to the difficulty of obtaining authorization and shorter lengths of stay. In one state, respondents noted that a psychiatric diagnosis is required for acute inpatient admission, even if the primary problem is substance abuse; continued stay is rarely, if ever, authorized for a chemical dependency diagnosis after five days of medical detoxification. In another state, a 14-day limit for inpatient substance abuse treatment was reported, and, according to stakeholders, consumers are discharged without sufficient treatment and not ready for step-down services (even where they exist). Because of the difficulty in obtaining authorization for inpatient substance abuse care, respondents in yet another state indicated that only two inpatient substance abuse programs remain in existence of the seven that were available pre-managed care reform.

A major concern with respect to reduced access to inpatient service is the lack of sufficient capacity to provide home and community-based services as alternatives. Although the availability of home and community-based services reportedly is increasing, in a number of states, stakeholders observed that alternatives to inpatient care were not sufficiently developed prior to reducing admissions and lengths of stay, which they cited as an example of poor strategic planning on the part of states.

As in 1997, a range of problems were associated with reduced inpatient access and with premature discharge from hospitals:

- Children are discharged prior to stabilization and return to the community in highly vulnerable conditions.
- Children may be overmedicated so that they can be discharged from hospitals after very brief stays.
- Readmission rates have increased due to the reduced lengths of stay and children leaving hospitals in a fragile state (reported in four states in the 1999 sample).
- In some states, increased use of residential treatment was associated with the lack of access to inpatient care (reported in three states in the 1999 sample).

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. Child welfare respondents noted that child welfare is forced to pick up the cost of continued hospital stays or to transfer children to residential treatment centers when the managed care system's judgment is that care is no longer medically necessary.

The maturational analysis suggests that the problems associated with access to inpatient care have continued and perhaps 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; in some states, inpatient services reportedly are denied unless a child is homicidal or imminently suicidal, and charges persist that children are discharged prior to stabilization, exceeding the ability of providers in the community to serve them.

Few efforts to address access to inpatient services were identified either in the 1999 or maturational samples.

In the 1999 sample

- In **Maryland–MH**, discharge reportedly is not forced if there is no established follow-up plan, and children without a placement can remain in a hospital setting at a reduced administrative rate beyond the period that they are judged to no longer meet medical necessity criteria.

In the maturational analysis:

- In **Utah**, the state has been working to clarify when inpatient services are indicated. If inpatient care is denied, a written explanation of the reasons are required and MCOs are required to offer alternative care.
- **Iowa's** contract with the MCO requires follow up within 72 hours when inpatient admission is denied and alternative services and contacts must be provided. Hospital discharge requirements include a detailed discharge plan and facility monitoring of discharge plan implementation.
- **Connecticut** has adopted risk sharing with the MCOs for hospital stays for children in child welfare.

Residential Services for Mental Health Treatment

In half of the states in the 1999 sample, stakeholders highlighted the issue of access to residential treatment as a problem area with respect to their managed care systems. The consensus in these states is that access to services in residential treatment centers (RTCs) has become more difficult due to more rigorous standards for admission, greater scrutiny of the need for residential treatment by MCOs, and increased documentation needed to support the need. More frequent scrutiny of continued need for children in RTCs also was reported, as well as reduced lengths of stay. In some states, respondents agreed that access to residential treatment was too easy in the past and that this level of care had been overutilized. However, many felt that the pendulum has swung too far in the direction of curtailing these services under managed care. As in 1997, stakeholders expressed concern about eliminating longer-term residential treatment as an option under managed care systems. While acknowledging previous overuse and inappropriate use of this level of care in the past, they emphasized that this level of care may be clinically appropriate in some cases.

A particular concern cited is that capacity in home and community-based services has not been sufficiently developed in many states to meet the needs of youngsters diverted from RTCs or discharged after shorter lengths of stay. One respondent called it “naive” to tighten up on RTC admissions in the absence of alternatives. It was also characterized as dangerous to discharge youngsters after short stays in RTCs without appropriate step-down services to promote stabilization and to generalize treatment gains to the community. In many states, such step-down services and community-based supports are reportedly inadequately developed.

In Colorado, RTC dollars were excluded from the managed care system due to the concern that MCOs would curtail admissions or reduce length of stay too severely, creating particular problems for children involved with the child welfare system. However, many stakeholders now believe that RTC dollars should be included in the managed care system for a number of reasons, including potential cost shifting.

In one state, a review process was adopted to monitor access to residential treatment services.

- In **Pennsylvania**, MCO denials of residential treatment must be reviewed by the state mental health agency. Respondents reported that the state finds for the MCO in about 20% of the cases, overturns denials in about 60% of the cases, and modifies the service package in about 20% of the cases.

The maturational analysis revealed that stakeholders in most states continue to regard access to residential treatment as problematic. Complaints include fewer RTC beds available, onerous and cumbersome approval processes for this level of care, infrequent authorization of residential treatment by MCOs (even though this service is part of the benefit), long waiting lists for residential treatment, and difficulty in obtaining longer-term residential treatment even when judged to be clinically appropriate.

Residential Services for Substance Abuse Treatment

Hypothesis: In most states, managed care will make it more difficult to access adolescent substance abuse treatment in longer-term, residential settings.

Finding: Upheld

In 1997, respondents in most states reported that residential services for youth with substance abuse services were more difficult to obtain than before managed care reforms. While previously scarce, these resources reportedly became even more difficult to access due to the emphasis within managed care systems on reducing the use of residential services. Consistent with 1997 findings, and shown on **Table 30**, respondents in five of the seven states including substance abuse indicated that adolescent substance abuse treatment in residential settings is more difficult to access, particularly for longer-term stays, as a result of managed care reforms. The problem appears to be more pronounced in managed care systems with integrated designs as compared with carve outs; the issue was identified in all of the states with integrated designs.

Table 30					
Access to Residential Substance Abuse Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Adolescent substance abuse treatment in longer-term residential settings is harder to access	1	4	2	0	2

In one state, respondents reported that residential substance abuse services, other than detoxification, are not covered in the managed care system at all, leaving the state substance abuse agency (and, in some cases, child welfare and juvenile justice agencies) to assume the costs for these services to the extent possible. In other states, these services were characterized as extremely difficult to access due to more stringent authorization requirements and drastically reduced lengths of stay, with frequent and strict continued stay reviews. Juvenile justice respondents in particular complained about the lack of authorization for residential substance abuse treatment for adolescents through managed care systems. The problem is compounded by the fact that alternative substance abuse treatment services for adolescents are poorly developed across states, leaving many youngsters without any appropriate interventions.

Development of New Alternative Services

In 1997, half of the states in the sample reported developing new levels of care to provide alternatives to inpatient care. Crisis alternatives, such as crisis stabilization units and other subacute levels of care, were among the service approaches that appeared to be evolving as access to inpatient services was curtailed and length of stay decreased. The trend toward the development of such alternative services is even more pronounced in the 1999 samples. Stakeholders in eight of the nine reforms noted the development of new levels of care for this purpose, as shown on **Table 31**.

Table 31 Development of New Alternative Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
New levels of care are developing as alternatives to hospitalization	5	3	0	1	

A range of services are emerging as community-based alternatives to hospitalization, most commonly, 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. Five states in the maturational analysis of the 1997 sample also noted further development of these services in an attempt to provide alternatives to inpatient care. Examples include the following.

In the 1999 sample:

- In **Maryland–MH**, crisis services have been growing as a hospital diversion strategy. In many areas, crisis beds and mobile crisis response teams are developing. For example, Baltimore is developing a new crisis response system to include 24-hour triage, emergency mobile crisis response, and crisis beds.

In the maturational analysis:

- In **Utah**, some CMHCs have developed observation and evaluation units which typically are short-term residential programs for evaluation and assessment; in some places, they include sub-units that provide 24 to 48 hour stabilization services. Some of the programs are jointly funded with juvenile justice and/or child welfare agencies and are used to reduce the use of both inpatient and residential services.

Access to Other Services

Access to Specific Types of Services

As in 1997, stakeholders in a number of states in the 1999 sample indicated that outpatient services are easier to access as a result of managed care reforms. Although respondents in several states felt that home and community-based service options are easier to access as well, this observation was nearly always qualified by concerns about uneven service capacity for these types of services, making access variable across service areas, and about demand that exceeds current ability to provide care.

According to stakeholders, access to certain other types of services has been impaired by managed care reforms (beyond inpatient and residential care, as previously discussed). Psychological evaluations were seen as particularly difficult to obtain across states; child welfare respondents reported that child welfare funds often are used to pay for psychological evaluations that were previously covered under Medicaid fee-for-service systems. Psychiatric evaluations were also singled out as a type of service that is more difficult to obtain. In general, stakeholders indicated that prior authorization and other utilization management processes, coupled with lack of service capacity, complicate access across the service continuum.

Psychotropic Medications

A number of problems were expressed by stakeholders related to obtaining prescription medications. Issues related to this were raised by respondents in five states in the 1999 sample, and by two states in the maturational analysis. Problems were attributed to:

- Preauthorization requirements
- Restricted formularies that do not cover certain medications
- MCOs' not stocking particular medications
- Lengthy delays in waiting for authorization of prescription refills
- Denial of brand name drugs in favor of generics regardless of physicians' orders
- Pharmacies denying a physician's prescription because the drug is not on the plan's formulary
- Difficulty in getting children qualified for high-cost medications
- Inappropriate psychotropic medications prescribed by PCPs
- Requiring that psychotropic medications be obtained through the physical health MCOs and not the behavioral health carve out

The maturational analysis revealed an attempt by only one state to address problems related to access to psychotropic medications.

- In **Massachusetts**, guidelines have been developed by the state for prescribing and purchasing psychotropic medications through the managed care system. ■

VII. Impact on Children with Serious Disorders and Systems of Care

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

Throughout the Tracking Project, findings have consistently confirmed a lack of focused attention to the needs of children and adolescents with serious behavioral health disorders. Only two of nine reforms studied in the 1999 Impact Analysis sample (MD-MH and OK) reportedly had dedicated planning processes that considered the special needs of this group (shown on **Table 32**). Similarly, only two of the 10 states in the 1997 sample reported having a specific planning process around this population.

Also shown on **Table 32**, only one state in the 1999 sample reportedly has incorporated differential benefits in their managed care system (OK) to address the distinctive clinical needs of the population of youngsters with the most serious and complex disorders. This finding represents a decline from the 1997 sample in which 40% reportedly incorporated some differential benefits for this group. Further, stakeholders in only four states in the 1999 sample indicated that special management mechanisms are incorporated to manage care for children with serious disorders. Thus, the hypothesis that most states will not have dedicated planning, different/enhanced benefits, or special provisions in their managed care systems for this high-need population was upheld.

Table 32 Children and Adolescents with Serious Disorders					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There was a specific planning process for children and adolescents with serious disorders	1	1	4	3	
There are differential benefits for children and adolescents with serious disorders	0	1	5	3	
Special management mechanisms are incorporated to manage care for children with serious disorders (high utilizers)	3	1	2	3	

The results of the 1997–98 State Survey present a similar picture in this area, with just under half of the reforms nationally (49%) indicating that differential coverage and/or special service management provisions for children and adolescents with serious disorders are incorporated into their managed care systems; reforms with carve out designs were twice as likely to do so as those with integrated physical-behavioral health designs.

In some cases, the rationale provided by stakeholders for not including special benefits for children with serious disorders is that the managed care system is designed to provide whatever services are needed by any individual child and adolescent, guided by medical necessity and other clinical decision making criteria. For example, the Maryland-MH carve out has no special benefits; respondents indicated that the goal in designing the system was to keep it simple and available to everyone based upon need, with no artificial barriers or benefit limits. Similarly, no special benefits are incorporated in Pennsylvania, where RFPs and contracts place a high priority on services to children with or at risk for serious behavioral health disorders, or in Colorado where MCOs are expected to provide whatever is needed for each child. In these states and others, the services covered in the benefit design are intended to be sufficiently broad to address the needs of those with serious disorders. Theoretically, then, children in these systems should not need “special” benefits — their needs should be met if the system functions as intended.

Even in some of the states without different benefits, however, special provisions were incorporated to manage care for this group. In the four reforms reporting having special management provisions, the mechanisms described included more intensive case management and local interagency treatment and service planning (PA, MD-MH, and NE) and the special level of care designation created for individuals with serious disorders in Oklahoma that includes both an enhanced benefit and special management mechanisms.

Some specific strategies for addressing the needs of children and adolescents with serious disorders identified in the 1999 sample include the following.

- In **Oklahoma**, a Special Behavioral Health Needs (SBHN) level of care was created that includes an enhanced benefit (for both mental health and substance abuse services) for children and adults who are high service utilizers. Each MCO must create a full-time staff position dedicated to SBHN whose role is to oversee treatment planning for enrollees in this level of care.
- In **Nebraska**, Regional Clinical Coordinators employed by MCOs do case planning for individuals who are identified as high utilizers and also become involved when a case becomes challenging in some way.

Despite the use of either different benefits or special management mechanisms in some states, a number of problems or barriers to providing services to children with serious disorders were noted in many states:

- Medical necessity and other clinical decision making criteria are rigid or are interpreted and applied too stringently, thus making it difficult for children with serious disorders to obtain approval for admission to (or continuing services within) intensive service options.
- MCOs often do not participate in local interagency treatment and service planning processes for children with serious behavioral health disorders. In many states, these service planning processes occur outside the managed care system, and MCOs are not required to be represented, nor are they required to provide or pay for behavioral health services that might be recommended by the service planning team.
- Managed care systems may include unintended financial incentives to underserve consumers with the most serious (and potentially the most expensive) service needs—children and adolescents with serious behavioral health disorders are seen as one of the most expensive populations to serve.
- There is a tendency within many managed care systems to emphasize short-term treatment. Some stakeholders asserted that managed care systems are inherently more effective for a commercial-type population with minimal behavioral health needs and are less responsive and appropriate for a high utilizer population with serious disorders. (One respondent stated that the MCOs look at children with serious disorders and long-term needs as “cases that should be better in three months.”)

The maturational analysis found that two states have initiated planning processes focusing on the needs of children and adolescents with serious disorders and their families since the time of the 1997 site visits. Beyond additional planning, however, no changes in the benefits or management of services for this challenging population were identified in the 1997 sample update.

- In **Rhode Island**, a work group was created to consider the needs of children with serious behavioral health disorders within the managed care system, and a Leadership Roundtable on Children with Special Needs was created by the Medicaid agency.
 - In **Arizona**, significant planning for this population has resulted from a lawsuit representing a class of Medicaid-eligible children. The planning process is resulting in greater emphasis on extended care services for children with serious behavioral health disorders and on working with other child-serving systems to meet their multiple needs.

Overall, the Tracking Project has found 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.

Systems of Care

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

An important focus of the Tracking Project was to assess the link between efforts to develop community-based systems of care for children and adolescents with serious behavioral health disorders and their families and managed care initiatives in states. As in 1997, most states in the 1999 sample did not use managed care reforms as a strategic opportunity to advance system of care development, shown on **Table 33**. Respondents in only three states in the 1999 sample (MD-MH, PA, and CO) reported that the managed care reform was used deliberately and planfully to advance the goal of developing community-based systems of care in communities across the state. Similarly, only three of 10 states in the 1997 sample reportedly used this reform to advance a system of care development agenda.

Table 33 Systems of Care					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Managed care reform has been used as a strategic opportunity to advance system of care development	3	0	2	4	
Some system of care principles are incorporated as requirements in the managed care system	4	2	1	2	
Managed care reform has generally supported/facilitated local systems of care	4	0	1	4	

Examples of the use of managed care reforms to cultivate the growth of systems of care can be found in Pennsylvania and Maryland–MH.

- In **Pennsylvania**, the movement to managed care included a major focus on system of care-related issues. For example, the performance monitoring system incorporated in the state's managed care system includes indicators related to system of care principles, and readiness reviews and compliance monitoring provide opportunities to determine whether system of care goals are being implemented. The state also uses its CASSP Training Institute to train MCOs and providers about system of care goals in the managed care system.
- In **Maryland–MH**, respondents indicated that the state's managed care planning was informed by earlier system of care demonstrations and that the system of care approach was seen as the direction in which to take the entire mental health system. One respondent called the managed care reform a “massive, spectacular, strategic opportunity” in that most mental health resources in the system became consolidated under the control of the Mental Hygiene Administration (MHA), enabling MHA to shift the system in the desired direction. The state built system of care services into the managed care system, including billing codes for the wide range of services and supports associated with the system of care philosophy. Consultants were also brought in to teach system participants about the system of care philosophy and services.

Incorporation of System of Care Principles

Although only a few states used managed care reforms as a strategic opportunity to further develop systems of care, more than half of the reforms in the 1999 sample (six of nine) 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 (four of the five carve out reforms did so), but some inclusion of system of care principles was also observed in two of the reforms with integrated designs. 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. One state (PA) took this further and developed monitoring mechanisms that are tied to system of care principles.

- In **Pennsylvania**, RFPs and contracts require incorporation of system of care values and principles, and the state performance monitoring system has indicators tied to these system of care principles. In addition, the state's Readiness Assessment Instrument incorporates criteria tied to system of care principles.

The finding from the 1999 study in which more than half of the states incorporated system of care principles confirms 1997 Impact Analysis results in which half (five of ten) of the states in that sample, all with carve out designs, reportedly incorporated some system of care values and principles as requirements in their managed care systems. Interestingly, however, the impact analysis results in this area from both 1997 and 1999 differ substantially from the results of the 1997–98 State Survey. In the all-state survey, all of the carve out reforms and more than half of the integrated reforms (a total of 85% of the reforms studied) reportedly were “building on their previous efforts to develop systems of care” as they developed their managed care systems, and nearly 80% of the reforms reportedly incorporated system of care values and principles in their systems (such as broad service array, family involvement, individualized care, interagency treatment planning, case management, and cultural competence). The discrepancy may be due to the fact that state agency representatives completed the state survey, while the impact analysis process incorporated the perceptions of an extensive group of stakeholders with differing perspectives about the how managed care reforms have played out in their states and communities and the effects they have experienced.

The maturational analysis found little change related to managed care reforms and systems of care. In Rhode Island, respondents indicated that the Medicaid agency now has a better understanding of the system of care concept and philosophy, although no operational changes have resulted as yet. In three states, specific advances were noted.

- In **Connecticut**, a new memorandum of understanding was developed between the Department of Child and Family Services and the health plans that includes language related to system of care values and principles.
- In **Utah** and **Oregon**, new grants from the federal Comprehensive Community Mental Health Services for Children and their Families Program were obtained, both bringing greater attention and commitment to the system of care concept and philosophy and how to put this into practice in the context of their managed care systems.

Effects on Local Systems of Care

Regarding effects on local systems of care, in four of nine reforms (all with carve out designs—CO, PA, MD-MH, and NE) stakeholders felt that managed care reforms have generally supported or facilitated the development of systems of care in local communities (**Table 33**). The basis for this assessment generally was that managed care reforms have allowed for coverage and payment for services that are linked to the system of care philosophy and have created incentives for the development and use of these services. In Nebraska, for example, the managed care reform has reportedly expanded the array of services, promoting the development of intermediate services and encouraging the use of community-based rather than institutional service approaches. In Pennsylvania and Maryland-MH, the array of covered services was expanded to include a broad array of community-based approaches, believed to support and facilitate systems of care. In addition to expansion of the service array and incentives to use community-based approaches, some states have incorporated other features considered to be supportive

of local systems of care. Each Pennsylvania county, for instance, is supposed to have a children's system coordinator and interagency collaboration at both the system and service levels, as well as a broad array of services.

Although managed care reforms were seen as generally supporting systems of care in these four states, considerable regional variation was noted. Stakeholders across states (both in 1997 and 1999) speculated that such regional variation is based on the degree of local commitment to the system of care approach and on the existence of a well-developed system of care infrastructure when managed care is introduced. In those areas where the system of care philosophy and approach was already entrenched, the managed care initiative reportedly was more likely to build on this history and to implement managed care processes in a way that complements, supports, and further develops these systems of care. A study of effects of managed care on systems of care in communities funded by the federal Comprehensive Community Mental Health for Children and their Families Program came to similar conclusions.³ Specifically, 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.

In 1997, stakeholders in some states in that sample felt that managed care reforms impeded system development, based on their assessment that the design and features of the managed care system were discrepant with the system of care philosophy and approach. In the 1999 sample, similar judgments were expressed by respondents in several states (all states with integrated physical-behavioral health designs). In one state for example, the managed care system was described as traditional and medically driven. Stakeholders in this state felt that system of care development efforts have been "derailed" and priorities shifted to surviving in the competitive managed care environment. In another state, system of care development efforts are separate from the managed care system and operate with Medicaid fee-for-service dollars and other resources. The interface between existing systems of care and the managed care system was described by most stakeholders as problematic, with opportunities for cost shifting, fragmentation, and confusion for families. ■

³ Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998). *Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program — Special Study on Managed Care*. Atlanta, GA: Macro International, Inc.

VIII. Impact on Family Involvement

Family Involvement at the System Level

Family Involvement in Planning and Oversight

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

Findings: Unclear

Findings from the 1999 Impact Analysis are mixed regarding this hypothesis. Findings from previous Tracking Project activities that indicated a trend toward increasing system-level family involvement in managed care reforms were not strongly upheld in the 1999 sample. As shown on Table 34, according to stakeholders in the 1999 sample, families were involved in the early stages of planning for the managed care reforms in three reforms, all of which have carve out designs. With respect to current levels of family involvement in system planning, oversight, and refinement, stakeholders reported that family involvement had increased in two reforms but had decreased in one reform. Thus, only a very slight increase in system-level involvement of families (from three to four reforms) was reported from the initial stages of implementation of managed care systems to current operations; it would be difficult to characterize this as a “trend.”

Table 34 Family Involvement in Managed Care Reform at the System Level					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Families were initially involved at system level	3	0	2	4	
Families are currently involved at system level	4	0	1	4	
There are requirements for family involvement at the system level	3	0	2	4	
There are supports for family involvement at the system level	2	0	3	4	
Training is provided for MCOs and providers on family involvement	1	0	4	4	

In comparison, however, a trend toward increasing system-level family involvement was very evident in the 1997 Impact Analysis sample. Stakeholders reported that families initially were involved at the system level in only one state, but that families were currently active in system planning in nearly all states (nine of 10) — a significant improvement over

time in family involvement at the system level, leading to the prediction that a similar trend would be found in the 1999 sample. Further, the maturational analysis found that family involvement at the system level has reportedly increased significantly over time in eight of the 10 states in the 1997 sample. The 1997–98 State Survey also explored family involvement at the system level in managed care planning and implementation, also revealing increasing family involvement over time in managed care systems. States reported that families had significant involvement in initial planning in 28% of the reforms (significant involvement was far more likely in systems with carve out designs); significant family involvement in current system planning and refinement reportedly increased to 38% of the reforms (also much more likely in carve outs — 47% as compared with 13% of the integrated reforms).

Thus, a trend toward increasing family involvement in system level planning, oversight, and refinement activities was far more clear in the 1997 sample and 1997–98 State Survey than in the 1999 Impact Analysis sample. Since family involvement at the system level is far more likely in reforms with carve out designs, the oversampling of carve out reforms in the 1997 sample may partially explain the larger effect. Overall, however, results suggest that the involvement of families in managed care reform planning and implementation is increasing, but at a slow rate. For example, there is a higher proportion of states with *initial* family involvement at the system level in the 1999 sample than in 1997. In addition, the 1997-98 State Survey suggests that family involvement increases as managed care reforms mature. On the other hand, over 60% of the states in the 1997–98 State Survey and five of the nine reforms in the 1999 Impact Analysis reportedly still lack current significant family involvement in their reforms.

One indicator of the incremental progress being made in family involvement at the system level is the number and types of examples that respondents identified as methods that their reforms are using to include family members. Previously, the data from the 1997 sample and the 1997–98 State Survey indicated that the most common approach was to involve families as members of various state advisory structures to the managed care reform. While this remains true, respondents in the 1999 sample and in the maturational analysis also identified several examples of where family involvement has been institutionalized in the ongoing operation and monitoring of managed care reforms.

In the 1999 sample:

- Families in **Pennsylvania** participate in the state’s readiness assessment process for counties and in ongoing monitoring and evaluation activities.
- In **Maryland–MH**, families serve on the advisory committee for the Administrative Service Organization.

In the maturational analysis:

- In **Iowa**, parents are members of the clinical advisory committee of the MCO. The MCO has hired a full-time parent advocate who is working to expand family input.
- In **Rhode Island**, the state Medicaid authority has hired a parent advocate and conducts periodically a survey of parents of children with special needs enrolled in the managed care reform.

Requirements for Family Involvement

Respondents reported that three of the nine reforms in the 1999 sample (all carve outs) incorporate requirements for family involvement at the system level (**Table 34**). This represents an improvement from the 1997 sample in which only one of the 10 states reported requirements for family involvement at the system level. Specific examples of requirements for system-level family involvement were identified in Pennsylvania in the 1999 sample and in one state in the maturational analysis that indicated improvement in this area, Utah.

In the 1999 sample:

- **Pennsylvania** policymakers incorporate several requirements for family involvement in the RFP and in the Readiness Assessment Instrument used to gauge county readiness for managed care. Families are required to be involved in: program oversight, quality assurance, development of member handbooks, development of satisfaction surveys and participation on consumer satisfaction teams, and participation in decisions on how reinvestment dollars are used.

In the maturational analysis:

- **Utah** incorporated a new requirement for families to be members of the quality monitoring teams that monitor the MCOs.

Preparation and Facilitation of Family Involvement

Preparation and facilitation of family involvement at the system level includes training for family members on managed care reforms as well as payment for family members' time, transportation, and child care expenses. Stakeholders in only two of the nine reforms included in the 1999 sample reported that supports are provided to family members for their participation. These results are similar to the 1997 Impact Analysis where few instances of support for family members' participation were identified.

There were improvements within the 1997 sample identified through the maturational analysis.

- Parents have been hired in five states (**IA, MA, RI, OR, and WA**) to prepare and support parents for system-level involvement.
- In **Utah**, a number of resources are used to provide training for families to prepare them for system-level involvement, and some payment is available to families for their participation.
- Parents in **Rhode Island** are paid \$15 per meeting for participation in the Consumer Advisory Council.

Overall, stakeholders in both the 1997 and the 1999 samples reported that the managed care systems offer few supports to family members to facilitate their involvement in system level planning and oversight activities; some progress was noted over time through the maturational analysis of the 1997 sample.

Training for MCOs and Providers on Family Involvement

According to respondents, only one state in the 1999 sample provides training on family involvement for its MCOs and provider networks (**Table 34**). These results are similar to the 1997 sample in which only one of the 10 states offered training on family involvement. According to the stakeholders interviewed for the maturational analysis little progress has been made in these states on this issue. An example of training on family involvement was identified in Pennsylvania.

In Pennsylvania, family organizations in two counties have been involved in educating the MCOs about system of care values and principles, including family issues and concerns. In Delaware County, for example, the family organization conducted a three-day training program for the MCO and repeats it annually for any new MCO staff.

Family Involvement at the Service Delivery Level

Family Involvement in Planning Services

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.
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Finding:	Upheld
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Both document reviews and the reports of key stakeholders indicated that there are requirements for family involvement at the service delivery level incorporated into seven reforms (five carve outs and two integrated systems) in the 1999 state cohort (**Table 35**). These results are similar to the 1997 sample in which most states (eight of 10 — all carve outs) included family involvement mandates at the service planning level. One difference in the results between the two samples is that in the 1999 sample, two states with integrated physical health/behavioral health designs included requirements for family involvement; no integrated systems included these requirements in the 1997 sample.

Table 35 Family Involvement at the Service Delivery Level					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There are requirements for family involvement at the service delivery level	5	2	0	2	
Reform has supported family involvement in planning services for their own children	3	0	2	4	
Focus of services is on the identified child rather than on the family	5	4	0	0	

However, even in the states where there are such requirements for family involvement, many respondents reported that the implementation is spotty and variable from provider to provider. These observations are further supported by stakeholder reports that, in the 1999 sample, managed care generally facilitates and supports family involvement in service planning in only three states (**Table 35**). This finding represents a substantial decrease from the 1997 sample, in which six of the 10 states reported that their reform facilitates family involvement in treatment planning. Thus, while requirements for family involvement in service planning are included in managed care systems in most states in the 1999 sample, managed care is not perceived as facilitating or supporting such involvement in most states, and actual family involvement in service planning is variable among MCOs and providers, even when required.

The maturational analysis found that this is an area that states in the 1997 sample are addressing, both with respect to requirements for family involvement and strategies to increase its occurrence.

- **Arizona** has added contract language requiring family involvement. Families in Arizona report that there is now an expectation of family involvement in treatment planning within the MCOs.
- In **Delaware**, the Medicaid office now requires that primary care physicians be trained in child abuse and neglect and in the roles of natural and foster families. Child welfare stakeholders reported that physicians are more willing to involve both foster families and natural families in treatment planning as a result of this training.
- MCOs in **Utah** have been provided with training and technical assistance on family involvement in service planning, and the Medicaid office plans closer monitoring of compliance with the requirement for family involvement in service planning.
- In **Iowa**, the MCO's contract ties incentives to a specific rate (96% minimum) of consumer/family involvement in treatment planning meetings.

Extent of Family Focus of Services

The perceptions of stakeholders in all nine managed care reforms studied during the 1999 Impact Analysis is that the focus of services in managed care systems is limited to the identified child, and that family needs typically are neither considered nor addressed. This finding suggests even less family focus in service delivery than found in the 1997 sample; respondents in half of the states in the 1997 samples (five of 10) reported that the focus of services was limited to the child, rather than the entire family. Stakeholders in both 1997 and 1999 emphasized that the lack of family focus in services was due, in part, to the application and interpretation of medical necessity criteria by the Medicaid office and/or MCOs. Additionally, respondents felt that, for some MCOs, “family focus” is translated as the need for family therapy, rather than broader consideration of families’ strengths and needs for services and supports in caring for a child with behavioral health problems. Some exceptions were noted.

- In one region in **New Mexico**, automatic authorization of several family sessions is offered when individual therapy is approved for a child.
- In **Maryland’s** mental health carve out, a billing code for family intervention (without the child present) is included, as is a reimbursement mechanism for multifamily education and support groups.

The perception of respondents in several states in the maturational analysis was that a family focus in treatment planning and service delivery has increased somewhat.

- The MCOs in **Delaware** reportedly are more willing to consider services for the entire family, especially families in the child welfare system, due to the realization that the family focus will likely result in better outcomes and lower costs.
- In **Utah**, a parent mentor program has been initiated that is offered to families when their child enters treatment. The program provides information, support, and encouragement to families to remain involved in services.
- **North Carolina** added a “family intervention” code to its Medicaid system.

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. Stakeholders also noted that family-run programs did not exist prior to the managed care reform and continue to be a rarity. 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. Only two of the managed care systems included in the 1999 sample reportedly use families or youth as paid staff, Colorado and Pennsylvania.

- In **Colorado**, the new MCO contract has an added requirement that the MCO hire a parent of a child with mental health problems as a paid staff member.
- In some counties in **Pennsylvania**, family members and youth are paid to participate on family satisfaction teams. In addition, one county pays family members to be involved in provider profiling and quality improvement processes.

These findings are consistent with findings from the 1997 sample. According to stakeholders, managed care reforms had no impact on the pre-existing lack of family-run programs in all 10 states in the sample, and there were few examples of parents being hired in staff roles. However, some progress was noted in the maturational analysis in the area of hiring parents as staff.

- In **Rhode Island**, the Medicaid authority has hired a parent advocate to work in the Medicaid office.
- In **Utah**, the first group of parents is being trained as case managers. Once they are certified, the parent case managers will be part of the pre-paid mental health plan.
- In **Iowa**, the MCO has hired a parent advocate and reportedly strongly supports her role of increasing parent involvement.

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 study support the hypothesis that, in most states, managed care will not increase family financial burden. As **Table 36** indicates, the perception of stakeholders from six of the nine reforms is that the reforms have not increased the financial burden on families eligible for Medicaid. These results are similar to the 1997 sample; reportedly, financial burden on families increased in only two of the 10 reforms studied.

Stakeholders were also asked whether they believed that family financial burden has decreased as a result of the managed care reform. Again, the results are similar in both samples. In the 1999 sample, as shown on **Table 36**, respondents from two reforms, reported that financial burden on families has decreased for families eligible for Medicaid. Similarly, in two of the 10 reforms included in the 1997 sample, stakeholders reported that financial burden had decreased as a result of the reform. Several respondents across sites in the 1999 sample observed that financial burden for many families 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.

Table 36					
Impact on Family Financial Burden					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Financial burden on families has increased	2	1	3	3	
Financial burden on families has decreased	2	0	4	3	

There were a few isolated reports of financial burden increasing for families as a result of decreasing lengths of stay in residential treatment. Family participants noted that family financial burden can be increased in two ways when the length of stay in residential treatment is curtailed—families sometimes either have to pick up the cost of care for extended periods, or one parent must stay home from work, or miss work, to care for a child who is discharged home without necessary supports. In addition, families reported that they sometimes must pay for services or psychotropic medications that are not covered in the benefit package.

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. In the five states where this was identified as a pre-existing problem, stakeholders in only two perceived that managed care has intensified the problem of custody relinquishment in order to obtain needed but expensive treatment for their child. In one of these systems, there was strong consensus among stakeholders that the reform had increased the practice of parents needing to surrender custody of their children to the child welfare system in order to receive long-term residential care. In three additional states, participants reported that relinquishing custody in order to receive needed treatment was a pre-existing problem, but that the problem has not been made any worse by the introduction of managed care.

In comparison, stakeholders in half of the states in the 1997 sample indicated that managed care reforms had, in fact, exacerbated the problem of custody relinquishment. According to the maturational analysis, little change has occurred regarding this issue in the first cohort of states.

In several states, stakeholders explained why custody relinquishment to obtain services is not a problem. In two states, respondents reported that custody surrender is not necessary because Medicaid pays the cost of residential treatment, and, even if a child is uninsured, the child becomes eligible for Medicaid as a family of one if this level of care is needed. In some states, parents can do a voluntary placement without giving up full rights to their child. It should be noted that the perception of stakeholders in some states was that the number of voluntary surrenders has increased, although there were no data to substantiate this claim. In addition, some states have passed legislation to prohibit custody relinquishment solely for the purpose of obtaining services. ■

IX. Impact on Early Identification and Intervention

Identifying Problems Earlier

Hypothesis: Managed care reforms will not result in improved early identification and intervention for behavioral health problems, even if EPSDT is incorporated into the reform.

Finding: Upheld

As in 1997 and as shown on **Table 37**, stakeholders in most reforms (six of nine in the 1999 sample) reported that managed care reforms have had little or no effect on the ability to identify and intervene in mental health and substance abuse problems in children and adolescents at an earlier stage. This remains the case despite the fact that in most of the reforms studied (eight of nine), stakeholders reported that the Early Periodic Screening Diagnosis and Treatment Program (EPSDT) is incorporated into the managed care reform in some manner. Respondents across states agreed that managed care theoretically should result in catching behavioral health problems earlier and in more timely referrals for specialty care since all children are assigned to PCPs who are required to perform periodic screening. In addition, managed care theoretically should create incentives to catch problems earlier in order to avoid more serious problems and costs in the future. Similar to 1997 findings, however, these incentives appear to be more operative with respect to physical health services and have not as yet had a significant impact on earlier identification of behavioral health problems.

Table 37					
Family Identification/Intervention					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Reform has had little or no effect on early identification and intervention for behavioral health problems	4	2	1	2	
EPSDT is incorporated into the managed care system	4	4	1	0	
EPSDT is not perceived as an effective vehicle for early identification of behavioral health problems	4	4	0	0	1

Stakeholders cited a number of factors that have likely contributed to the negligible effect of managed care reforms on catching behavioral health problems earlier:

- Capitation financing creates disincentives for identifying problems, i.e., case finding, and thus being obligated to provide services. Further, contracts with MCOs typically are not for sufficiently long durations for them to anticipate reaping any cost savings by providing services earlier and preventing more serious problems from developing.
- PCPs may resist conducting screens, even if such screening is required upon entry and/or at specified intervals, and even if particular screening tools are required, because of the time and cost screening involves. PCPs may be penalized by MCOs for spending “too much time” with patients or for referring to specialty providers, further reducing their incentive to conduct behavioral health screens, which add time to the screening process.
- In many cases, screening tools that are used have weak, if any, components focusing on mental health and substance abuse issues.

In one state, it was reported that all adolescent and adult members of MCOs must be screened at least once for substance abuse problems by ascertaining their history of substance use and using a standardized instrument such as the Alcohol Use Disorders Identification Test (AUDIT), the Substance Abuse Screening and Severity Instrument (SASSI), or the CAGE (a guideline and mnemonic for quickly assessing a patient’s relationship to alcohol). In addition, written policies for the managed care system include an extensive list of behavioral health problems (both mental health and substance abuse) which should serve as a basis for PCPs to refer individuals for specialty behavioral health care. Despite these measures, compliance remains unclear, and stakeholders in this state and others expressed skepticism about the actual use and effectiveness of screening processes in identifying either mental health or substance abuse problems and channeling individuals into appropriate treatment.

Consistent with these findings is the observation by stakeholders in every reform incorporating EPSDT (eight of eight), that EPSDT is not being used as an effective vehicle for the early identification of behavioral health problems. Although EPSDT screens are required by contract in many states, contract language does not necessarily specify that behavioral health assessments must be part of the screening process. When some type of behavioral health component to the EPSDT screen was reported, this was typically judged by respondents to be weak, with the major focus of the screening process remaining on physical health. In addition, rates of PCP completion of EPSDT screens were reported to be low in several states, attributed in some cases to low payment for such screens. For example, respondents in one state reported that the high compliance rate with EPSDT screens under the previous Medicaid fee-for-service system dropped precipitously under managed care; in another state MCOs reportedly are dissatisfied with the rates they receive for EPSDT screens and compliance rates are decreasing. Thus, results of the 1999 Impact Analysis indicate that the inclusion of EPSDT in managed care systems (EPSDT is incorporated in 93% of managed care reforms according to the 1997–98 State Survey) is unlikely to result in earlier identification of mental health and substance abuse problems. Stakeholders across states noted that an increased focus on behavioral health screening through EPSDT is needed, as well as increased incentives and monitoring of MCOs and PCPs in relation to performing the screening function.

Among the states in the 1999 sample, a number of strategies to address earlier identification of behavioral health problems were cited.

- In **Maryland–MH** and **Colorado**, clinicians are now placed in the schools, making earlier identification and intervention more likely. In one area in Maryland, children are identified by tracking those with high absenteeism and suspension rates; counselors and mentors are then obtained to work with these children.
- In **Vermont**, there is a requirement in the managed care system that all children entering care in the child welfare system receive both physical and behavioral health screens within the first 72 hours to improve the early identification of problems needing attention.
- An MCO in Bucks County, **Pennsylvania** reportedly is developing a joint program with the child welfare system that would train foster parents to recognize early warning signs of behavioral health problems.
- In **New Mexico**, EPSDT compliance is being tracked as a contractual requirement, and an incentive to use the process has been built into the system by linking the assignment of new cases to rates of EPSDT screening.
- In **Oklahoma**, fiscal incentives have been incorporated into the managed care system for a 60% compliance rate for EPSDT.
- In **Colorado**, strong requirements to complete EPSDT screens were incorporated in MCO contracts.

The maturational analysis revealed that several of the states in the 1997 sample also have adopted strategies to increase the likelihood of earlier identification of behavioral health problems.

- In **Delaware**, a K-3 program has been established which involves placing child welfare caseworkers in the schools who identify children in need of behavioral health assessments and potential intervention. Mental health workers conduct assessments when indicated and work with caseworkers to accomplish referrals for appropriate specialty behavioral health services. In addition, nearly half of the state's school districts have agreed to have student assistance teams in the schools for early identification of problems and to serve as formal liaison persons to the mental health system to facilitate access to care.
- In **Utah**, nine traveling "clinics" that include medical and mental health personnel travel around the state and convene several times each year in different areas of the state to serve children under age 18, allowing for earlier identification of both physical and behavioral health problems.
- In **Arizona**, a "Pediatric Symptom Checklist" with a developmental and behavioral focus has been adopted as part of EPSDT screens and is now required of PCPs at every visit. The state has worked with the behavioral health coordinators of MCOs around using the tool.
- In **Massachusetts**, a new provision was implemented requiring that all children entering the child welfare system be screened for behavioral health problems within seven days of entering state custody.

Service 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 (shown on **Table 38**), a finding consistent with the 1997 Impact Analysis. In addition, the Early Intervention Program, Part C under the Individuals with Disabilities Act (IDEA), which targets young children, was reported to be outside of the managed care system in all nine reforms in the sample, just as it was outside the managed care system in all 10 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.)

Table 38 Services to Young Children and their Families					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Managed care system provides few services to infants, toddlers, preschoolers, and their families	5	4	0	0	
Part C is outside of the managed care system	5	4	0	0	

Similar to 1997 findings, several major barriers to serving young children and their families were described by respondents. Few providers reportedly have expertise in working with the early childhood population. Although this is a problem pre-existing managed care reforms, it is difficult to increase services delivered to this group given the widespread lack of familiarity and knowledge about behavioral health problems and appropriate interventions for this group. As also noted in 1997, stakeholders in 1999 indicated that some providers may not even see behavioral health services as appropriate for this age group. Among the states in the 1999 sample, while pockets of expertise with young children were noted, such as the Peanut Butter and Jelly Program in New Mexico and the Lourie Center in Maryland, a general lack of capacity and trained providers was pervasive.

Another major barrier stems from the typical focus of Medicaid services on an “identified patient,” precluding, in some states, working with parents in the absence of the child—which is often required and appropriate when addressing the needs of very young children. In some states, stakeholders reported that it is a particular problem to work with parents if they are not Medicaid eligible, that is, if only the child is a Medicaid recipient. A third barrier in some states stems from strict medical necessity criteria, the requirement for a diagnosis (considered by some to be inappropriate for young children), and the need for a high level of dysfunction before behavioral health services will be authorized.

These findings are particularly significant in view of the results of the 1997-98 State Survey which revealed that almost all reforms (95%) reportedly include coverage of behavioral health services for young children and their families. The 1997 and 1999 Impact Analyses, however, suggest that few services are actually being delivered to this population, even if they are covered by the managed care system.

Strategies to address the needs of young children and their families were noted in several states in the 1999 sample:

- In **Colorado**, the legislature has approved using Medicaid funds to serve young children without requiring them to have a DSM IV diagnosis.
- In **Maryland-MH**, adjustment disorder diagnoses are allowable for young children, and the managed care system allows providers to work with the family as well as with the identified child. In addition, Head Start, child care centers, and the like can access mental health services through the managed care system.
- In **Nebraska**, some reinvestment dollars have been used to develop services for the 0–5 population.

The maturational analysis revealed some activity among states in the 1997 sample as well to address young children and their families:

- In **Utah**, screening tools for the early childhood population have been adopted for statewide use, services for young children are covered by the managed care system, and monitoring activities have emphasized this area. There has been some expansion in services to young children and their families, and the state has provided extensive training to providers focusing on the zero–five age group.
- In **Arizona**, collateral therapy and family therapy codes in the managed care system now allow providers to work with families of young children; the state has established an early intervention task force; and there have been efforts to train providers to work with this population, including a large conference on this topic.
- In **Connecticut**, one health plan released an RFP for multidisciplinary assessment of infants. ■

X. Impact on Service Coordination

Interagency Service Planning at the Child and Family Level

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 Tracking Project has explored the effect of managed care reforms on interagency treatment and service planning, a process whereby representatives of all involved child serving agencies and systems come together, in partnership with the family, to jointly develop and implement a coordinated, individualized service plan for a child and family. Interagency service planning, which is characteristic of systems of care, typically is reserved for youngsters with serious and complex disorders who have multiple needs and are involved with multiple child-serving agencies and systems. Although the results of the 1997 Impact Analysis suggested that managed care reforms may make it more difficult to accomplish such interagency service planning, this hypothesis was not upheld in the 1999 sample. Interagency service planning was reported to be impeded in only four of the nine reforms studied.

Table 39					
Interagency Service Planning					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Managed care has made it more difficult to do interagency service planning at the child and family level	0	4	5	0	
There are requirements for interagency service planning in the managed care system	3	2	2	2	
Interagency service planning is occurring	5	2	0	2	

Of note, however, is that 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 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.

Some of the barriers to interagency service planning were delineated by stakeholders. Providers in some states reported that they cannot bill for participating in treatment/service planning meetings, an obvious disincentive; in many systems, there is no billing code for this activity. Additionally, respondents across states noted that interagency service planning is complicated simply by the need to include yet another player — the MCO. Stakeholders in one state noted that since MCOs often do not participate in interagency service planning meetings, providers spend an inordinate amount of time attempting to obtain authorization for services that the service planning team agreed upon for a child and family. Another factor affecting the ability to conduct interagency service planning appears to be the availability of case managers to convene and coordinate the process. In one state, the decline in such planning was attributed to the decrease in case managers under the managed care system, while in another state it was reported easier to do interagency treatment and service planning primarily due to an increase in case managers (resulting from the managed care reform) to initiate this function.

Requirements for interagency service planning reportedly are incorporated into managed care systems in five of the nine reforms in the 1999 sample (three of the five having carve out designs). This finding is consistent with the 1997 sample in which half of the states (all with carve out designs) reported having such requirements. A change from the earlier impact analysis, however, is that in 1997, stakeholders in very few states (only three of the 10) indicated that interagency service planning was occurring to any degree. In the 1999 sample, however, stakeholders in most reforms (seven of nine — all five of the carve outs and two reforms with integrated designs) reported that interagency service planning is, in fact, occurring. Examples of strategies used to encourage interagency service planning include the following.

- In **Pennsylvania**, RFPs include requirements for interagency service planning and criteria related to this are included in the state's Readiness Assessment Instrument. County managed care contracts require interagency agreements between MCOs and children's systems, including physical health HMOs, local school districts, juvenile court, juvenile probation, health department, child welfare, income maintenance, and county mental health and mental retardation agencies. In some counties, contracts reference the pre-existing local interagency service planning teams and require interagency service planning for children requiring residential or wraparound services. MCOs were oriented to the value of interagency service planning through the technical assistance and orientation provided by the state.
- **Maryland–MH** incorporated a billing code for "interdisciplinary team planning" in its managed care system that can be used twice per year for an individual client.
- In **New Mexico**, a new requirement was incorporated to ensure that schools participate in discharge planning from residential treatment centers so that youth will not be precipitously discharged and referred to schools without prior notice, coordination, planning, and appropriate arrangements.
- In **Nebraska**, MCOs have created Regional Clinical Coordinators who often initiate and participate in local interagency service planning and coordination for individual children and families.

The maturational analysis revealed some evidence that states in the 1997 sample are also addressing the need to improve interagency service planning in their managed care systems.

- In **Iowa**, the MCO added joint treatment planning sessions to its benefit package after recognizing that such planning would contribute to their efforts to manage services more effectively. The contract between the state and the MCO now includes a performance expectation that the MCO will participate in a minimum of 20 joint treatment planning sessions per month, with incentives attached to this indicator.
- In **Arizona**, an Interagency Case Management Project involving joint case planning among agencies has been implemented in two service areas.
- In **Utah**, an interagency “rapid response team” that serves as an intermediary to plan and broker services has been instituted to focus on children whose needs cross systems. To activate the team for an individual case, there has to have been previous attempts to meet the child’s needs through the local interagency team, but difficulty in either meeting the child’s needs or in financing services.
- In **Delaware**, interdivisional case planning is now mandated for children requiring services from multiple divisions, and MCOs now participate on the teams and in the treatment planning process.

Service Coordination

Coordinating Multiple Services

A mixed picture emerged when the Tracking Project explored, through the 1997 Impact Analysis, the impact of managed care reforms on the coordination of services to children and adolescents with behavioral health disorders and their families. In the 1997 sample, stakeholders in half of the states felt that managed care reforms had facilitated the coordination of multiple services, and stakeholders in half of the states reported that managed care made service coordination more difficult. As shown on **Table 40**, similarly mixed results were obtained with respect to the 1999 sample—managed care reforms were reportedly facilitating coordination in four of the nine reforms and impeding coordination in four (in one reform, managed care was deemed by stakeholders to have no effect).

Consistent with the findings related to interagency service planning, the effects of managed care reforms on service coordination 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.

Table 40 Service Coordination					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Managed care is facilitating the coordination of multiple services	4	0	1	4	
Managed care is impeding the coordination of multiple services	0	4	5	0	

In reforms in which stakeholders reported enhanced coordination, this typically was attributed to the establishment of a focal point of responsibility for providing and coordinating children's behavioral health services (the MCO); the addition of case management, such as targeted case management services in Maryland-MH that did not exist previously; or the addition of other types of care coordinators, such as the Regional Clinical Coordinators in Nebraska. Where coordination has faltered, respondents blamed the addition of a new player to the complicated challenge of coordinating multiple services (again, MCOs), or to the decline in case management services attributed to managed care reforms, which reportedly occurred in two states.

Coordinating Mental Health and Substance Abuse Services

The difficulties involved in coordinating mental health and substance abuse services were described by stakeholders across states as a pre-existing problem. In the 1997 sample, respondents in only one state noted improvements in the coordination of mental health and substance abuse services resulting from the managed care reform, which they attributed to the increased communication between the two systems in planning and implementing the reform.

Consistent with these results, in the 1999 Impact Analysis sample, stakeholders did not observe improved coordination of mental health and substance abuse services in any of the nine reforms. In most states, the lack of such coordination was described by stakeholders as a pre-existing problem that has remained largely unaffected by managed care reforms and is a particularly troublesome obstacle to effectively serving youngsters with the dual diagnosis of substance abuse and mental health disorders. In one state in which the utilization management system handles both mental health and substance abuse services, respondents noted the potential for creating coordinated treatment plans, but complained that such potential is rarely realized, and individuals are seen as having either mental health *or* substance abuse problems.

In two reforms, respondents indicated that coordinating mental health and substance abuse services has become even more difficult as a result of the managed care reforms. In one state, stakeholders complained that two separate sets of authorization are needed for mental health and substance abuse services. In Maryland, the challenge of coordinating these services was reported to be exacerbated by the separation of mental health services into its own carve out, while substance abuse services are integrated with physical health services in what is essentially a separate system. Stakeholders reported

efforts in Maryland to address this problem, and the maturational analysis revealed attention to this issue in Iowa as well. In neither state did stakeholders believe that the solution was to move mental health into an integrated design with physical health. Other strategies, as described below, were deemed to have more potential to improve coordination.

- In **Maryland**, a Mental Health/Substance Abuse Task Force meets regularly to develop recommendations as to how to better coordinate care. In situations with co-occurring disorders, care managers from the mental health carve out (ASO) are supposed to work with special needs coordinators at the physical health MCOs to determine the most appropriate providers for the consumers' needs, to facilitate referrals for mental health and substance abuse care, and to coordinate services.
- In **Iowa**, two separate carve outs (with separate benefit programs for mental health and substance abuse) were replaced with the Iowa Plan, blending mental health and substance abuse with a view toward promoting better integration between mental health and alcohol and other drug services. Under the Iowa Plan, the MCO created five regional care teams, which include both mental health and substance abuse expertise and are responsible for leading integrated planning for individuals with needs in both areas.

Case Management

In the 1997 sample, some expansion of case management services resulting from the managed care reforms was reported in six states (all with carve outs). In contrast, expansion of case management services related to the managed care reform was reported by stakeholders in only one state in the 1999 sample, the Maryland mental health carve out, which added targeted case management services that were not offered previously (**Table 41**).

In two of the reforms in the 1999 sample, case management services reportedly have been constricted as a result of the implementation of managed care reforms. In one state, respondents explained that case management responsibilities were assumed internally by the MCO and have become limited to telephone referrals and utilization management functions. Stakeholders in the other state with a reported decline in case management attributed this to the need for case management to be authorized and the perception that these services are neither approved nor reimbursed as readily as under the previous fee-for-service system. In the remaining reforms, no effect on case management services was noted by respondents; in some cases, case management services are provided and funded outside of the managed care system, such as the state-funded Professional Partners Program in Nebraska, which provides intensive case management using a wraparound approach to a group of children and adolescents with serious disorders.

Table 41 Case Management					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Case management services have expanded as a result of managed care	1	0	4	4	
Case management services in the managed care system are consistent with the public sector concept of case management	4	1	0	3	1

The Tracking Project also has explored the extent to which the concept of case management in managed care systems is consistent with the concept used in public sector systems of care, including such functions as accessing, coordinating, brokering, monitoring, and advocacy, as opposed to the care authorization or utilization control focus of case management often found in managed care systems. In the 1999 sample, case management services were characterized as being consistent with the public sector concept in five of the nine reforms, including four of the five with carve out designs. Case management services were reported to be consistent with the public sector concept in only one reform with an integrated design, specifically within Oklahoma's Special Behavioral Health Needs (SBHN) level of care. In the other integrated reforms, case management reportedly is limited to a utilization management function. Stakeholders in these reforms felt that the managed care systems have neither understood nor accepted the broader case management approach associated with the system of care concept. These findings mirror those from 1997 in which all eight reforms with carve outs reportedly had case management approaches consistent with the system of care definition, while case management in the states with integrated designs was characterized as focusing primarily on service authorization and fiscal/utilization control. Thus, across the 1997 and 1999 samples, case management services are significantly more likely to be consistent with the public sector concept in managed care systems with carve out designs.

These findings are consistent with the results of the 1997–98 State Survey which found that most of the carve out reforms nationally (nearly 70%) include both functions (accessing, brokering, coordinating, etc. as well as utilization management) in their case management approaches as compared with fewer than half (45%) of the integrated reforms. Further, very few of the carve out reforms nationally (only 7%) reported a case management model focusing exclusively on service authorization and utilization management, whereas nearly half of the integrated reforms reported this as their exclusive case management focus.

As in 1997, some reforms in the 1999 sample reportedly offer different levels of case management based upon need.

- In **Maryland–MH**, targeted case management services are modeled after the system of care approach for children and adolescents with multiple problems and multi-agency involvement. The role includes accessing and brokering a broad array of services and coordinating care, and is not limited to service authorization or utilization management. A lower level of case management also can be provided. In addition to targeted case management services, the ASO also has “care managers” who have a service authorization and utilization management role and who monitor cases to ensure appropriate interventions.

Through the maturational analysis, some changes in case management approaches were identified in states included in the 1997 sample.

- In **Arizona**, a Primary Behavioral Health Professional (PBHP) is now required for all children in Maricopa County, requiring that fixed responsibility for services, coordination of care, and clinical decision making rests with a responsible professional. This reportedly does not preclude other case management and intensive case management services, but is seen by state stakeholders as “bolstering” case management by requiring oversight by a certified behavioral health professional. The plan leaves it up to the MCOs to determine whether they will retain dedicated case managers, opening up the potential for other professionals to fulfill the case management function as appropriate.
- In **Utah**, statewide training was provided for case managers. Trainees included 43 family members, as well as CMHC staff and coordinators of local coordinating councils.
- In **Massachusetts**, the MCO created an interagency case management pilot for a group of children in foster care with serious and complex behavioral health needs. ■

XI. Physical Health/Behavioral Health Linkages

Primary Care Practitioner (PCP) Identification of Children and Adolescents with Behavioral Health Problems

Identification and Referral by PCPs

Hypothesis: In most states, there will be inadequate identification and referral by primary health care practitioners of children and adolescents with behavioral health problems, regardless of the design of the managed care system.

Finding: Upheld

As shown on **Table 42**, stakeholders in most states (eight of nine reforms in the 1999 sample) identified problems with primary health care practitioners' (PCPs) identifying and referring children to specialty behavioral health care. Respondents across states identified this as a problem that pre-existed the introduction of managed care and one which has not improved as a result of managed care reforms, regardless of whether the reform has an integrated or carve out design. The one exception noted was that some substance abuse respondents in some of the states with integrated designs reported some increase in coordination between physical health and behavioral health services as a result of managed care. These reports were always qualified, however. Stakeholders noted that PCPs receive little training regarding the appropriate identification of behavioral health risk indicators and have little information on how to make referrals for specialty mental health or substance abuse care. Some stakeholders noted that the screens that PCPs use for new members either do not include behavioral health indicators or have only one or two questions related to behavioral health.

Table 42					
Identification and Referral of Behavioral Health Problems by PCPs					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Problems with identification and referral by PCPs	4	4	1	0	

Many stakeholders across states also felt that PCPs do not conduct behavioral health screens in a thorough manner due to decreases in payment rates and time constraints. In one managed care system, a more extensive substance abuse assessment (the CAGE) is required at admission, but stakeholders still feel that it is difficult to obtain PCP

authorization for substance abuse services. Stakeholders in another state with an integrated reform reported that families involved in substance abuse services now have better access to physical health services; however, an individual with a substance abuse problem is not more likely to be identified and referred for substance abuse services by a PCP.

Other stakeholders believe that the identification and referral of behavioral health treatment needs by PCPs varies considerably depending on the individual PCP. For example, they noted that some PCPs do identify behavioral health problems and make appropriate referrals of children to specialty behavioral health services; some PCPs do not have these skills; and others try to offer behavioral health care themselves without appropriate consultation or support. At one site, family members stated that there is an incentive for PCPs to provide care themselves or to avoid referring to behavioral health providers, since the MCO penalizes PCPs if they make too many specialty behavioral health referrals.

Training of PCPs on Identification and Referral to Specialty Behavioral Health Care

As **Table 43** indicates, only two of the nine reforms studied in the 1999 sample offer any training activities for PCPs on appropriate identification of mental health and substance abuse problems and referral to specialty services. Even in the two reforms where training activities have occurred, stakeholders agree that much more needs to be done in this area. Many stakeholders across states concurred that there is a need for training of PCPs, but that no training efforts have taken place.

Table 43 Training of PCPs on Identification and Referral to Behavioral Health Care					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Training for PCPs is provided	1	1	4	3	

These results are similar to those found in the 1997 sample — only two states, and one county in another state, reported any training initiatives targeted to PCPs' identification and referral to behavioral health specialty services. Despite the paucity of training activities identified by stakeholders, some examples of training activities were reported in the sites studied in the 1999 Impact Analysis and in the maturational analysis.

In the 1999 sample:

- In **Maryland**, a two-part videotape has been sent to PCPs. The first part of the video provides an overview of the prepaid mental health plan; the second part provides specific information on the identification of mental health problems and how to make referrals. At a pilot site in Baltimore, three MCOs are providing training for PCPs on how to screen for substance abuse problems.

In the maturational analysis:

- In **Utah**, grant funds have made possible joint training activities for case managers of health care plans and behavioral health care entities where they can learn about each other's responsibilities and roles.
- The Division of Children's Mental Health Services, which acts as the MCO in **Delaware** for children with serious behavioral health needs, is developing a pocket guide for PCPs with questions to ask to help identify mental health and substance abuse problems.

Changes in the Role of PCPs in the Provision of Behavioral Health Services

Stakeholder perceptions across states varied as to whether or not the role of PCPs has changed in the provision of behavioral health services as a result of managed care reforms. In some of the sites studied, the physical health managed care reform includes the provision of a limited amount of behavioral health services, such as clinical evaluation and assessment and two to three therapy sessions. In these states, stakeholders felt that the role of primary care practitioners has increased, especially in assessments and prescription of psychotropic medication for such disorders as ADHD and depression. Reportedly, in these states with integrated designs with limited behavioral health benefits, doctors and nurse practitioners, rather than psychiatrists, prescribe most of the psychotropic medications for children, especially in rural areas. Family members across sites expressed concerns that PCPs sometimes provide behavioral health services without the appropriate skills and/or consultation needed. Other stakeholders stated that these practices by PCPs existed prior to managed care, but may have increased somewhat post-reforms. The 1997 Impact Analysis findings were also mixed regarding PCP role changes.

Coordination Between Physical Health and Behavioral Health Services

Respondents across sites made the observation that lack of coordination between physical health and behavioral health services is a problem that pre-existed managed care, and little improvement has been noted with managed care reforms. In states with integrated physical health/behavioral health designs, stakeholders reported that improved coordination is a stated goal of the reform and remain hopeful that it may occur. For example, in one state with an integrated design, the child welfare stakeholders expressed hope that the creation of a medical home will provide more coordinated information about medications, especially psychotropic medications, for child welfare caseworkers and foster parents than was the case under fee-for-service. However, respondents across states indicated that, regardless of design, coordination of physical health and behavioral health service remains a daunting challenge.

Respondents provided examples of poor coordination of physical and behavioral health care in systems with both integrated and carve out designs. For example, in three states with carve-out designs, stakeholders observed that coordination between physical health and behavioral health has been aggravated by the issue of who pays for psychotropic medications. In two states, drug costs are included in the rates for HMOs, but are prescribed by psychiatrists in the behavioral health carve out. HMOs in these states complained that they have no control over what has become an escalating cost. Some stakeholders in these states indicated that there is pressure from the HMOs to use the least expensive psychotropic medications, and there are often delays as HMOs refuse to authorize payment. In addition, each HMO has developed its own formulary, which adds confusion to the situation. In one of these states, there are plans to move the cost of anti-psychotic medications from the HMOs to the BHOs. In the third state, the problem has revolved around who pays for medication review visits when an HMO physician prescribes psychotropic medications for children. At the time of the site visit, the issue was being resolved, with the HMOs agreeing to pay for up to 12 medication check visits, and the BHO agreeing to pick up costs for the 13th and any further visits. This agreement also permits the BHO's quality review process to begin at the 13th visit.

Another problem identified by stakeholders in the 1999 sample relates to disagreements between physical health care providers and behavioral health care providers regarding responsibility for specialty needs populations, such as children with neurological impairments, autism, or Tourette's Syndrome, and children with both serious medical needs and behavioral health needs. Stakeholders pointed out that responsibility needs to be clarified at a policy level to avoid battles at the provider level.

Similar problems with physical health-behavioral health coordination were identified in the 1997 sample. One improvement and note of progress is that, in the 1999 sample, many of the managed care documents reviewed identify this as an issue and propose strategies for improving communication. For example, in several reforms there are requirements that PCPs be notified when a child is enrolled in behavioral health services and/or is admitted to inpatient psychiatric care. In one state with a carve out design, each physical health HMO is required to have a Special Needs Unit that is responsible for the coordination of care for individuals with special needs, including behavioral health. One BHO asks its behavioral health care practitioners to formally agree that they will share information with PCPs.

Some efforts were identified in the 1999 sample and through the maturational analysis to improve the coordination of physical health and behavioral health care.

In the 1999 sample:

- In **Maryland**, the uniform treatment plan includes an item that asks whether care has been coordinated between physical health and mental health sectors. When an individual is admitted to inpatient psychiatric care, the admitting facility is reminded to contact the individual's PCP so that care can be coordinated.
- One BHO in **Vermont** holds combined clinical rounds for PCPs and behavioral health specialists on children with complex behavioral health problems. In addition, written policy requires that communication take place with PCPs regarding children with serious behavioral health needs.
- In **Colorado**, some of the behavioral health MCOs offer PCPs consultation with behavioral health MCO clinical staff.

In the maturational analysis:

- If parents agree, in **Arizona** and **Delaware**, a letter is sent to a child's PCP when the child is admitted to specialty behavioral health care. In Delaware, the letter provides the name of the treatment team leader and invites inquiries. ■

XII. Impact on Cultural Competence

Impact on Overall Level of Cultural Competence

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

Finding: Upheld

Findings from the 1999 sample indicate that the overall level of cultural competence in the behavioral health care system is not impacted one way or another by the introduction of managed care. As shown on **Table 44**, the perception of stakeholders in all nine reforms studied 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. Respondents in two states credited managed care with “raising consciousness” about cultural competence and creating a focal point of accountability in the MCO or BHO.

Some efforts to increase cultural competence in managed care systems were noted during site visits to the 1999 sample

- In **Maryland–MH**, efforts to increase cultural competence included awarding grants for this purpose, holding a statewide conference on cultural competence, and designating a staff member with responsibility for cultural competence.
- In **Nebraska**, the MCO has sponsored prevention and education activities in five Native American reservation communities through the development of culturally sensitive substance abuse prevention and parenting classes. In addition, the MCO funds parenting classes in Spanish in eight communities with the highest concentration of Spanish speaking families.
- In **Massachusetts**, an Office of Multicultural Affairs was established within the Department of Mental Health to more systematically and effectively address cultural issues.

Even in states noting such efforts, however, the perception of stakeholders is that, thus far, the overall level of cultural competence in the system has not increased. In one state, several respondents felt that this pre-existing problem has been exacerbated by the managed care reform. They explained that some providers are leaving the system due to managed care requirements, making it even more difficult to find providers of color or linguistically competent providers. In addition, it is believed that MCOs and BHOs typically have limited understanding of the needs of tribal communities.

Table 44 Impact of Managed Care on Overall Level of Cultural Competence					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
No effect on overall level of cultural competence	5	4	0	0	

Although no states in the 1999 sample reportedly experienced improvements in cultural competence as a result of managed care reforms, stakeholders in three states in the 1997 sample did feel that managed care had improved the overall level of cultural competence to some degree. Some progress in this area was noted among states in the 1997 sample through the maturational analysis as well.

- In **Utah**, the state has hired a cultural competence specialist who is working with each of the MCOs to provide culturally appropriate services. In addition, a collaborative effort is taking place with the Navaho nation to identify and address unmet needs.
- In **Delaware**, the MCO holds quarterly forums with providers that cover cultural competence issues.

Inclusion of Culturally Diverse Providers

In the 1997–98 State Survey, 80% of reforms reported having provisions that address the inclusion of culturally diverse providers in provider networks. However, in the 1997 Impact Analysis sample, respondents in four of 10 states asserted that managed care reforms had actually impeded the inclusion of culturally diverse providers. The primary reason identified by stakeholders was that credentialing requirements in managed care systems reportedly are more difficult for some providers to meet and may serve as a barrier to culturally diverse providers.

In the 1999 sample, as shown on **Table 45**, respondents in only one state reported that the reform has impeded the inclusion of culturally diverse providers. In this integrated reform, it is believed that some smaller, culturally diverse providers, especially in the substance abuse area, have been unable to participate in provider networks, also primarily because of their inability to meet the credentialing requirements. Respondents in most other states identified the inclusion of culturally diverse providers as a pre-existing problem that has neither improved nor been exacerbated by managed care. In one state, it was reported that there are efforts to recruit culturally diverse providers, but that the credentialing requirements are a serious barrier.

Table 45 Inclusion of Culturally Diverse Providers in Managed Care Systems					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Reform has impeded inclusion of culturally diverse providers	0	1	5	3	

Thus, the results of both the 1997 and 1999 Impact Analyses suggest that credentialing requirements present a substantial barrier to the participation of culturally diverse providers.

Training for MCOs and Providers on Cultural Competence

Respondents in only three reforms (all carve-outs) reported that training has occurred on cultural competence for MCOs and providers, as shown on **Table 46**. These results are consistent with findings from the 1997 sample in which only three of the 10 states reported that specific training activities on cultural competence had taken place.

Table 46 Impact of Managed Care on Overall Level of Cultural Competence					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Training is provided for MCOs and providers on cultural competence	3	0	2	4	

Examples of training on cultural competence include the following.

- In **Pennsylvania**, both the Readiness Assessment Instrument and the RFP require the county MCO to develop a training plan for the provider network on culturally relevant service delivery.
- A statewide conference was held in **Maryland–MH** on cultural competence, and the ASO has trained case managers and other staff on culturally sensitive services.

Addressing the Needs of Culturally Diverse Groups

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

Table 47 Analyzing the Needs of Culturally Diverse Groups					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There is some analysis of the needs of culturally diverse children and families	2	0	3	4	

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. As indicated on **Table 47**, respondents in only two of the nine reforms reported that some analysis is undertaken of the needs of various cultural groups. In Pennsylvania and Maryland's mental health carve out, RFPs require that MCOs conduct an analysis of the needs of culturally diverse populations and develop strategies to address these needs. In another state with a highly diverse population, utilization data reportedly can be analyzed by ethnicity, but this has not as yet been done.

Table 48 Outreach to Culturally Diverse Populations					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There is outreach to culturally diverse populations	2	0	3	4	

The 1999 results are similar to those found in the 1997 sample, in which only three of the 10 reforms reported that some analysis of the needs of culturally diverse populations had occurred.

Outreach to Culturally Diverse Children and Families

According to the stakeholders interviewed, only two of the nine reforms in the 1999 sample are conducting outreach to culturally diverse children and families. As noted earlier, in Nebraska the MCO has reached out to Native American populations by collaborating with the agencies that serve these communities in the delivery of culturally sensitive substance abuse and parenting classes; the MCO also has sponsored parenting classes in Spanish in predominantly Spanish-speaking communities.

Again, these findings mirror those from the 1997 Impact Analysis. Only two of the 10 reforms in the 1997 sample reported outreach efforts to culturally diverse populations.

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.

Findings: **Partially Upheld**

The results of the 1999 Impact Analysis are mixed regarding cultural competence requirements. In 1997, more than half of the states in the sample incorporated requirements related to cultural competence in their managed care systems. However, stakeholders in 1997 indicated that these requirements typically focused narrowly on the provision of linguistically appropriate services and failed to address cultural competence in a more comprehensive manner. As in 1997, and displayed on **Table 49**, the majority of reforms in the 1999 sample do incorporate requirements related to cultural competence. However, fewer states characterize these as focusing primarily on linguistically appropriate services, suggesting that cultural competence requirements may be more far-reaching in some states. According to the documents reviewed and the perceptions of respondents, in the six reforms that include cultural competence requirements, three reforms limit their requirements to culturally appropriate services and three reforms add other requirements.

Table 49					
Requirements for Cultural Competence					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Cultural competence requirements included	4	2	1	2	
Requirements focus primarily on linguistically appropriate services	2	1	2	1	3

As examples, stakeholders in Pennsylvania and Nebraska described cultural competence requirements that have been incorporated into their managed care systems.

- In **Pennsylvania**, there are a number of cultural competence requirements in the RFP and the Readiness Assessment Instrument. MCOs must ensure that the provider network represents the cultural and racial diversity of the members and neighborhoods, and that an assessment is conducted to ensure that the provider network meets the needs of culturally diverse groups. MCOs also are required to develop policies to ensure that provider network administrative and treatment staff reflect the diversity of the communities served. The state's performance monitoring system includes indicators that relate to cultural competence and the state monitors the number of requests and complaints related to culturally competent services.
- In **Nebraska**, the MCO is required to report annually on how the MCO has encouraged cultural sensitivity by providers.

The maturational analysis revealed that progress reportedly has been made in three states in extending cultural competence requirements beyond language.

- In **Utah**, the quality of care reviews now place a greater emphasis on cultural competence. The Medicaid agency requires MCOs to submit lists of providers with skills in working with culturally diverse populations and interpreters. In addition, the MCOs are now required to develop long-range
- In **Arizona**, the new contract in Maricopa County requires that provider networks conduct evaluations and intakes in clients' languages.
- In **Rhode Island**, specific cultural competence requirements have been added into RFPs and contracts. ■

XIII. Impact on Providers

Range of Providers

Provider Inclusion and Exclusion

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

As postulated, managed care reforms, according to stakeholders, have expanded the range of providers in most states, but have also resulted in the exclusion of certain types of providers. **Table 50** shows that in eight of the reforms studied (both with carve out and integrated designs), respondents indicated that managed care has resulted in an expanded range of providers, attributed to the inclusion of new types of practitioners, new provider types, and/or new service modalities included in the benefit plan. For example, in Vermont, New Mexico, and Maryland–MH, new types of practitioners are included that were previously excluded from Medicaid fee-for-service. Licensed social workers, marriage and family counselors, nurses, licensed alcohol and drug abuse counselors, and licensed professional counselors were mentioned as professionals newly included in provider networks. New service modalities frequently noted by respondents as additions to managed care systems include targeted case management, respite, in-home services, behavior management, mentors, and substance abuse outpatient and day treatment services.

Table 50 Provider Networks					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Reform includes an expanded range of providers	4	4	1	0	
It is more difficult for smaller, nontraditional providers to participate	3	4	1	1	
Certified substance abuse counselors are excluded	0	1	3	3	2

The finding that nearly all of the reforms studied in the 1999 sample reported an expanded array of providers represents a substantial increase from the 1997 sample in which only half of the states reported such an expanded array of providers included in managed care systems. The 1999 Impact Analysis suggests that managed care reforms are, indeed, “opening up” provider networks — a stated goal of many reforms.

Trends noted by stakeholders in the maturational study also reflect increases in the array of providers included in the managed care reform. 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.

- In **Utah**, the CMHCs have increased their use of private practitioners to ensure that providers with specialized expertise are available (such as specialists for victims and perpetrators of sexual abuse).
- In **Delaware**, the MCO (the mental health authority) has set a benchmark that all providers should have the capacity to conduct both mental health and substance abuse assessments and make appropriate referrals. The MCO is encouraging mental health providers to add certified addictions counselors to their staff.
- In **Arizona**, a new RFP for Maricopa County has added requirements for specialty providers with specific areas of expertise as well as specifications about the numbers and types of providers (such as a minimum number of crisis providers and a requirement for school-based services) that must be included in the network.

As **Table 50** indicates, despite the finding that the range of providers has increased as a result of managed care, smaller and nontraditional agencies reportedly still struggle to participate in managed care reforms. The reasons offered by respondents include a lack of administrative infrastructure, fiscal challenges such as moving from grant-funding to a reimbursement rate structure, and the inability to take on financial risk. In Pennsylvania, the state has attempted to encourage the participation of smaller, nontraditional and indigenous providers by the allowance of a “Type 80” provider, which is defined by the state as a nontraditional provider.

Based on findings from the 1997 sample, it was predicted that certified substance abuse counselors would be among the provider types experiencing exclusion from managed care networks in some states. In the 1999 sample, only one of the reforms studied reported that certified substance abuse counselors are excluded. However, the perception of stakeholders in many other states is that substance abuse providers experience many challenges in managed care reforms. Substance abuse providers reportedly often lack the administrative infrastructure to handle the paperwork requirements of managed care. In one managed care system, CMHCs reportedly were credentialed as an agency, but substance abuse agencies were required to have each staff member credentialed. In another state, recent changes in the licensing law prohibit

licensed substance abuse counselors from conducting assessments of substance abuse disorders. Assessments must be done by licensed mental health clinicians. In addition, the new law requires that licensed mental health therapists must provide supervision for substance abuse counselors. Respondents in other reforms noted that substance abuse providers are faced with serious financial problems due to low reimbursement rates and a lack of referrals from health plans.

Mandates Regarding Inclusion of Providers

Requirements to include certain types of providers were noted in only three of the nine reforms included in the 1999 sample (**Table 51**). This represents a slight decrease from the 1997 sample in which half of the reforms had mandates for the inclusion of certain provider types. In the 1997–98 State Survey, nearly half (44%) of all reforms reportedly designate essential providers that MCOs are required to include in their provider networks. All Tracking Project activities suggest that some states do mandate the inclusion of certain types of providers in managed care system, though probably less than half of all states do so.

Table 51 Mandates Regarding Inclusion of Providers					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There are mandates for inclusion of certain types of providers	1	2	4	2	

Only a few examples of mandating providers were noted among the states in the 1999 sample, and in one case the requirement has been dropped.

- **Oklahoma's** integrated reform required during the first two years of implementation the inclusion of CMHCs, federally qualified health centers (FQHCs), and other providers that historically had provided a certain level of Medicaid services, but the state has since dropped this requirement.
- In **Vermont**, FQHCs are the only mandated providers. Some stakeholders noted that mandated provider requirements eliminate a healthy competition among providers.

Inclusion of Child Welfare Providers

The perception of respondents in seven of the eight reforms in the 1999 sample that serve children in the child welfare system is that agencies that traditionally serve the child welfare population are included in provider networks. This represents an increase from the 1997 sample in which six of the 10 states reported that child welfare providers were included. In several sites visited in 1999, stakeholders noted that many child welfare providers had been Medicaid providers previous to the reform and thus were automatically

included as providers in the reform. Respondents in one state noted that both juvenile justice and child welfare providers have little incentive to join provider networks, however, because these providers already receive behavioral health dollars through fee-for-service child welfare and juvenile justice funding streams. In those states in which higher reimbursement rates are paid by fee-for-service mechanisms than by managed care, providers prefer retaining their fee-for-service status to participation in managed care systems. As a result, some provider networks may lack expertise in areas required by child welfare and juvenile justice systems, such as sexual abuse treatment, sexual offender programs, and therapeutic foster care.

Table 52 Inclusion of Child Welfare Providers					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Child welfare providers are included in provider networks	5	2	0	1	1

Inclusion of School-Based Providers

In six of the reforms in the 1999 sample, stakeholders reported that school-based providers are included in networks, and, in many of these sites, the perception is that the number of school-based providers and programs has increased as a result of managed care. For example, in Vermont and Maryland-MH, respondents noted that the reform has resulted in an increase in individual practitioners and that more practitioners are now working in schools. In Indiana, education stakeholders reported that the number of case conferences for children with special needs has increased as a result of the reform, and MCOs in New Mexico are required to “make every effort” to include school-based providers in provider networks. In Pennsylvania, one MCO has used several strategies to develop linkages with schools, such as providing information to school nurses about managed care, encouraging providers to offer services in schools, and partnering with the state to increase school-based adolescent substance abuse services through the use of reinvestment dollars. Respondents in Oklahoma noted that there is an increase in school-based mental health services, but this increase is attributed to school districts’ ability to enroll as Medicaid providers separate from the managed care reform.

Table 53 Inclusion of School-Based Providers					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
School-based providers are included in provider networks	4	2	1	2	

Interestingly, in one state, the managed care reform has created a conflict between schools and the behavioral health system. Previously, schools were able to easily access EPSDT-funded wraparound services, which typically include a behavioral specialist and a therapeutic support staff (TSS) worker. Schools developed an expectation that TSS workers would be available to maintain a child in the classroom. With the advent of managed care, efforts are being made to control the use of TSS workers through utilization management. In addition, education stakeholders believe that the MCOs tend to look at coordination with schools as “case finding.” Family respondents in this state commented that an interagency agreement needs to be developed between schools and the behavioral health MCOs to clarify expectations and responsibilities.

Both progress and challenges were noted in the area of school-based services in the maturational analysis. In Utah, it was reported that there is an increase in school-based services as a result of the managed care reform. The MCO in Iowa has hired a “school-based specialist” to help providers transition youth from day treatment programs into less intensive services. The perception of Rhode Island respondents was that some school clinics are not included in provider networks, even though they are considered to be “essential providers,” because the clinics do not meet NCQA standards. School-based clinics in Connecticut also are mandated providers but continue to struggle with reimbursement issues. In Connecticut, school-based clinics can go through their parent organization for health care reimbursement, but on the behavioral health side each clinic must go through a behavioral health organization for reimbursement.

Inclusion of Private Practitioners

According to respondents in seven of the nine reforms, managed care has resulted in an increase in the use of individual private practitioners (**Table 54**). The increase is attributed to two factors:

- Reforms have added new types of mental health professionals eligible to offer Medicaid reimbursable services, such as marriage and family therapists, licensed social workers, and others.
- In some reforms, Medicaid payment rates were raised to make them more attractive to private practitioners.

Despite the greater inclusion of private practitioners, some stakeholders raised some concerns about increased use of private practitioners in managed care systems. First, concern was expressed that individual practitioners may not have adequate supervision, training, or peer review mechanisms. Another issue noted is that individual practitioners cannot play the advocacy role that provider agencies can with MCOs and other key stakeholders. A third concern is that individual practitioners sometimes are favored by MCOs because they have less overhead and may be less willing to question service denials.

Table 54 Increase in the Use of Private Practitioners					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Increased inclusion of private practitioners	4	3	1	1	

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**

Respondents in only two of the nine reforms (both integrated reforms) in the 1999 sample indicated that the practice of credentialing individual practitioners rather than agencies limits the use of paraprofessional staff, student interns, and family members as staff. Respondents in all other reforms in the 1999 sample did not identify this as a problem, whereas in 1997, nearly half of the states in the sample (four of 10) identified this as an issue.

In most of the states visited for the 1999 Impact Analysis, respondents reported that it was possible to license entire agencies or programs, and, in that way, reportedly making it possible to include providers such as paraprofessionals, interns, and family members. In Oklahoma's integrated reform, mental health agencies can be credentialed, but substance abuse providers must have each of their staff credentialed individually. In one state, although the managed care reform does require the licensing of individual practitioners, this was not perceived as limiting the use of paraprofessionals, student interns, or family members.

Inclusion of Culturally Diverse Providers

Hypothesis: In most states, managed care reforms will have no impact on the inclusion of culturally diverse or indigenous providers.

Finding: **Upheld**

As indicated on **Table 55**, the perception of respondents in nearly all of the reforms in the 1999 sample (eight of the nine reforms studied) is that managed care has had little or no effect one way or the other on the inclusion of culturally diverse providers in the system. This finding is noteworthy, given that respondents to the 1997-98 State Survey reported that 80% of managed care reforms have requirements that address the inclusion of culturally diverse and indigenous providers. Despite the presence of these requirements in MCO contracts, stakeholders in the 1999 sample reported that there is little emphasis, pressure, or incentives from the state, MCOs, or BHOs to include culturally diverse providers. For example, few premiums or differential rates are available to recruit culturally diverse providers.

Table 55 Impact on Inclusion of Culturally Diverse and Indigenous Providers					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
No impact on the inclusion of culturally diverse providers	4	4	1	0	
Less inclusion of culturally diverse providers	0	1	5	3	

In 1997, stakeholders in most states also reported that managed care reforms had no impact on the inclusion of culturally diverse or indigenous providers. However, respondents in four states in that sample believed that managed care reforms had a negative impact in this area, actually resulting in decreased participation of culturally diverse providers. In contrast, respondents in only one reform in the 1999 sample reported less inclusion of culturally diverse providers as a result of managed care.

One example of a reform in which stakeholders felt there was greater inclusion of culturally diverse providers was identified in Maryland's mental health carve out as a result of the reform.

- In **Maryland–MH**, there has been a strong emphasis on the recruitment of culturally diverse providers. Coupled with a substantial increase in the provider network in general, respondents believe that the participation of culturally diverse providers has substantially increased. In addition, the state and the ASO have collaborated with the Black Mental Health Alliance to encourage participation of minority providers. The Administrative Service Organization (ASO) maintains a list of culturally diverse providers.

Front-Line Practice

Use of Brief, Problem-Focused Approaches

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

Finding: Upheld

As **Table 56** indicates, according to respondents in five of the nine managed care reforms studied in 1999 (all four integrated reforms and only one with a carve out design), an increase in the use of short-term, problem-focused treatment modalities has occurred with the introduction of managed care. This finding represents a shift from the 1997 Impact Analysis study in which respondents in all 10 states reported a move to briefer treatment models. The findings 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. 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.

Table 56					
Use of Brief, Problem-Focused Treatment Approaches					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Increased use of brief treatment approaches	1	4	4	0	

In those states with increased use of brief treatment approaches, individual therapy is typically limited to about six sessions, according to stakeholders; longer-term therapy generally is no longer provided. Serious concerns were raised by substance abuse stakeholders in some sites about the reduction in duration for intensive outpatient treatment and residential services. Reportedly, the average length of stay for intensive outpatient services has been reduced from four to six weeks to two to three weeks in one state. Respondents emphasized that a brief treatment model often does not fit the chronic and progressive nature of substance abuse disorders.

The trend to not rely as extensively on short-term treatment approaches is substantiated by the findings from some states in the maturational analysis.

- In **Arizona**, a lawsuit has prompted the managed care reform to recognize that a brief therapy model does not meet the needs of children with serious and multi-agency needs. As a result, the reform is now promoting longer-term, interagency approaches for this population. Training and technical assistance have been offered to provider networks on home-based and wraparound service approaches.
- **Utah** respondents reported a growing recognition on the part of MCOs that short-term treatment is not appropriate for all children. Maintenance services are now offered to children needing long-term supports and services. Greater use is also reported of a wraparound approach and services such as respite, case management, and day treatment.

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

According to respondents in eight of the nine reforms studied, managed care reforms have necessitated training for providers in new skills and approaches used in managed care systems. These findings are consistent with the 1997 sample; respondents in most states indicated that managed care has created the need for training providers. Stakeholders across sites in both the 1997 and 1999 samples identified 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 constitute a serious obstacle to the successful implementation of managed care.

Table 57 Need for Training for Child and Adolescent Providers					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Reform has created a need to train child and adolescent providers	5	3	0	1	

Use of Mental Health Professionals to Provide Substance Abuse Treatment

Hypothesis: Managed care reforms will result in increased use of mental health professionals to provide adolescent substance abuse treatment services.

Finding: **Not Upheld**

In four of the nine reforms, stakeholders reported that managed care has resulted in increased use of mental health professionals to provide adolescent substance abuse treatment services (**Table 58**).

Table 58					
Use of Mental Health Professionals to Provide Substance Abuse Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Increased use of mental health staff to provide substance abuse treatment	3	1	2	3	

Several reasons were cited by respondents, in some states, as to why mental health professionals are providing more substance abuse treatment than they were prior to managed care reforms. The primary explanation offered is that there is a serious shortage of adolescent substance abuse specialists in most states. Although this shortage predated managed care, neither has it improved as a result of managed care. Increased access to and demand for care in many states, coupled with the shortage of substance abuse staff, leaves mental health professionals to provide these services. The shortage of substance abuse staff in some states is further exacerbated by the difficulty experienced by substance abuse providers in meeting credentialing standards. For example, in one reform, certified addictions counselors (CACs) can be certified only if they are master's level.

Findings from the maturational analysis indicated that shortages of substance abuse treatment specialists, credentialing issues, and the use of mental health professionals to provide substance abuse assessments and treatment continue to be challenging for managed care systems, and some states reported efforts to address these issues.

- In **Connecticut**, for example, the state recently conducted a survey to determine whether substance abuse providers are included in the health plans' networks and found that, by and large, they are included.
- In **Delaware**, a concerted effort has been made to enhance providers' capacity to conduct both mental health and substance abuse assessments. As part of this initiative, mental health providers are being encouraged to hire CACs.

One state in the 1997 sample reported through the maturational analysis that changes in its licensing and certification laws have confounded the issue of who can offer adolescent substance abuse treatment. Recent revisions in this state's law require that mental health therapists conduct assessment and diagnosis of both mental health and substance abuse disorders; licensed substance abuse counselors are no longer permitted to perform these tasks. Further, licensed mental health therapists must provide supervision for substance abuse counselors.

Administrative Paperwork Requirements

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

Finding: **Upheld**

In the 1997 sample, the perception of respondents in all states was that managed care reforms had resulted in greater paperwork demands on providers. Findings are the same in the 1999 Impact Analysis; stakeholders in all nine of the reforms indicated that the paperwork burden has increased for providers due to managed care reforms. As one provider observed, managed care is like "being nicked and dined to death." Similar to the 1997 findings, the administrative and paperwork requirements that providers 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 (typically without any feedback).

Findings from the maturational analysis also affirmed that the paperwork burden continues to be a serious issue for providers. Small improvements were noted in two states. In Connecticut, the paperwork burden has decreased because the number of health plans has been reduced from 11 to five plans, and the state is requiring use of consolidated forms. In Arizona, the state has made an effort to streamline data reporting requirements, although providers still reported excessive paperwork requirements.

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, stakeholders reported that managed care reforms did not result in the disruption of ongoing relationships between children and their therapists to any significant degree (**Table 59**). Disruption was noted as more of a problem for children in the child welfare system who make frequent moves—a problem not necessarily caused by managed care reforms.

Table 59					
Disruption of Relationships with Providers					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Disruption of child and families' relationships with providers	1	2	4	2	

Strategies to prevent disruption of relationships were identified in the 1999 sample as follows.

- In **New Mexico** and other states, MCOs made diligent efforts to “grandfather in” and enroll existing therapists into networks specifically to avoid disrupting ongoing therapeutic relationships.
- In **Vermont**, efforts have been made to rectify this particular problem with a requirement that each child be allowed a six-month transition period with his/her existing provider. In addition, if a child changes from one MCO to another, the child’s therapist can be added to the new MCO’s network.

Structure and Organization of Providers

Hypothesis: There will be a trend toward new structural and organizational arrangements among providers resulting from managed care reforms.

Finding: Upheld

As in 1997, some structural and organizational changes among providers were noted by respondents in six of the nine reforms studied in the 1999 Impact Analysis (**Table 60**). However, the actual degree of restructuring that has occurred varies greatly from state to state. For example, respondents in one state noted that there was much “scrambling” among providers in preparation for the managed care reform, including use of external consultants, formation of legal entities, formation of informal alliances, and positioning to be included in networks. In Oklahoma, for example, three of the four CMHCs in Tulsa merged, and in the Oklahoma City region one urban and one rural CMHC merged. In two other states, major structural changes occurred because the CMHCs lost their monopoly on Medicaid behavioral health services. However, other states reported that little structural change in the market place has taken place as a result of managed care. Even if such changes as mergers have not occurred, respondents noted that providers have needed to make internal organizational changes to meet the administrative demands of managed care.

Table 60 Provider Structural and Organizational Changes					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Reform has resulted in structural and organizational changes in provider community	3	3	2	1	

Few changes were noted in this area in the maturational analysis. One exception was noted in Utah where mental health and substance abuse local authorities and providers have formalized a nonprofit organization, the Utah Behavioral Health Care Network. The new entity performs an advocacy and lobbying function and has the potential to consolidate administrative services and perhaps bid on managed care contracts in the future.

Provider Likes and Dislikes

What providers like and dislike about managed care in 1999 remains quite similar to the providers’ likes and dislikes found in the 1997 sample. There are many features of managed care that providers identified as positive, including:

- A broad and/or expanded benefit package.
- Expanded access to behavioral health care coverage for children.
- Greater clinical autonomy in subcapitated arrangements, where they exist.
- The inclusion of any willing provider in managed care systems, where this is allowed.
- Relaxed authorization requirements for outpatient services where this is incorporated.

Providers also identified many problem areas in managed care reforms. First, many providers observed that they were not and are not included in planning, implementation, and refinement processes, despite the enormous impact of managed care on providers. In addition, providers noted the following problem areas:

- Burdensome administrative and paperwork requirements in such areas as credentialing, billing, authorization and utilization management requirements.
- Serious delays in payment, especially in early implementation stages.
- Inability to obtain authorization for adequate lengths of stay in inpatient and residential treatment programs.
- Payment rates are too low to support best practices.
- Rigid and conservative medical necessity criteria and other utilization management processes that interfere with treatment decisions. ■

XIV. Impact on Interagency Relationships

Interagency Collaboration

Increased Collaboration

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

Finding: Upheld

Stakeholders in seven of the nine reforms in the 1999 sample reported that problems and challenges related to managed care are forcing child-serving systems to increase collaboration and joint problem-solving at both state and local levels (**Table 61**). This is consistent with findings from the 1997 Impact Analysis in which stakeholders in eight of the 10 states reported the same phenomenon. Stakeholders noted that implementation of managed care is a developmental process, in which, in most states, in the design and early implementation stages when establishing managed care processes, insufficient attention is paid to cross-systems issues. By mid-implementation, however, stakeholders pointed out that the cross-systems issues have created so many challenges, that state and local attention to them is inevitable. Even in states with strong interagency collaboration requirements in RFPs and contracts, stakeholders indicated that insufficient attention was devoted to working out cross-systems issues in the design and start-up stages. Stakeholders also expressed concern that as states and locales do begin to engage in interagency collaboration as a result of managed care, they tend to focus initially on individual high-cost children before beginning to address systemic issues.

Table 61					
Interagency Collaboration					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Increased interagency collaboration due to problems/changes of managed care reform	3	4	2	0	

Stakeholders noted that while interagency issues have posed longstanding challenges to states, they are made more complex by managed care, which adds new and more players to the table and tighter parameters around certain dollars, leaving other children's funding more exposed. A group of stakeholders in one state said that, "Managed care brings both the opportunity for better interagency collaboration and the danger of deteriorating relationships among agencies face-to-face." Another group of stakeholders in

a state in the early stages of implementing managed care noted that, "There is a lot of money across children's systems in our state, that is, we have highly funded categorical systems, with child welfare and juvenile justice basically having parallel mental health and substance abuse systems, so at the moment there is not a lot of incentive to collaborate. However, as managed care 'ratchets down' mental health spending, it will heighten pressure on other systems' budgets, and this will lead to greater interagency collaboration."

In states with carve outs that have pushed risk to the local level, such as Pennsylvania and Colorado, stakeholders reported that interagency collaboration related to managed care was occurring earlier and more effectively in counties with previous interagency system of care development efforts. In contrast, in states with integrated designs operating state-run managed care systems, such as Vermont, MCOs reportedly do not understand nor participate in local collaborative planning or local systems of care. In these states, local system of care efforts and managed care reportedly are on parallel tracks.

Some states in the 1999 sample and in the maturational analysis indicated they have put in place regular interagency workgroups or hold regular interagency meetings to address cross-systems issues related to children's behavioral health in managed care. In addition, several states and counties, for example, Delaware State and Bucks, Philadelphia and Delaware Counties in Pennsylvania, reported that they are engaged in interagency planning to develop new service capacity for managed care, such as therapeutic group care in Delaware State. In Iowa, the MCO reportedly has identified 11.6% of its population in care as also having DHS case workers and has begun to track utilization and to step up joint planning with the child welfare system around this group of children.

Among the populations of children and adolescents with which states and locales particularly struggle across systems are children with dual diagnoses of emotional disorders and mental retardation and developmental disabilities, youth with diagnoses of conduct disorders, and those who are sexual offenders. In the maturational analysis, respondents from Delaware State reported that the state engaged in an interagency planning process to apply for a federal Center for Mental Health Services grant to develop outcomes-driven service criteria, expand service capacity, and better manage care for some of these more difficult- to-serve populations, in particular, children with mental retardation/emotional disturbance diagnoses. Delaware also reportedly is working on the issue of youth transitioning into adult mental health and substance abuse systems, and youth transitioning from juvenile detention to community settings.

While interagency collaboration remains a challenge at state and local levels as in many states, Pennsylvania provides an example of a state that incorporated strong interagency requirements into its managed care system.

- In **Pennsylvania**, MCOs are required to have agreements in place with the following: physical health HMOs; local school districts; county juvenile courts; county health departments; county income maintenance offices; county juvenile probation offices; county mental health and mental retardation offices; and county child welfare offices. Agreements with child welfare must address the following: procedures for referral, authorization and coordination of care; provision for release of records; MCO representation in court proceedings; procedures to ensure continuity of care for children in substitute care; and procedures for communicating denials of service. MCOs also are required to have policies in place to address the needs of children served by multiple agencies. They are required to have policies in place to monitor the performance of providers from the standpoint of coordination with other agencies and the schools.
- At the local level, **Philadelphia County's** MCO, which is a quasi-governmental entity established by the county, is working with the child welfare and juvenile justice systems to coordinate residential placements and credential residential providers, and the MCO is collaborating with the juvenile justice system to implement a Multisystemic Therapy (MST) pilot.

Coordination Between Mental Health and Substance Abuse

Regardless of design, managed care reportedly has had no effect to date on improving (or worsening) collaboration between substance abuse and mental health systems at state or local levels. Stakeholders in seven of the nine reforms in the current sample reported that managed care has had no impact one way or another on this pre-existing problem (see **Table 62**). Two states (MD and PA) were exceptions, noting improved coordination between mental health and substance abuse agencies. Maryland stakeholders reported that some attention was paid to the coordination between the two in the design stage precisely because the state was separating the two, putting substance abuse in with the physical health MCOs and mental health into a carve out. Each physical health MCO is required to have a Special Needs Coordinator in place to focus on coordination issues between substance abuse and mental health, among other special needs populations. Pennsylvania stakeholders reported that state-level systems planning between substance abuse and mental health has improved as a result of managed care, but that there has been to date little effect at the local level. Even in Pennsylvania counties with a strong system of care interagency structure, stakeholders indicated that local substance abuse agencies tended not to be involved. In part, stakeholders attributed this to the fact that most adolescent substance abuse services were being paid for by children's systems, not by the substance abuse system, which they described as very adult-oriented.

Table 62 Coordination Between Substance Abuse and Mental Health Systems					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Collaboration between mental health and substance abuse systems has improved	2	1	3	3	

Payment Responsibility and Cost Shifting

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 the 1999 sample of states indicated that managed care is exacerbating the age-old issue of which system is responsible for paying for which services (**Table 63**), particularly for children and youth with complex and serious disorders. Exacerbation of this pre-existing problem was noted in seven of nine reforms in the sample.

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.

Table 63 Payment Responsibility Across Systems					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Managed care has worsened the problem of determining who is responsible for payment	3	4	2	0	

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 some states reported that MCOs will not pay for any services that are included in a child's IEP, including counseling services beyond a few office visits. As a result, costs to state and local education systems in these states reportedly are increasing, particularly for children with serious emotional disorders. These reports primarily were found in states with integrated designs. On the

other hand, in some states with carve outs, there were reports of local education districts cost-shifting to MCOs. In some of these states, education districts reportedly are using threats of lawsuits to resolve payment disputes with MCOs for treatment services included in IEPs.

Stakeholders in several states 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. There were some reports (in PA, NE, and IA) of MCOs working closely with child welfare and juvenile justice at local levels to resolve payment responsibilities and, in some cases, to co-fund service provision.

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. Maryland’s mental health carve out was the only reform in which such cost shifting was not alleged; of note is that this system is not capitated. As was also the case in 1997, there are little data to substantiate or refute these claims because few states reportedly are tracking cost-shifting (**Table 64**). Colorado was the only state in the current sample to report that it has started an interagency process to try to track cost-shifting. In the previous sample of ten states, two states reported in the maturational analysis that they have initiated some efforts to track cost-shifting. Delaware reported that the child welfare system is tracking how children in its custody are faring under managed care, and in Iowa, as noted earlier, the MCO is gathering, maintaining, and analyzing data on children in their care who have DHS caseworkers.

Table 64 Cost Shifting					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Cost shifting is alleged	4	4	1	0	
Cost shifting is being tracked	1	0	4	4	

Reports of cost-shifting into residential treatment services funded by other children’s systems, particularly child welfare, were widespread as managed care reportedly decreased inpatient utilization and costs. Only one state, however, (Colorado, which was also the only state reporting that they are tracking impact on other systems) provided

actual data showing a decline in inpatient costs and an increase in residential placement costs, from \$59 million in residential costs in the year prior to managed care implementation to \$189 million four years post implementation. Child welfare stakeholders in several states also reported that cost shifting was occurring from inpatient to shelter care beds operated by child welfare, and one state child welfare agency reported that it is considering increasing the rates paid to shelter care providers to reflect the increased acuity of the children they are serving.

Child welfare stakeholders in some states, primarily those with integrated designs, also claimed that cost shifting was occurring with respect to basic counseling services because MCOs would authorize only a few sessions, with child welfare having to pick up the cost of additional therapy. Also, there were reports of child welfare agencies' having to pay for psychological and neurological evaluations which MCOs would not authorize. Stakeholders indicated that these services previously had been paid for by Medicaid fee-for-service or by mental health system grants with the CMHCs. On the other hand, there also were a couple of states in which stakeholders indicated that child welfare was cost shifting to the MCOs, having managed care pay for services previously paid for by child welfare monies even though child welfare had not contributed dollars to the managed care pool.

Stakeholders in many of the states indicated there was cost shifting from the MCO to juvenile justice systems. They reported increases in the number of youth in detention facilities with serious mental health problems, which stakeholders attributed, at least in part, to managed care's ratcheting down of inpatient care. Stakeholders in some states said that judges are becoming frustrated with managed care system refusals to guarantee a certain number of months of care, and so are committing youth to treatment beds in the juvenile justice system. There were reports from a number of states that juvenile justice was increasing its expenditures on behavioral health services, creating, in effect, a parallel delivery system to the one in mental health (and, in many states, to the one in child welfare as well). In many states, there is tension between managed care and other systems created by differences of opinion over the appropriate setting for children with "primarily behavioral problems", i.e., children with diagnoses of conduct disorders.

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. These stakeholders asserted that state legislatures should be concerned about the total cost issue and mandating tracking of cost shifting as a result. ■

XV. Impact on Financing Behavioral Health Services for Children

Financing Mechanisms

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. As **Table 65** indicates, in all of the states with integrated physical health/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 attributed 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 in these states has enabled Medicaid to be used more flexibly and to cover a broader array of services than was the case under Medicaid fee-for-service. For example, some states, such as Pennsylvania, included the entire federally approved list of Medicaid services with their implementation of managed care, even though the previous state Medicaid plan did not include all services. They also used managed care as an opportunity to create new Medicaid provider types, for example, for wraparound service provision.

These findings essentially mirror those in the 1997 Impact Analysis, in which all of the states with carve outs reported that managed care made it easier to use Medicaid, and the two states with integrated designs indicated that basically it had not. Because there was an over sampling of states with carve out designs in 1997, it appeared as if it would be easier to use Medicaid in most states. In fact, it seems to be related to the integrated versus carve out approach.

Table 65 Using Medicaid to Finance Behavioral Health Services for Children and Adolescents					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
It is easier to use Medicaid as a funding source for behavioral health services for children and adolescents	4	0	0	4	1*
*Indiana's managed care reform does not include Medicaid dollars					

Use of Early Periodic, Screening, Diagnosis and Treatment (EPSDT)

Only two states in the 1999 sample (PA and VT) reported that managed care is enhancing the use of EPSDT to finance behavioral health service delivery. Two other states (CO and OK) indicated that managed care is enhancing the use of EPSDT screens, but not necessarily use of EPSDT dollars. The remainder of the states in the current sample reported that managed care has had no effect one way or another on use of EPSDT. This finding appears to reflect pre-existing issues with states' failure to use EPSDT as an effective financing mechanism for behavioral health services for children. Across the 1997 and 1999 samples, states with integrated designs were more likely than states with carve outs to use managed care to enhance use of EPSDT screens and funding, though primarily for physical health services. An example of the use of EPSDT to finance behavioral health service delivery was identified in Pennsylvania.

- In **Pennsylvania**, EPSDT dollars are used to fund wraparound services, which include behavioral specialists, therapeutic support staff, and mobile therapy. Stakeholders indicated that managed care is providing greater accountability for use of EPSDT wraparound services at the same time it is expanding use of EPSDT, particularly for certain populations of children and adolescents, including those with dual diagnoses of emotional disturbance and mental retardation, adolescents with substance abuse problems, and children involved in the child welfare system.

Use of Blended Funding

While, theoretically, managed care allows for the flexibility to blend funds to create more integrated delivery systems, only two of the states in the current sample (CO and PA—both carve outs—indicated that blending of funds was occurring as a result of managed care. In Colorado, blending of funds from child welfare, juvenile justice, mental health, and Medicaid is occurring in some localities in connection with managed care, for example, in El Paso and Boulder Counties. In Pennsylvania, blending of funds is occurring at both state and county levels as a result of managed care. Across the 1997 and 1999 samples, none of the states with integrated designs reported efforts to blend funds related to behavioral health service delivery for children, and only a handful of states with carve outs.

- **Pennsylvania's** carve out reportedly is financed by blending mental health and substance abuse block grant and general revenue dollars, Medicaid, and child welfare funds; child welfare was reported to have contributed \$50 million to the managed care pool when residential treatment was made part of the benefit design. At the local level, several counties indicated that they are co-funding new program development using blended dollars from managed care, child welfare and reinvestment dollars, for example, co-funding therapeutic foster care in the southeast region and co-funding a comprehensive youth services program in the southwest region using a blended case rate approach.

Reinvestment

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

Finding: Upheld

Three states in the current sample (CO, NE, PA)—all states with carve outs—require reinvestment of savings back into behavioral health services, though not specifically into children's services. None of the states with integrated designs in this sample reported that they have requirements for reinvesting savings into the behavioral health arena or into children's services. In fact, one of these states has legislation specifically prohibiting reinvestment of savings. This mirrors findings from the 1997 Analysis in which four of the 10 states in that sample (again, all carve outs) indicated they had requirements for reinvestment of savings into behavioral health services, and none of the states with integrated designs reported having such requirements.

Table 66 Reinvestment of Savings into Behavioral Health Services					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There are requirements for reinvestment of savings into behavioral health services	3	0	1	4	1*
*Maryland–MH is not a capitated system, so the concept of savings does not apply					

The issue of reinvestment is a critical one in that, in every state in the sample, stakeholders reported serious shortages of services, particularly of home and community-based alternatives to hospitalization and residential treatment, and many states reported that waiting lists attributable to lack of service capacity are hampering the effectiveness of managed care experiments.

Examples of reinvestment were identified in the 1999 sample as follows.

- **Nebraska** amended its original contract with its MCO to require that a percentage of profits above 3% be reinvested in new services and other system supports. In the first year of reinvestment, \$154,000 was available and used principally for child and adolescent services, including prevention services and training of clinical staff to work with youth returning from out-of-state placement. Other reinvestment projects included telemedicine targeted to the hearing impaired and the development of a statewide clinical resource book.
- In **Pennsylvania**, savings revert back to the county that generates them, and counties are required to have in place a county advisory committee, which must include family members, to develop reinvestment plans, that must be approved by the state. ■

XVI. Accountability of Managed Care Systems

Tracking Service Utilization

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 many states in the 1999 sample were considered to be a major impediment to incorporating effective and useful accountability systems in managed care systems. As shown on **Table 67**, stakeholders in not even one state in the 1999 sample regarded their MIS system to be sufficient to meet the demands of managed care systems. Similarly, in 1997 respondents judged MIS capacity to be sufficient in only two of 10 states.

Table 67					
Management Information Systems					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
The MIS system is sufficient to meet the demands of the managed care system	0	0	5	3	1

In general, the MIS systems at the MCO level were judged to be more adequate than at the state level. In one instance, stakeholders reported that the state abolished its MIS system and is relying on the MCO's information system exclusively. Even with better MIS systems at this level in some states, however, a number of problems were raised with respect to obtaining and using data on managed care system operations:

- Although the goal in many states is to have a data-driven system, much of the MIS data emanating from managed care systems is not as yet in a usable form. State and MCO stakeholders indicated that both staff and financial resources have been insufficient to allow for the management and analysis of the data in a timely manner to inform system refinements and to be useful to various system stakeholders.
- In some cases, states have had difficulty obtaining encounter data from MCOs for reasons including: lack of appreciation of the importance of encounter data, breakdowns in the exchange of data between providers and MCOs, information systems that are designed primarily for claims processing, and lack of clarity regarding what data are requested from MCOs and providers and in what format, and lack of financial incentives for either providers or MCOs to provide data.

States included in the maturational analysis reported attention to this area both in terms of learning what data to ask for and by including sanctions in contracts to ensure that data are provided.

- In **Iowa**, the contract now includes incentives and penalties related to data submission. The MCO's MIS reportedly has improved and is generating monthly reports with information that is helpful for management decisions. The child welfare population has been targeted as a subpopulation to regularly track with regard to service utilization.
- In **Connecticut**, MCOs are now penalized for not reporting required data to the state.
- In **Delaware**, funds were allocated and improvements made to the MIS. Each division within the children's agency has targets and receives reports from the system; the data emanating from the MIS reportedly has helped in legislative budget negotiations.

Tracking Service Utilization by Children and Adolescents

In 1997, all of the states with carve out designs reported tracking service utilization by children and adolescents across the full continuum of behavioral health services. As shown on **Table 68**, in the 1999 sample, four of the five carve outs (and one state with an integrated design) also reportedly are tracking children's behavioral health service use.

Despite reports of tracking, little service utilization data were available across states. In one state, respondents indicated that after nearly two years of system operation, no utilization data had yet been released. In another, data reportedly were not in usable form; utilization reports were awaiting further refinements to the data system. The maturational analysis revealed ongoing work on tracking utilization, but little concrete progress in producing utilization reports to inform further system planning and refinements.

Table 68 Tracking Service Utilization					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
The managed care system tracks service utilization across the full continuum of services for children and adolescents	4	1	1	2	1
The managed care system disaggregates data on adolescent substance abuse treatment	1	0	1	2	5

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

In the 1999 sample, the prediction that managed care systems would not disaggregate data on adolescent substance abuse treatment was upheld. **Table 69** shows that three of the four states with data do not separate out information on utilization of substance abuse services by adolescents; only one state (PA) reported doing so. This finding is consistent with the relative lack of attention to adolescent substance abuse services in managed care systems found throughout the Tracking Project activities.

Service Utilization Patterns

As in 1997, the Tracking Project attempted to explore specific effects of managed care reforms on service utilization patterns, as shown on **Table 69**. In spite of the lack of data in some states, stakeholders across all states offered their impressions of the impact of managed care on service utilization. Specifically:

- Penetration rates were reported to have increased in four of the five states with data, indicating that more Medicaid-eligible individuals (adults and children combined) are using behavioral health services than prior to managed care reforms in these states. In Nebraska, for instance, penetration rates were reported to have increased from 3/1000 to 7.5/1000 as a result of the managed care reform. In 1997, most states (eight of 10) states reported increased penetration rates in general. While overall penetration rates may have increased, some states were unable to break this down to determine if penetration rates for children and adolescents have increased.
- As in 1997, stakeholders reported that managed care reforms appear to have resulted in increased use of outpatient, home, and community-based services. In the 1999 sample, six of nine reforms reported this change; increased utilization of these services was reported in seven of 10 states studied in 1997.
- Four of nine reforms (all carve outs) reported increased use of wraparound services, consistent with 1997 when three of 10 reported greater use of wraparound approaches as a result of managed care reforms.
- As in 1997, some states in the 1999 sample indicated increased use of residential treatment as a result of managed care reforms (three of nine reforms), a change attributed by stakeholders primarily to the tighter controls on, and decreased access to, inpatient services. Length of stay in residential treatment, however, was reported to have declined in most states.
- Decreased use of inpatient services was reported by stakeholders in nearly all reforms in the 1999 sample (eight of nine), also consistent with 1997 findings in which eight of 10 states reported reduced admissions and lengths of stay in inpatient settings.

Table 69 Effects on Service Utilization					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Increased penetration rates are reported	3	1	1	0	4
Increased utilization of outpatient, home, and community-based services is reported	3	3	2	1	
Increased utilization of wraparound services is reported	4	0	1	4	
Increased utilization of residential treatment services is reported	2	1	3	3	
Decreased utilization of inpatient services is reported	4	4	1	0	

Quality Measurement

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

Finding: Partially Upheld

The 1997 Impact Analysis found some efforts to assess the quality of services in managed care systems in most states (seven of 10). In addition, all reforms reportedly incorporated some efforts to measure quality on the 1997-98 State Survey. Similar findings applied to the 1999 sample. As shown on **Table 70**, some efforts to measure quality were noted in nearly all reforms in the 1999 sample (eight of nine with data). In 1997, most quality measurement efforts appeared to center around the process of service delivery. In 1999, however, of those states reporting quality measurement efforts, half reported a primary focus on process, while half indicated that they go beyond the process of service delivery in their assessment of quality. Thus, the prediction that quality measurement would focus primarily on process indicators in most states was not upheld in the 1999 sample.

In 1997, few instances where quality measures or standards were specific to behavioral health services for children and adolescents were found. In the 1999 sample, few or no child-specific quality indicators were identified in five of the eight states with data. Thus, the prediction that quality measurement would not be specific to child and adolescent behavioral health services in most states was upheld. (The results of the 1997–98 State Survey were discrepant in that nearly 90% reported child-specific quality measures. The more in-depth look through the site visiting process suggests that the survey results may represent an overestimation of the extent to which child-specific quality measures are in use.)

Table 70 Quality Measurement					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
There are efforts to assess the quality of services	5	3	0	0	1
Quality measurement focuses primarily on the <i>process</i> of service delivery	1	3	4	0	1
Few quality measures focus specifically on behavioral health services for children and adolescents	2	3	3	0	1

The processes used to measure quality in states in the 1999 sample included a range of approaches and components, including:

- On-site reviews and audits of MCOs, including such activities as a review of records, assessment of priority issues, and review against requirements (CO, PA, MD-MH, NM)
- Focus groups with consumers and family members (CO)
- Report card with uniform indicators for each MCO, enabling comparisons on a set of indicators (IN)
- Committees and work groups focusing on quality. Examples include: a quality improvement advisory committee, including consumers and providers, that meets quarterly (VT); a Quality Integration Technical Work Group which in turn creates issue groups to focus on identified problem areas in the system (VT); and a Quality Improvement Coordinating Committee (NM)
- Review and analysis of grievances, appeals, and complaints tied to quality improvement (VT, MD-MH, NM)
- Requirements that each MCO develop and implement its own quality measurement and improvement process (PA, NM)
- Contract with external entity to conduct quality reviews and studies (MD-MH, NM)
- Use of HEDIS measures (though these have little focus on child and adolescent behavioral health) (OK, NM)
- Focused studies addressing quality in certain aspects of the system. Examples include a planned study on EPSDT implementation (OK) and a study on screening for depression by PCPs (NM)

Few specific results regarding quality measurement were provided by stakeholders that related to children and adolescents.

- In **Pennsylvania**, although no quality results have been released, quality monitoring teams have identified priority areas to focus on in quality measurement, including continuity of care, sufficiency of the rate structure (for MCOs and providers), use of EPSDT wraparound services, issues related to children in the child welfare system, transition issues from fee-for-service to managed care, and the degree of family education. In addition, state staff indicated that a quality management plan with six measures specific to children is under development.
- In **Oklahoma**, quality monitoring processes identified a decline in services after children were discharged from inpatient care with a diagnosis of clinical depression; corrective actions were then taken to address this problem.

Some focus on quality measurement was found among the states included in the maturational analysis.

- **Iowa's** contract now includes a set of 60 performance indicators, including 10 with financial incentives and ten with financial penalties.
- In **Delaware**, a statewide quality measurement system is under development since at present, each MCO has its own quality measurement approach.
- In **Utah**, a new monitoring model has been developed involving an adult team and a children's team that goes to each area annually. For a sample of clients, team members review records, meet with staff, meet with families, etc. to assess the quality of care. The children's team includes state staff, families, and contract psychiatrists and psychologists. The annual monitoring site visits also are a vehicle for technical assistance; the team meets with the directors and staff of the CMHCs following the visit to review findings, identify gaps, and recommend corrective actions.
- In **Arizona**, a Quality Management Committee was created and staff was added at the state level to expand the quality improvement function. Information collected relative to quality is now stratified by population so that results are analyzed for children, children with serious behavioral health disorders, and other populations.

Outcome Measurement

Measuring Clinical and Functional Outcomes

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 1997 Impact Analysis, the measurement of clinical and functional outcomes for behavioral health services was at an early stage of development, particularly with respect to children and adolescents. None of the 10 states in that sample reported having an outcome measurement system in place, but respondents in six states reported that the development of measurement systems for clinical and functional outcomes was in process. In the 1999 sample (shown on **Table 71**), some progress in this area is evident, with two states reporting measurement systems in place (CO and NM), but even in these, and in three additional states, these 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.

Table 71					
Outcome Measurement					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Outcome measurement system for clinical and functional outcomes exists	1	1	4	2	1
Outcome measurement system for child and adolescent behavioral health services is under development and is at an early stage of development	3	2	2	1	1
There are formal evaluations of the managed care system with a specific focus on children and adolescents	3	0	2	4	

Strategies used for measuring clinical and functional outcomes include the following.

- In **New Mexico**, the federal Mental Health Statistics Improvement Program (MHSIP) package is required for outcome measurement; the CAFAS is included in this package for measuring functional outcomes in children.
- In **Maryland–MH**, the Consumer Satisfaction and Outcomes Study obtains caretaker assessments of outcomes for children. Although no pre-managed care baseline data exist, the study found improved functional outcomes reported by caretakers for children after service delivery. For eight of the 14 outcomes examined, 60% or more of the 492 caretaker respondents agreed that children had improved as a result of the mental health services received. For example, improvement was reported with respect to the extent of interference with school, daily, and social activities resulting from emotional problems. Most children were not arrested nor did they spend time in juvenile justice facilities. Considerable stakeholder input reportedly was solicited in the development of instruments and in planning methods for the outcomes study.
- In **Pennsylvania**, MCOs are required to use an outcome measurement instrument specific to children, but the state does not require a particular instrument. The indicators related to clinical and functional outcomes that are prescribed for measurement include: increased community tenure and less restrictive services, increased vocational and educational status, and reduced criminal/delinquent activity.

In the maturational analysis, some efforts to further develop and refine measurement of clinical and functional outcomes were identified. For example, several states (DE, MA, and IA) are adopting or expanding their use of the CAFAS for this purpose, and Washington State has received a three-year grant from CMHS to support the development of performance indicators.

As in 1997, the 1999 Impact Analysis found that although some states are conducting formal evaluations of their managed care systems, few include a specific focus on behavioral health services for children and adolescents. In the 1999 sample, stakeholders in only three states reported that their evaluations include a specific focus on children and adolescents. Similarly, in the 1997 sample, only two states (out of the five with formal evaluations underway) reported a specific focus on children and adolescents. The 1997-98 State Survey also found that less than half of the states conducting formal evaluations of their managed care systems included a specific focus on children and adolescents.

An example of an evaluation focusing on children was identified in Colorado.

- In **Colorado**, a study used family focus groups and case studies to examine the following: how treatment and support needs of children are addressed, to what extent needs are being met according to various stakeholders, and why needs are perceived to be met or unmet. The study, conducted during the first year of the reform, yielded generally positive results on the extent to which families felt their children's needs had been met.

The maturational analysis did not reveal significantly greater attention to children in evaluations undertaken in the 1997 sample since the time of the site visits. Respondents in several states (WA, MA, and IA) reported that new evaluations were completed or underway, however, minimal data and few specific references to children's issues were included in any of them.

Measuring Satisfaction

In the 1997 sample, respondents in four of the 10 states related that family satisfaction with behavioral health services for children and adolescents was measured in some systematic way, with two additional states planning to introduce a measure of family satisfaction. The 1997-98 State Survey also 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, indicating the importance ascribed to family satisfaction as an outcome domain. These results are substantiated by the 1999 Impact Analysis sample. As shown on **Table 72**, family satisfaction with behavioral health services reportedly is measured by seven of the nine reforms, all of the carve outs and half of those with integrated designs.

Table 72 Measurement of Satisfaction					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Family satisfaction with behavioral health services is measured	5	2	0	2	
Youth satisfaction with behavioral health services is measured	3	0	2	4	
Provider satisfaction is measured	2	2	3	2	

Efforts to measure satisfaction take several forms among the states studied, including those specific to behavioral health, but which may or may not have instruments, items or processes specifically designed to assess the perceptions of *families of children* receiving behavioral health services. Other methods explore satisfaction with the overall managed care system including both physical health and some behavioral health focus. Examples of efforts to measure satisfaction include the following.

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- In **Pennsylvania**, an annual family satisfaction survey is conducted by the state. In addition, contracts with MCOs require that they have consumer and family satisfaction teams to follow up with recipients of services and assess satisfaction through surveys, random calling, and face to face discussions. Some counties reportedly are contracting with family organizations to develop family satisfaction teams.
 - In **Oklahoma**, a “Consumer Assessment of Health Plans” is required that includes two optional behavioral health modules. In addition, state respondents reported that they have conducted focus groups with adult consumers and parents of children with behavioral health problems to obtain feedback.
 - In **Colorado**, the MHSIP Consumer Survey is mailed to a sample of adult consumers and family members, with respondents paid \$5 for returning the completed survey.
 - In **Maryland–MH**, a consulting firm conducted a satisfaction survey with a specific focus on children’s mental health services that will be repeated. The survey addressed general satisfaction with services provided through the managed care system, and specifically explored whether families felt they had a choice in selecting their children’s provider, unmet service needs, and satisfaction with a subset of service approaches (outpatient, family support, inpatient, and residential treatment) on dimensions including access to services, adequacy, and quality. Questions addressed location, staff willingness to help, returning calls, inclusion in treatment planning, giving information regarding rights, cultural sensitivity, confidence in the knowledge and abilities of staff, and others.

With the exception of Maryland-MH where study results showed family satisfaction to be generally high (though pre-reform baseline data for comparison were not available), no data on family satisfaction were provided by the sites visited.

Some efforts to refine measurement of family satisfaction were noted through the maturational analysis.

- In **Utah**, the Family Perception of Care Scale was developed through a contract with a consultant and has now been implemented. In addition, the Utah Burden of Care Scale is used to go beyond measuring satisfaction by measuring stress on families.
- In **Arizona**, the MHSIP consumer perception survey is now used, including a version for families. A version for youth is under development.

States in the 1999 sample appear to be paying greater attention to the measurement of provider satisfaction than those visited in 1997; four states reported assessment of provider satisfaction (CO, MD-MH, NM, and OK) as compared with only two in the 1997 sample. Although no data were provided, stakeholders across states agreed that provider satisfaction has likely decreased as a result of managed care reforms due to such problems as increased administrative burden and paperwork, lower rates in some cases, stringent and onerous utilization management processes, loss of control in making clinical decisions, the need to deal with multiple MCOs, claims processing problems and late payments, and other factors.

Less attention is paid to youth satisfaction—three states in the 1999 sample (all carve outs) reported assessing youth satisfaction. This represents an increase from the 1997 sample in which no states were measuring youth satisfaction at the time of the site visits.

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

As noted, an explicit and major goal of managed care reforms is to control costs, specifically in state Medicaid programs. As in 1997, the 1999 Impact Analysis found that this goal is not necessarily being achieved as intended (**Table 73**). In two of the six reforms in the 1999 sample providing information about Medicaid costs, decreased aggregate Medicaid behavioral health costs were reported by stakeholders, but in two other reforms (of the six providing information) increased aggregate costs to Medicaid were reported. In the other two states, it is assumed that Medicaid costs have remained constant.

Although costs may not have decreased in some states, and even if increases are reported, managed care reforms may be achieving some success in controlling the rate of growth in Medicaid costs. For example, respondents in New Mexico reported that prior to the reform, overall Medicaid costs were growing at a rate of about 20% per year, and the post-reform rate of growth was estimated at about 6%. It should be recalled that states reported different cost-related goals, with some specifically wanting to cut Medicaid expenditures with managed care reforms, while others were more interested in controlling the rate of growth.

The effect of managed care reforms on the proportion of funds spent on outpatient, home, and community-based services versus hospital services is also shown on **Table 73**. Noteworthy is the fact that 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 did shift in this direction. The lack of data from more than half of the states in the sample makes it difficult to draw conclusions on the impact of managed care in this area among states in the 1999 sample.

Table 73 Cost					
N=9	Yes		No		N/A or No Data
	Carve Out	Integrated	Carve Out	Integrated	
Increased aggregate Medicaid behavioral health costs are reported	1	1	3	1	3*
Decreased aggregate Medicaid behavioral health costs are reported	1	1	3	1	3*
The proportion of funds spent on outpatient, home and community-based services vs. hospital services has increased	2	0	1	1	5
* Indiana's reform does not involve Medicaid funds, and respondents in two other states could not provide information on aggregate Medicaid costs					

Data on the impact of reforms on the cost per child served, cost per eligible child, and the impact on the costs of behavioral health services to other child-serving systems also were not available from the majority of states in the 1999 sample. ■

XVII. Overall Stakeholder Impressions

During the site visits, respondents were asked to identify what they believed to be the most positive effects of the managed care reform and what they believed to be the most serious problems resulting from these reforms. The positive effects and problems they related are summarized below.

Stakeholder Impressions of Most Positive Effects

Across the nine reforms studied in the 1999 Impact Analysis sample, a range of beneficial effects was noted. The positive effects noted below represent those for which there was general consensus across stakeholder groups within a state that this was one of the “most positive effects” of the managed care reform in their state. It is important to recognize that many of these effects are found in other states as well. However, they are included in this section only if stakeholders in a state, with some degree of consistency, judged them to be the *most significant positive impacts* in their respective states. It should also be noted that some areas described as significant positive outcomes present a different picture than that presented in the discussion of findings elsewhere in this report. These seeming discrepancies raise interesting questions about what stakeholders perceive as positive outcomes, even when the outcomes may be less clear when they are questioned more specifically or when data are examined. This section should be seen simply as stakeholder perceptions of positive effects, regardless of the degree or of whether they are substantiated. For comparative purposes, the most positive effects cited by stakeholders in the 1997 sample are noted as appropriate. With several exceptions, many of the same positive effects were noted by stakeholders in both the 1997 and 1999 samples. The positive effects cited by respondents in the 1999 sample included the following:

- **Improved Access to Behavioral Health Care Services** — In nearly all of the reforms studied in the 1999 sample (eight of nine), improved access to behavioral health services was considered to be an important positive outcome. This appears inconsistent with findings discussed earlier that initial access was perceived to be easier in only four states, and access to extended care was perceived to be more difficult in nearly all states. However, despite ongoing access problems, stakeholders cited coverage of more children, expanded provider networks, toll free numbers for access, single points of entry, standards governing the timeliness of service provision, and reduced waiting lists were all cited as contributing factors to improvements in access in various states. Improved access to care was characterized as a significant positive outcome by most states in the 1997 sample as well.
- **Increased Array of Community-Based Services** — Expansion of the array of services, particularly community-based services was also noted as a major positive effect by nearly all reforms in the 1999 sample (seven of nine) and by half of the states in the 1997 sample. Respondents noted that managed care reforms have resulted in coverage for an expanded array of services in many states, some growth in outpatient, home, and community-based service options (though capacity problems remain pervasive), and increased incentives to use these types of services.

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- **Increased Focus on Accountability** — Stakeholders in the majority of reforms in the 1999 sample (seven of nine) believed that an increased focus on accountability is a significant positive outcome of managed care reforms, though this was cited by only 3 states in 1997. The introduction of quality standards and quality measurement processes, performance monitoring, greater focus on outcomes, and greater emphasis on data-based decision making were seen as contributing, even though all of these processes are in early developmental stages in most states.
 - **Expanded Provider Network** — In five states in the 1999 sample, expansion of the provide network was seen as a major positive effect based upon allowing new types of providers to participate (such as licensed mental health counselors and licensed social workers), as well as opening up the system to new types of programs and services. Interestingly, this was not mentioned by stakeholders as a major positive effect in the 1997 sample.
 - **Decreased Use of Inpatient Services** — Respondents in four states in the 1999 sample (six states in 1997) felt that decreased use of inpatient services was a positive effect, particularly given historical overreliance on inpatient care. Many stakeholders regarded the tightening of criteria for inpatient admission and reduced lengths of stay as progress in moving systems toward more community-based models. However, at the same time, stakeholders expressed concerns about excessive restrictions on access to needed inpatient care and about discharging youngsters prematurely, prior to stabilization and linkage with appropriate community services.
 - **Increased Consistency in Clinical Decision Making** — In four states, increased consistency in clinical decision making was regarded as major positive effect; this was also seen as a positive outcome in half the states in the 1997 sample. The use of criteria such as ASAM criteria for adolescent substance abuse treatment and level of care criteria to guide clinical decisions was credited.
 - **Increased Attention and Priority on Children** — Respondents in three states in 1999 (and four in 1997) felt that managed care reforms had generally stimulated an increase in the attention given to children's behavioral health services and increased the priority placed on them.
 - **Improved Interagency Relationships** — Improved interagency relationships and partnerships were cited as an important positive outcome in three states in 1999; stakeholders in four states in 1997 also agreed that this was a positive effect. Improved relationships resulting from managed care reforms were based on greater discussion across systems for both planning and problem solving and the resulting clarification of responsibilities for services and payment across child-serving systems.
 - **Increased Flexibility in Service Delivery** — Respondents in two states in 1999 and two states in 1997 indicated that managed care reforms increased opportunities to provide more flexible and individualized services and regarded this as a major positive effect.

Stakeholder Impressions of Most Serious Problems

In addition to identifying positive effects, respondents were asked to identify the most serious problems that they felt were caused by or associated with managed care reforms. The problems discussed below are those in which there was general agreement among stakeholders in a state that this was one of the “most serious problems” resulting from the reform. Again, these problems are found in other states, but the states included below are those in which stakeholders, with some degree of consistency, judged them to be the *most significant problems* in their respective states. Again, for comparative purposes, the most serious problems cited by stakeholders in the 1997 sample are noted where relevant.

- **Increased Administrative Burden** — Increased administrative burden was deemed a most serious problem by respondents in many states (six in 1999 sample and five in the 1997 sample). This indicates that all the various processes related to managed care systems from eligibility determination to credentialing, service authorization, utilization management, claims processing and accountability requirements are regarded by many stakeholders as more time consuming and cumbersome than before, often adding significant administrative costs.
- **Resistance to Managed Care Reform** — Resistance to change, particularly on the part of providers, has created serious problems for managed care reforms, according to stakeholders in six states in the 1999 sample. Interestingly, resistance was not mentioned by respondents in any states in the 1997 sample as one of the most serious problems, although such resistance was noted. Respondents in one state described “howls of protest” by providers facing this system reform. The pervasive resistance to managed care necessitates, according to stakeholders, extensive efforts to involve and educate providers and other stakeholders about the reform in order to begin to overcome their opposition.
- **Lack of Service Capacity/Insufficient Investment** — In five of the nine reforms in the 1999 sample (and in three of 10 in 1997), lack of sufficient service capacity and lack of sufficient resources to invest in service capacity development were considered to be daunting problems for managed care systems. Service availability remains uneven within states— particularly for home and community-based services and within rural and frontier areas. Lack of service capacity was seen as especially serious given the focus of managed care systems on reducing the use of inpatient and residential treatment settings. Without corresponding increases in outpatient, home and community-based service capacity, respondents noted that this is “setting up children to fail.” Stakeholders across states emphasized that attention and substantial investments in service capacity development are needed, especially in rural areas, to begin to meet the need and demand for services. The goal and apparent progress of managed care systems in increasing access underscores the critical importance of tackling the challenge of service capacity development.

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- **Lack of Substance Abuse Services for Adolescents** — A related problem is the critical lack of substance abuse services for adolescents, cited as one of the most serious problems related to managed care reforms by stakeholders in five states. In these, and in most other states, substance abuse treatment options for adolescents were described as largely unavailable. Although this problem clearly pre-existed managed care reforms, the reforms have highlighted the need and compounded the capacity problem by the barriers and limits often imposed by MCOs.
 - **Problems Related to Provider Networks** — Respondents in five states in the 1999 sample (none in 1997) cited problems related to provider networks as being among the most serious issues associated with managed care reforms. Aspects of this problem related to provider readiness to deliver the range of services that may be incorporated in managed care systems, such as lack of providers with the knowledge and skills to deliver the wider range of treatment modalities included in managed care systems, getting providers reconfigured and trained to provide the new services and moving providers away from the more traditional paradigm of services to new ways of thinking. Stakeholders also cited problems related to providers choosing not to participate, struggling, or even being forced out of business as a result of lower rates and excessive administrative burden within managed care systems.
 - **Low Rates** — In the 1999 sample, respondents in five states cited low rates as a serious problem. In some cases, this related to provider payment rates which were considered too low for agencies to maintain and adequately staff and provide quality services. In other cases, stakeholders felt that capitation rates were too low, providing insufficient compensation for and creating incentives to underserve individuals with the most serious and complex disorders. In some states, respondents believed the entire managed care system was underfunded.
 - **Insufficient Education of Stakeholders** — In four states in the 1999 sample (three in 1997), insufficient education of stakeholders was characterized as a serious problem by stakeholders. They emphasized that there is a “learning curve” for stakeholders to become familiar with the managed care system and its processes and that, for the most part, insufficient information has been provided about the system to partner agencies, families, providers, and others such that they do not have an adequate understanding of system goals, procedures, and requirements. (An example provided in one state was that most child welfare staff were unaware that a certain number of outpatient visits were allowable without prior authorization.) The need for more systematic ways of reaching out to, informing, and educating stakeholders, who are critical to the effective implementation of the system, was highlighted by many respondents.

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- **Problematic Service Authorization Processes** — Respondents in four states in the 1999 sample agreed that service authorization processes were among the most serious problems related to their managed care systems; these complaints were pervasive in other states as well. In general, service authorization processes were described as stringent, lengthy, cumbersome, onerous, inconsistent, and frustrating. In many cases, stakeholders complained that these processes make it difficult to gain access to adequate levels and durations of treatment, perhaps felt even more strongly with respect to substance abuse services. One respondent described “level of care creep” whereby the system used authorization processes initially to restrict access to inpatient and residential care, and are now beginning to clamp down on lower end services.
 - **Problems Serving Children with Serious Disorders** — Stakeholders in three states felt that a serious problem was related to adequate service provisions for youngsters with serious behavioral health disorders within managed care systems (also noted by two states as a most serious problem in 1997). Problems included: insufficient focus on children with more serious disorders, lack of inclusion of special services or strategies for managing care for this high utilizer population, and lack of financial incentives to adequately serve this group, among others.
 - **Narrow Interpretation of Medical Necessity** — Overemphasis on medical necessity and a medical orientation was seen by stakeholders in three states as a serious barrier to providing appropriate behavioral health care. Narrow definitions of medical necessity, especially as applied to seriously ill populations, strict interpretation of these criteria by MCOs even when state definitions are broad, and ongoing debates as to whether treatment needs relate to “medical” or “psychosocial” issues were seen as problematic.
 - **Use of Multiple MCOs** — Stakeholders in three states regarded the use of multiple MCOs as a serious problem, based on the different procedures, processes, guidelines, and services that might be authorized and provided by each. The resulting inconsistency, confusion, and administrative “nightmare” created by the use of multiple MCOs was especially troubling to providers, but also to state agencies charged with the task of overseeing and monitoring system operations.
 - **Fragmentation of Funding Streams** — In two states in 1999, and in four in the 1997 sample, fragmentation among the multiple funding streams supporting behavioral health care to children and adolescents was considered a serious issue. From multiple funding streams, comes confusion as to responsibility for payment for various children and various services as well as potential for cost shifting. Although this is a perennial problem for children’s services, the confusion may be exacerbated by managed care reforms that involve new players (MCOs), processes, and rules regarding access to and payment for services. Multiple funding streams for children’s behavioral health services were cited by some stakeholders as one of the greatest challenges in achieving continuity of care in managed care.

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- **Inadequate Data Systems** — Though most states reported this problem, two states in the 1999 sample (and two in the 1997 sample) singled out the issue of inadequate data systems as one of the most serious problems, contending that data systems are not sufficiently developed to assist in system planning and management.
 - **Negative Views or Unrealistic Expectations of Managed Care** — Generally negative views or unrealistic expectations of managed care were seen as a major problem by respondents in three states in the 1999 sample and four in the 1999 sample. Negative views included myths, misconceptions, and negative impressions of managed care in general, leading to suspicion and fearfulness of all aspects of the reform. One stakeholder said that managed care is seen as a “giant monster” and that people spend a great deal of energy fighting it. More attention to the front-end introductory and educational process around the managed care reform reportedly is needed to mitigate some of the negative expectations and to improve acceptance of the reform, as well as to counter some of the unrealistic expectations that stakeholders may harbor about the reforms, for example, that service capacity problems would be solved quickly or quality of services would dramatically improve immediately.
 - **Implementation Problems** — In the 1997 sample, two states (none in the 1997 sample) described tremendous administrative and systemic glitches and failures during the implementation of the system, leading them to designate this as one of the most serious problems associated with managed care reforms. In one state, for example, the system infrastructure was not adequate to handle the volume of calls, authorizations, utilization reviews, enrollment, claims processing, and other demands of the system resulting in extensive errors, delays, and frustration. One stakeholder described the situation as an “implementation disaster” that has taken a great deal of time to work through and correct. ■

XVIII. Stakeholder Advice

Stakeholders in all states in the 1999 sample were asked what advice they would offer, based upon their experience, to other states or communities that are implementing managed care systems. Respondents were asked to provide advice to states and communities in the process of planning, implementing, or refining managed care systems. Recommendations were provided related to system planning, stakeholder relationships, MCOs and providers, utilization management and service delivery, and data and accountability.

System Design and Planning

- Allow adequate start-up time for planning and implementing a managed care system; expect that a major system change such as a managed care reform will take a great deal of work and time.
- Incorporate a slower implementation period allowing for phasing in or piloting of approaches before statewide implementation.
- Learn from other states' experience.
- Eliminate demarcations and boundaries within the system to the extent possible; every boundary around eligibility, responsibility, funding streams, and services will create serious operational problems.
- Incorporate a broad benefit design.
- Incorporate acute and extended care in a single behavioral health system to minimize cost shifting and to ensure that all players manage care effectively over time.
- Build system of care principles and values into RFPs and contracts.
- Do not split mental health and substance abuse into two separate systems.
- Create a behavioral health carve out.
- Build in enhanced benefits for children with high end needs and incorporate this into the pricing of the system.
- Design a carve out for children with serious and complex behavioral health disorders based on the system of care approach.
- Address the special needs of the child welfare and juvenile justice populations in planning the managed care system and incorporate both risk adjusted rates and special provisions to meet their needs.
- Avoid focusing solely on cost containment to the detriment of quality of care.
- Build on the states' existing strengths and system of care infrastructure in planning and implementing the managed care system.
- Recognize the changes in the state mental health agency structure that may be required by the implementation of managed care reforms and ensure that appropriate expertise and staff are brought in, for example, procurement and data management staff.

Stakeholder Relationships

- Listen to and involve stakeholders involved in behavioral health services for children and adolescents from the outset in all aspects of system planning, implementation, and refinement.
- Value consumer and family experience and perspectives and incorporate their input into all aspects of the system.
- Create an effective advisory structure in which all key stakeholders, including families, meet on a regular basis.
- Develop a close working relationship with state Medicaid officials and become highly knowledgeable about behavioral health requirements and options under Medicaid.
- Know the politics and leaders in the system, work with them to focus on children's services.
- Educate the Medicaid agency, MCOs, BHOs, and other stakeholders about the system of care philosophy and approach and issues related to child-serving systems.
- Incorporate an aggressive approach to educating all stakeholders about system goals, operations, strengths and limitations (including how it works, what is covered, and what is possible within the system) to avoid and correct misconceptions. Provide ongoing training and technical assistance that involves all stakeholders.
- Hold regular monthly meetings to resolve issues and problems.
- Anticipate fear, anger, and resistance due to the reform.
- Incorporate an ombudsman role in the system.
- Hire a coordinator or liaison to manage the interface between the MCOs and other systems.
- Educate consumers, families, and providers about the grievance and appeals process and provide assistance for them in negotiating the process.

MCOs and Providers

- Use one BHO per county or region (or one BHO statewide) to minimize complexity.
- If multiple MCOs or BHOs are used, require standardization of key aspects of system operations such as credentialing, medical necessity and level of care criteria and the like to reduce the burden of complying with different sets of rules and procedures.
- Consider using nonprofit and government entities as MCOs.
- Set realistic capitation rates and provider payment rates.
- Create higher capitation rates for children involved in the child welfare and juvenile justice systems so that MCOs will be more willing to serve these populations.
- Set contractual caps on administrative costs and profits for MCOs and BHOs.
- Educate MCOs and providers about the needs of youth with serious behavioral health disorders and about system of care concepts.
- Allow sufficient time to build an adequate provider network.
- Streamline administrative processes and paperwork requirements for MCOs and providers.
- Recognize the importance of obtaining “buy-in” from front-line clinicians and provide extensive education and training about system operation and new treatment approaches.

Utilization Management and Service Delivery

- Use uniform statewide criteria for clinical decision making to improve consistency and to create a template against which monitoring can be done.
- Ensure that medical necessity criteria allow for consideration of psychosocial and environmental factors.
- Ensure that unrealistic definitions of medical necessity are not applied as a precondition for substance abuse treatment.
- Reduce the use of prior authorization for outpatient services and make authorization and reauthorization processes less burdensome.
- Incorporate a strong focus on service capacity development, particularly in rural areas.
- Mandate reinvestment of savings into service development.
- Focus on building substance abuse treatment capacity for youth, particularly for youth with co-occurring disorders.
- Develop the array of intermediate services before phasing in populations with more serious and complex disorders.
- Incorporate care coordinators and case managers who work closely with other community agencies and are integrally involved in interagency treatment and service planning efforts for children with serious disorders.
- Streamline administrative processes and paperwork requirements for MCOs and providers.
- Require the use of a behavioral health assessment as part of the EPSDT screening process and require reporting of the results to the behavioral health system and ongoing communication between physical health and behavioral health providers.

Data and Accountability

- Incorporate a systematic way to monitor cost shifting to other systems as a result of managed care reforms.
- Develop, disclose, and make better use of data on system utilization, quality, and outcomes from the earliest stages of system development.
- Incorporate statewide standards for quality and outcomes
- Ensure assertive state monitoring of the managed care system to ensure accountability and quality of care. ■

XIX. Conclusions and Next Steps

Background

The Health Care Reform Tracking Project was initiated in 1995 in response to the rapid expansion of managed care from the private commercial sector to the public sector. Its purpose was to track and analyze the impact of public sector managed care reforms on children and adolescents with emotional and substance abuse disorders and their families. Over the past five years, the Tracking Project has been the only national study focused on the impact of managed care on this population. The project has produced extensive descriptive information and assessments of early stages of states' implementation of behavioral health managed care reforms.

As noted, the methodology of the Tracking Project has included two major approaches—surveys of all states and impact analyses through in-depth site visits to a sample of states. The all-state surveys were designed to identify, describe, and track the managed care reforms being implemented by states that affect behavioral health service delivery for children and adolescents. To review, an initial baseline survey was conducted in 1995 to identify and describe health care reforms, and the all-state survey was repeated in 1997-98 in order to document what changed and what remained constant during the rapid expansion of public sector managed care implementation in the mid-1990s.

The impact analyses were designed to explore the impact of these reforms on children with behavioral health problems and their families, and on the systems of care that serve them. The impact analysis process used a case study method involving site visits to states during which semi-structured interviews were held with multiple groups of key stakeholders. The first impact analysis was conducted in 1997 with a sample of 10 states with variability in managed care design, geographic diversity, and differences in state structure. During 1999, the impact analysis process was repeated with a new cohort of eight states. In addition, a maturational analysis, involving telephone interviews with key stakeholders, was conducted of the 1997 sample of states to identify changes in managed care systems that have been incorporated over time and the effects of these changes. Thus, over the past five years, the Tracking Project has described state managed care reforms through two surveys of all states, and analyzed the impact of state policy choices and strategies related to behavioral health managed care reforms in 18 states.

Conclusion

The Tracking Project overall, and the *1999 Impact Analysis*, in particular, suggest a “good news, bad news” picture. The good news is that, increasingly, in their policy decisions and purchasing specifications, states, particularly those with carve out designs, are moving toward choices and changes that would seem to benefit children and adolescents with behavioral health problems and their families—for example, broadening medical necessity criteria and the array of covered services; incorporating family involvement, cultural competence, level of care criteria and interagency collaboration into purchasing specifications; involving key stakeholders more in planning and redesign; doing more training of MCOs on the needs of the population; beginning to create more home and community-based services and alternatives to inpatient hospitalization; and working more collaboratively across child-serving systems to problem solve.

The bad news, however, is that stakeholder reports indicate a major disconnect between state policies and contractual requirements and what actually is occurring at the implementation level. For example, in spite of broader medical necessity criteria, clinical decision making and management remains rigid. In spite of a broader array of covered services, home and community-based services are in short supply, access is difficult, and waiting lists persist, in spite of contractual access standards. Though interagency problem solving is growing, reports of cost shifting and fragmentation of services, especially for children with serious disorders, abound. In spite of increased attention to issues of family involvement and cultural competence, operationalization of these concepts at policy and service levels is incremental.

Most stakeholders recognize managed care reform as a developmental process in which, initially, states focus on getting managed care “up and going” and, after a year or two, begin to focus on particular population issues, cross-agency issues, quality and outcome measurement, and the like. Developmentally, there often is a lag between state policy decisions that reflect this more deliberate focus and the effects of those decisions being felt at the implementation level. Thus, the Tracking Project is finding a certain dissonance within stakeholder perceptions—a level of optimism over policy changes at state levels and a degree of pessimism over continued implementation problems.

New Direction

The Health Care Reform Tracking Project will continue over the next five-year period, building on the results of its previous activities. The surveys and site visits conducted through the Tracking Project have raised many issues and questions related to public sector managed care reforms that are of particular concern and importance to serving children and adolescents with behavioral health disorders and their families. In addition, promising approaches to meeting the needs of children and adolescents with behavioral health disorders within the context of public sector managed care systems have been identified in a number of states and communities. The issues, questions, and promising approaches identified during the first five years of Tracking Project activities will form the basis for the project's continued exploration of public sector managed care and financing reforms over the next five-year period.

In addition, during the past few years there have been several other important developments in the financing of services for children with behavioral health problems and their families. The initiation of the State Children's Health Insurance Program (SCHIP), which

provides federal funds to expand health insurance for children, offers states the flexibility to use block grant funds to expand Medicaid coverage, to create or expand health insurance plans that meet certain benchmark coverage requirements, or to do a combination of these approaches. States also have a number of choices regarding the inclusion of mental health services within SCHIP. The Temporary Assistance to Needy Families (TANF) legislation reformed public welfare, including the imposition of time limitations on the receipt of welfare benefits. States' implementation of TANF has dramatically reduced the number of families receiving cash assistance, and the number of children who are eligible for Medicaid, some of whom may become eligible for SCHIP. In addition, some states have elected to use TANF funds for mental health and substance abuse services as a means of helping families find and keep jobs. Given the inter-relationships among Medicaid, SCHIP, and TANF, the policy responses that states are making to these new financial opportunities and relationships are important areas of inquiry for new Tracking Project activities.

Financing changes in children's behavioral health services are also occurring at the community level. The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA) has provided grants to local communities and states across the country. The purpose of the program, known as the Comprehensive Community Mental Health Services for Children and Families Program, is to enable communities to develop a comprehensive system of supports and services for children with emotional disturbances and their families. Some of the grantees (as well as other communities) are experimenting with blending funding, often in a managed care environment, to support more integrated service delivery. In addition, in many states, the financing and organization of children's behavioral health services is being affected by privatization initiatives in child welfare and juvenile justice, which often involve behavioral dollars and managed care applications.

The overall research questions for the next five years of the Health Care Reform Tracking Project are:

- What are the policy approaches and implementation strategies in the area of behavioral health care financing, and particularly within Medicaid managed care and SCHIP, that states and communities are using to promote effective services for children with emotional disturbances and their families?
- How well are these policy approaches and strategies working according to the perceptions of key stakeholders? What data are available and what do they indicate about the effectiveness of these policy approaches and strategies?

The Tracking Project will use a mixed method approach to answer these questions. The design includes three major components — surveys of all states, in-depth case studies of states and communities with promising managed care and behavioral health financing approaches, and a consensus conference held during the fourth year of the project.

State Surveys

The all-state surveys will be conducted in the first and fourth years of the project. The surveys will be designed to continue to track and describe the managed care and financing reforms affecting children's behavioral health services that are being implemented by states, especially in the areas of Medicaid managed care and SCHIP. In addition, the survey will be designed to identify promising managed care approaches and

promising features of managed care systems that offer effective strategies for meeting the unique needs of children and adolescents with behavioral health disorders and their families. Some items from the previous all-state survey instrument will be retained as appropriate so that changes and trends can continue to be tracked over time. Additional questions will be incorporated to identify promising system features and approaches and to explore more fully areas such as the behavioral health benefit under SCHIP and on the policy responses of states to critical issues identified earlier by the Tracking Project. Each of the two all-state surveys will result in a published report detailing survey findings.

Study of Promising Approaches

A case study methodology will be used for the promising approaches component of the Tracking Project. Site visits will be conducted in communities and states with promising approaches to financing and managed care reforms. Potential sites to visit will be identified by the responses to the all-state survey conducted during the first year of the project. Key documents will be reviewed and telephone interviews will be conducted to obtain the additional information needed for site selection purposes. Four site visits will be conducted during the second year of the project, and four additional visits will be conducted during the third project year, for a total of eight site visits. The site visits will involve interviews with key stakeholders across a number of constituency groups and child-serving agencies. The resulting case studies will be used to describe the salient features of the structures, financing arrangements, policy strategies, and system features that have facilitated the delivery of children's behavioral health services in managed care arrangements. The site visiting process will also be used to assess the impact of these promising approaches on children and adolescents with emotional disturbances and their families, and on systems of care. A report on the findings from the case study component will be published after the eight site visits are completed.

Consensus Conference

After both all-state surveys and the study of promising approaches have been conducted, a consensus conference will be convened towards the end of the fourth year of the project. The purpose of this invitational meeting is to review the overall findings from the study, compare them to findings from other studies, and reach consensus recommendations about the policy actions and strategies that most effectively serve children with behavioral health disorders and their families in the current environment. The consensus conference will result in a publication that will summarize the conference findings and lay out both a research agenda for future studies and a policy agenda to be considered by federal, state, and local officials as well as by advocates and families. ■

Summary of State Child Health Insurance Program (SCHIP) Issues

The Tracking Project has just begun to examine issues related to behavioral health service delivery for children and adolescents in states' implementation of SCHIP. For the 1999 Impact Analysis, stakeholders in the eight-state sample were asked some very basic questions about SCHIP designed to obtain preliminary information about the following:

- Whether there is coordination or connection between SCHIP and Medicaid managed care reforms.
- How behavioral health services are covered in SCHIP programs.

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 tends to be limited as in an acute care model.

Most of the effort in states to date related to SCHIP has focused on outreach and enrollment. States reportedly are only beginning to consider issues related to children moving back and forth between SCHIP and Medicaid managed care systems. The Tracking Project will be exploring these and other SCHIP-related issues in greater depth over the next five years of the project. ■

Special Analysis: Substance Abuse

Introduction

Purpose and Methodology

The Substance Abuse and Mental Health Services Administration (SAMHSA) provided additional resources to the Health Care Reform Tracking Project to explore more fully the impact of state managed care reforms on adolescents in need of substance abuse treatment. These resources enabled the Tracking Project to incorporate specialized expertise and a focus on substance abuse issues and to prepare special analyses summarizing findings, in conjunction with both the **1997 Impact Analysis** and the **1999 Impact Analysis**. The purpose of the substance abuse special analysis is:

- To determine the impact of state Medicaid managed care reforms on adolescents in need of substance abuse services and their families; and
- To identify effective strategies states are using within their managed care reforms to deliver substance abuse services to adolescents.

To achieve these objectives, consultants with expertise in adolescent substance abuse treatment participated in each of the site visits to the 10 states involved in the 1997 Impact Analysis and to the eight states involved in the 1999 Impact Analysis sample. The states included:

Table 74 Comparison of 1997 and 1999 Impact Analysis Sample	
1997	1999
Arizona Connecticut Delaware Iowa Massachussetts North Carolina Oregon Rhode Island Utah Washington	Colorado Indiana Maryland Nebraska New Mexico Oklahoma Pennsylvania Vermont

During each site visit, the substance abuse specialist interviewed a range of key stakeholders in the substance abuse area, including state substance abuse agency directors and staff, state and local substance abuse treatment providers, substance abuse advocacy groups, and families of adolescents receiving substance abuse treatment services. Interviews also were conducted with designated substance abuse specialists in child welfare, education, and juvenile justice state agencies, where they existed. A semi-structured interview protocol was used to guide the interviews with these stakeholders.

Several hypotheses were set forth for the 1999 Impact Analysis, based on the findings from the 1997 Impact Analysis and the Tracking Project's 1997-98 State Survey. These hypotheses were tested through the gathering of information during the site visits for the 1999 Impact Analysis and subsequent analysis of the information. The hypotheses provide the organizing framework for the full 1999 Impact Analysis report, which also incorporates substance abuse-related findings. The substance abuse special analysis generally follows the format of the full report. However, the substance abuse special analysis reflects the perceptions of stakeholders in the substance abuse area, while the full report reflects the perceptions of key stakeholders across a broad range of constituencies, including representatives from state and local agencies, providers, advocates and families involved in Medicaid, child mental health, child welfare, juvenile justice, and education arenas, in addition to the substance abuse area. In a few instances, there are discrepancies between the perceptions of substance abuse stakeholders, as reported in this special analysis, and the perceptions of the other key stakeholder groups, as reported in the full report. Both the special analysis and the full report note where these inconsistencies occur and provide reasons for differences if they were offered during the site visit process.

The 1999 Impact Analysis focuses on nine reforms in eight states.⁴ Substance abuse services are included in seven of the nine reforms. *This special analysis focused primarily on these seven reforms.* Of the seven reforms that include substance abuse, three are behavioral health carve outs and four are integrated physical/behavioral health designs. *Carve out designs* are defined in this report as arrangements whereby behavioral health services are financed and administered separately from physical health services; and, *integrated designs* are defined as arrangements in which the financing and administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted). Both the full report and this special analysis articulate differences in effects on adolescent substance abuse treatment services associated with these different design types, where such differences were noted by stakeholders.

Table 75 Design of Managed Care Reforms Including Substance Abuse Services	
Carve Out	Integrated
Indiana Nebraska Pennsylvania	Maryland—Physical Health/Substance Abuse New Mexico Oklahoma Vermont

⁴ In Maryland, two design types were studied — a mental health carve out and an integrated physical health/substance abuse design. Thus, the number of managed care reforms studied on site for the 1999 Impact Analysis totals nine reforms in eight states.

I. Planning and Design of Managed Care Systems

Planning

Hypothesis: In most states, adolescent substance abuse services will be perceived by most stakeholders to receive less attention in managed care planning and design than children's mental health services.

Finding: Upheld

Regardless of the design type, substance abuse respondents reported that substance abuse received less attention than mental health in the planning of managed care reforms in most of the seven reforms included in this analysis. Reportedly, it did not matter whether substance abuse was co-located with mental health in the same department or whether the two systems were located in different departments within state government. Substance abuse respondents reported that their input had little impact in determining the best fit for substance abuse services within managed care reforms. While state substance abuse agency respondents reported involvement in the early phases of planning and design, the further the discussions progressed, the more on the periphery substance abuse issues reportedly got pushed. Substance abuse respondents reported that part of the problem was a matter of their own lack of readiness and preparedness to contribute meaningfully, as well as a lack of knowledge about adolescent substance abuse on the part of key stakeholders who were influential in the planning and policy making arenas. In addition, state substance abuse agency representatives reported that, prior to managed care, they had limited involvement with their state Medicaid agencies and that state Medicaid plans included minimal coverage of substance abuse services.

Pennsylvania provides an example of a state in which substance abuse stakeholders reportedly were involved in the planning and design of the managed care reform. The state substance abuse agency reported that it was involved early on and throughout the planning and design process. This was attributed in part to the substance abuse agency's having forged a relationship with the state Medicaid office over the years that included expanding the substance abuse services covered under the state Medicaid plan.

Across the seven reforms included in this analysis, the perceptions of substance abuse stakeholders as to whether substance abuse received less attention than mental health in the planning and design of managed care reforms differed somewhat from that of other key stakeholder groups. In most states, other stakeholders did not feel that substance abuse received less attention than children's mental health. These other stakeholders reported that managed care is forcing attention to the issue of adolescent substance abuse services because of severe shortages of appropriate services.

It should be noted, however, that in the majority of states in the 1999 sample, even though most stakeholders believe that increased attention is being paid to both children's mental health and adolescent substance abuse issues, most also continue to believe, as they did in 1997, that neither area is receiving adequate attention nor is there sufficient involvement of stakeholders knowledgeable in these arenas.

Goals of Managed Care

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

Substance abuse respondents identified the same goals for state managed care reforms as mental health and other stakeholder groups. These included:

- Cost containment
- Improved access
- Expanded use and development of community-based services
- Increased accountability
- Improved quality
- Improved outcomes

The relative importance ascribed by stakeholders to the various goals of managed care reforms varied according to the level of involvement of the respondent group in managed care policy deliberations. This was true both for substance abuse and other key stakeholder groups. The respondents who were in a policy making or planning position were more apt to identify a number of goals as important. Respondents such as providers and consumers were more likely to identify cost containment as the most important goal of managed care reforms.

Substance abuse respondents identified “improved outcomes” as a goal that is difficult to assess due to lack of data. As discussed more fully in the Accountability Section of this analysis, most managed care systems reportedly are unable to disaggregate data related to adolescent substance abuse treatment.

Carve Out and Integrated Designs

Differences in Carve Outs

Hypothesis: States with carve out designs will cover a broader array of behavioral health services, more home and community-based services and allow greater flexibility in service delivery than states with integrated designs.

Finding: Not Upheld for Substance Abuse Services

This finding was upheld by all stakeholder groups for mental health services, but not for substance abuse. While there were some reports that substance abuse service coverage and flexibility were more constrained in the integrated designs than in the carve outs, according to substance abuse respondents, the potential of managed care reforms to create more flexible

delivery systems covering a broader array of services has not been realized to the degree these stakeholders anticipated in either carve out or integrated designs.

While substance abuse respondents did report an increase in coverage and availability of outpatient and intensive outpatient services in many states, overall, they reported that few innovative or new adolescent-specific substance abuse treatment services have been developed as a result of managed care, either because of lack of coverage in the benefit design or lack of knowledge on the part of purchasers and MCOs about the range of services needed. An exception noted was Pennsylvania's managed care reform, which reportedly offers a broad benefit package for adolescent substance abuse treatment services.

II. Managed Care Organizations

Use of Commercial Managed Care Organizations (MCOs)

Hypothesis:	Commercial, for-profit MCOs will be viewed as unfamiliar with the Medicaid population in general and with adolescent substance abuse treatment in particular.
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Finding:	Upheld
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All but one of the states in the 1999 sample (and six of the seven reforms that include substance abuse) use commercial companies as MCOs. As was the case in 1997, in most of the states using commercial companies, virtually all stakeholder groups complained that MCOs lack familiarity with the Medicaid population in general and with adolescent substance abuse treatment in particular. However, substance abuse respondents also felt that unfamiliarity with adolescent substance abuse problems was not limited to the commercial MCOs. They reported that the nonprofit, governmental and quasi-governmental entities being used by states as MCOs were equally uninformed regarding this population. Some substance abuse respondents reported that even the community mental health centers (CMHCs) in their states were not sufficiently knowledgeable about adolescent substance abuse.

Substance abuse stakeholders noted that, if substance abuse treatment issues are not addressed in contract language with the MCOs, the MCOs' knowledge base is not sufficient to ensure that substance abuse issues will be addressed appropriately. Even with appropriate contract specifications, these stakeholders expressed concerns over the MCOs' willingness to address substance abuse treatment issues, and indicated that MCOs need guidance and oversight from state substance abuse stakeholders, which often is not built into managed care system design.

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

Respondents across all stakeholders groups, including substance abuse respondents, noted significant problems resulting from the use of multiple MCOs, which, in turn, also may contract with different behavioral health organizations (BHOs). Respondents specifically identified as problematic the different processes, procedures and criteria for almost every aspect of system operation and management across MCOs (and BHOs), including processes for accessing, approving, and monitoring services, credentialing providers, billing and reimbursement, rate-setting, and accountability. One respondent characterized this situation as “a standardized concept with tremendous variation.” Like other, substance abuse stakeholders indicated that use of multiple MCOs has created inconsistency, fragmentation and lack of standardization in managed care systems. For consumers and providers, it reportedly has resulted in difficulty understanding and navigating systems. Substance abuse respondents, like other stakeholder groups, reported that choice of providers was more important to consumers than choice of MCOs.

III. Clinical Decision Making and Management Mechanisms

Prior Authorization of Substance Abuse Treatment

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

Finding: Upheld

Substance abuse respondents in six of the seven reforms reported that prior authorization and other management mechanisms create barriers to treatment. Reportedly, in some states, adolescents, who would have been granted access to treatment services prior to managed care, now routinely are denied substance abuse services. Even in states where denials are kept to a minimum, respondents reported that care is negotiated down to lower levels, based on gatekeepers’ interpretations of medical necessity criteria, even if this level of care is inappropriate according to substance abuse practitioners. In addition to denials, in some cases, the authorization process reportedly causes delays in access to treatment. Respondents complained that the gatekeepers responsible for authorization are not knowledgeable about

adolescent substance abuse treatment issues, including adolescents' resistance to seeking care, and that authorization processes create hurdles that heighten the resistance of adolescents to obtaining treatment.

Substance abuse providers reported a two-fold problem with prior authorization processes and other management mechanisms, such as utilization review. First, they cited added administrative burden in dealing with the different processes and requirements of managed care. These new requirements reportedly are especially difficult for stand-alone substance abuse providers that do not have well-developed administrative infrastructures. One respondent reported that clinicians are spending less time with clients and more time fulfilling the requirements of MCOs and BHOs. The second major issue cited by substance abuse providers was the need for them to have to learn the "language" of authorization and utilization review. When multiple MCOs and BHOs are involved, providers and clinicians have had to learn the particular nuances of each system in order to secure needed services for their clients.

Patient Placement Criteria

Hypothesis: Few states will have developed level of care or patient placement criteria specific to adolescent substance abuse treatment.

Finding: **Not Upheld**

One area of marked change noted in the 1999 Impact Analysis for adolescent substance abuse services is the adoption of patient placement criteria within states' managed care reforms. In the 1997 Impact Analysis, only one state (Iowa, which had a separate substance abuse carve out) reported the use of patient placement criteria for adolescent substance abuse treatment. Within the 1999 sample, five of the seven reforms reportedly use patient placement criteria for adolescent substance abuse services. All five reforms use the American Society of Addiction Medicine (ASAM) Patient Placement Criteria or a modified version of them.

Substance abuse respondents identified the implementation of patient placement criteria as accomplishing two major goals for the field. The first accomplishment they cited is the codification of substance abuse-specific criteria for client movement into and through levels of care. Secondly, the criteria have been incorporated into managed care contracts for substance abuse services. The net effect reportedly has been to help standardize access to and movement through levels of care, and to provide guidance to MCOs who may have little experience with the public sector substance abuse population. Further, state substance abuse agency respondents expressed the hope that the use of standardized criteria will lend greater credibility to the field of substance abuse treatment.

While use of ASAM criteria for adolescent substance abuse treatment is perceived to be improving the quality of clinical decision making in a number of states, stakeholders across respondent groups also noted that use of ASAM criteria (and level of care criteria in children's mental health) is not *necessarily* improving consistency in clinical decision making. Reasons offered were that MCOs may apply the criteria too rigidly, or, in states using multiple MCOs, each MCO may interpret the criteria differently, or MCOs may rely more on medical necessity criteria than on the use of ASAM criteria. Also, in all states, lack of available services can

render clinical decision making criteria meaningless. Substance abuse respondents also reported that, even when ASAM criteria are used for initial placement decisions, rarely are they used for continued stay or discharge decisions. Almost every substance abuse respondent reported that there is little monitoring of the MCOs as to their adherence to the ASAM criteria and no sanctions for those situations when the criteria are not used.

Grievance and Appeals

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

Finding: Upheld

The majority of substance abuse respondents reported that the grievance and appeals processes within managed care systems are problematic. Processes were described as not well publicized, not timely and not meeting the needs of providers or adolescents and their families. Substance abuse providers and consumers reported that, prior to managed care, they were not accustomed to the concept of denial of services, let alone having to go through a cumbersome grievance and appeals process. In addition, some substance abuse stakeholders pointed out that, unlike children's mental health, adolescent substance abuse does not have organized parent groups to advocate for adolescents and negotiate the grievance and appeals process. Further, the MCOs reported that clients who are denied services seldom use the grievance and appeals process. Rather, providers typically initiate the process on behalf of their clients.

Pennsylvania is an example of a state that has instituted mechanisms to assist clients in the grievance and appeals process. Consumer advisory groups reportedly assist parents in navigating the grievance and appeals process.

State substance abuse agency staff in some of the other states in the 1999 sample reported that they are working with the MCOs/BHOs to develop grievance and appeals systems that are more consumer friendly, timely, and impartial in their determinations.

IV. Impact on Service Delivery

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

There was a consensus among substance abuse respondents in every state that the adolescent substance abuse service delivery system has received little attention historically. Reportedly, the traditional core of the adolescent substance abuse treatment system has been inpatient and residential care, and even these treatment modalities reportedly have been in short supply. The only other service routinely available, according to stakeholders in most states, is individual and family outpatient services. With the advent of managed care reforms, stakeholders noted that the focus of service delivery has shifted from inpatient and residential to more community-based services. This shift has focused attention on the gaps in the adolescent substance abuse treatment continuum and the need to invest in service capacity development. Still, it was reported by substance abuse stakeholder that such investment has not occurred to date and is more likely to occur in the children's mental health arena.

Residential Services for Substance Abuse Treatment

Hypothesis: In most states, managed care will make it more difficult to access adolescent substance abuse treatment in longer-term residential settings.

Finding: Upheld

In 1997, respondents in most states reported that residential services for youth with substance abuse services were more difficult to obtain than before managed care reforms. While previously scarce, these resources reportedly became even more difficult to access due to the emphasis within managed care systems on reducing the use of residential services. Consistent with 1997 findings, respondents in five of the seven states including substance abuse indicated that adolescent substance abuse treatment in residential settings is more difficult to access, particularly for longer-term stays, as a result of managed care reforms. The problem appears to be more pronounced in managed care systems with integrated designs as compared with carve outs; the issue was identified in all of the states with integrated designs.

In one state, respondents reported that residential substance abuse services, other than detoxification, are not covered in the managed care system at all, leaving the state substance abuse agency (and, in some cases, child welfare and juvenile justice agencies) to assume the costs for these services to the extent possible. In other states, these services were characterized as extremely difficult to access due to more stringent authorization requirements and drastically reduced lengths of stay, with frequent and strict continued stay reviews. Juvenile justice respondents in particular complained about the lack of authorization for residential substance abuse treatment for adolescents through managed care systems. The problem is compounded by the fact that alternative substance abuse treatment services for adolescents are poorly developed across states, leaving many youngsters without any appropriate interventions.

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: Upheld

Substance abuse stakeholders in every state in the 1999 sample reported that managed care reforms have improved access for adolescents to short-term outpatient services but that it is more difficult to access extended treatment services. These perceptions were reported both in states with integrated designs and those with carve outs. The perceptions of substance abuse stakeholders regarding initial access to short-term outpatient services differed from those of stakeholders in general, who reported that even initial access was being compromised by managed care in some states. Substance abuse respondents believe that increases in the number of approved outpatient providers and development of more structured, intensive outpatient programs (IOP) are contributing to improved initial access for substance abuse services. Other stakeholders reported that rigid application of medical necessity criteria and lack of available services is compromising initial access.

There was consensus across stakeholder groups, however, that managed care is aggravating access to extended care. According to substance abuse respondents, managed care reforms exacerbate access to extended substance abuse treatment because the substance abuse benefit design is narrow in most reforms and because of rigidly applied medical necessity criteria.

Access to Expanded Array of Substance Abuse Services

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

Finding: Upheld

Substance abuse respondents in every state reported that, compared to children's mental health or even adult substance abuse treatment services, substance abuse services for adolescents are underdeveloped. As mentioned earlier, the lack of development of substance abuse services for adolescents existed prior to managed care reforms. Substance abuse respondents credited managed care reforms with highlighting service gaps in the adolescent substance abuse continuum, in particular, day treatment, step-down services for adolescents leaving residential treatment, aftercare services, and dual diagnosis programs for adolescents with co-occurring mental health and substance abuse disorders.

While substance abuse stakeholders noted that managed care reforms have the potential for development of new adolescent substance abuse treatment services, they also indicated that, in only two of the seven reforms (PA and VT), has investment in adolescent substance abuse service capacity development occurred. In these two states, the service array was

broadened. In the other five states, according to stakeholders, there was not a broadening of the service array but rather an expansion in the availability of a basic set of adolescent substance abuse services. Reportedly, as noted earlier, the services that have been expanded the most are outpatient services and structured intensive outpatient programs (IOPs) for adolescent substance abusers. Both represent increased use of short-term, community-based services, which was one of the goals of managed care reform in most states.

The perception of most substance abuse respondents is that the flexibility to design and implement innovative adolescent substance abuse services under managed care reforms is not yet being realized. Reportedly, providers are too busy learning to survive in a managed care environment, and there is little time and scant resources to innovate. A few exceptions were noted. For example, in Oklahoma, some providers changed their 24-hour hospital based inpatient programs to day treatment programs, while providers in other states added outpatient and/or intensive outpatient services in order to serve clients under the existing benefit package, as well as take advantage of the managed care funding stream.

Service Coordination

Respondents in five of the seven reforms reported that managed care has made it more difficult to coordinate services across the substance abuse continuum, as well as with other systems (i.e., mental health, juvenile justice and child welfare). The coordination of services within the substance abuse continuum reportedly is especially difficult due to the fact that residential treatment services are outside the managed care system in six of seven reforms. Respondents reported that there is a disconnect when adolescents move from nonresidential to residential treatment and vice versa. Reportedly, there also has been little impact on the pre-existing problem of lack of coordination between mental health and substance abuse services. One exception noted is Pennsylvania, which has included targeted case management in its benefit design for adolescents with multiple service needs.

V. Primary Care/Behavioral Health Care Linkages

Hypothesis: In most states, there will be inadequate identification and referral by primary health care practitioners of children and adolescents with behavioral health problems, regardless of the design of the managed care system.

Finding: Upheld

Respondents in the four states with integrated designs reported some increase in coordination of services between physical health and substance abuse. However, the majority of respondents also reported that the number of adolescents identified and referred to specialized substance abuse treatment services by their primary care physicians (PCPs) is much lower than expected (though data are not available to substantiate or refute this claim). Reportedly, in one state, most of the adolescent substance abuse treatment referrals come from physicians in hospital emergency rooms, as opposed to the adolescents' PCPs.

Respondents in all states reported that PCPs were neither trained in nor knowledgeable about adolescent substance abuse. Only one state (MD) required PCPs to administer a routine substance abuse screening instrument. Respondents in one state reported that the majority of adolescents do not have regular contact with their PCPs, and, therefore, the concept of integration of physical health and substance abuse services inherently does not work as well for adolescents as it does for adults or younger children, who may be more likely to be in more regular contact with their PCPs.

VI. Impact on Providers

Administrative Paperwork Requirements

Hypothesis:	In most states, managed care reforms will increase the paperwork burden for providers.
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Finding:	Upheld
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Most substance abuse providers across the states in the 1999 sample reported that the paperwork associated with managed care was burdensome. For example, different MCOs have different paperwork requirements that need to be submitted for authorization, continued stay, movement to another level of care and discharges. Some respondents reported that clinicians routinely spend one hour on paperwork for every hour spent with a client. The administrative burden reportedly has led to fewer clinician hours available to provide services. One respondent stated that a large substance abuse provider agency in this particular state designated a staff person to handle authorizations and utilization reviews full-time to free up clinicians to provide services.

Respondents reported that the larger and more stable adolescent substance abuse treatment providers, and those providers that provide adolescent substance abuse services in a multiservice agency (such as a community mental health center), were able to adjust more quickly to managed care practices. The smaller, stand-alone substance abuse programs struggled the most, according to respondents.

Provider Inclusion and Exclusion

Hypothesis:	In most states, managed care reforms will result in an expanded range of providers, but will also lead to the exclusion of certain types of providers, such as smaller, nontraditional providers and certified substance abuse counselors.
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Finding:	Upheld
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Inclusion of substance abuse providers in managed care networks and credentialing of substance abuse professionals were issues of concern raised by many substance abuse respondents. The degree of inclusion of adolescent substance abuse providers varied across the states in the 1999 sample. In two reforms, reportedly, community mental health centers were credentialed as agencies in the managed care provider networks, while the substance abuse provider agencies were required to have each staff person credentialed one by one. However, the converse of this situation existed in another state (OK). In Oklahoma, on the mental health side, the managed care organizations did not credential entire agencies or programs, but on the substance abuse side, the MCOs credentialed programs, rather than individual practitioners. This was the only instance of substance abuse program credentialing, however. All other states reportedly credential individual practitioners. The biggest obstacle, and the cause of immense concern to substance abuse respondents, was the requirement that individual practitioners be at the masters level or licensed to be eligible for reimbursement for services. One MCO in a state that credentialed certified substance abuse counselors required recovering substance abuse counselors seeking credentialing to provide documentation that they had completed a recognized substance abuse treatment program, and this particular MCO would not accept recovering individuals who attended self-help groups only, even if they had been in recovery for twenty years or longer.

Some states reportedly are increasing the requirements for providers' participation in managed care reforms. For example, one state is requiring substance abuse providers to become accredited by the Commission for Accreditation of Rehabilitation Facilities (CARF) in order to participate in managed care provider networks. Providers are faced with weighing the person hours and cost of becoming accredited against the percentage of their total revenues that managed care system participation generates. Reportedly, providers who generate little business from managed care will be more inclined not to pursue accreditation and will drop out of provider networks.

Provider Payment 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.
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Finding:	Not Upheld
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Without exception, substance abuse providers reported that the rates paid for adolescent substance abuse treatment services were inadequate, and, in most states, lower than they had been under fee-for-service or within grants to substance abuse programs. Substance abuse respondents also felt that the rates they were paid were less adequate than those paid on the mental health side (although mental health providers in most states also complained about the inadequacy of rates under managed care). Substance abuse respondents reported that substance abuse, as opposed to mental health, has less experience with cost studies to determine the actual cost of delivering substance abuse services, and that, therefore, the rates paid for substance abuse services, especially adolescent substance abuse services, are generally not based on the actual cost of services. Providers also reported that they are not

reimbursed for case management activities, collateral contacts with schools, probation officers, and significant other family members, or for family therapy sessions that are provided as part of the course of treatment for an adolescent and his or her family. In addition, in cases where the authorization process is slow, providers often deliver interim services to clients whom they later discover are ineligible, or are placed in a lower level of care, and, in such cases, providers end up absorbing the cost of services provided.

With the exception of one state (IN), rates for similar levels of care for adolescent substance abuse reportedly were less than for the equivalent services in children's mental health. In Indiana, providers are provided a case rate that covers all substance abuse services an adolescent would receive throughout a fiscal year, regardless of when they are approved for services. Indiana was the only state, in either the 1997 Impact Analysis or the 1999 Impact Analysis, where the rate for substance abuse services was higher than for mental health services. In addition, there are fewer risk-adjusted capitation rates paid to MCOs for adolescent substance abuse treatment than for children with serious emotional disorders, which also affects the provider reimbursement rate structure.

In most states, the substance abuse respondents reported that lack of referrals and low reimbursement rates have posed serious threats to the viability of many agencies. In particular, lengths of stay, and reimbursement rates for inpatient and residential services have declined dramatically, resulting in a decrease in utilization. Substance abuse respondents most states in the 1999 sample reported that average length of stay in inpatient and residential programs has declined from 28 days to 14 days maximum, and that typically, only five to seven days are authorized initially before reauthorization for continued services is required. In addition, several providers interviewed complained of slow payment of claims by the MCOs. The combination of decreased utilization and slow payment has threatened the survival of inpatient and residential programs, and, in some cases, reportedly were key ingredients in the demise of these programs.

Use of Mental Health Professionals to Provide Substance Abuse Treatment

Hypothesis: Managed care reforms will result in the increased use of mental health professionals to provide adolescent substance abuse treatment services.

Finding: Upheld

In four of seven states included in this special analysis, respondents reported that there has been an increase in the use of mental health professionals to provide adolescent substance abuse treatment services. This is especially true in the provision of outpatient services. Reportedly, individual mental health practitioners within managed care networks, who, in the past, limited their practices to child, adolescent and family mental health, are now getting referrals and authorizations to provide outpatient individual and family services to adolescents with substance abuse problems. Substance abuse respondents in these states complained that the mental health practitioners are not knowledgeable or experienced in adolescent substance abuse, and questioned the quality of services that adolescents and their families are receiving.

(Across the entire 1999 Impact Analysis sample of nine reforms, this hypothesis was not upheld; increased use of mental health professionals to provide adolescent substance abuse treatment was found in only four of the nine reforms.)

Reportedly, a major reason for the increase in the use of mental health professionals is that, in only two states (NM and PA), could certified substance abuse counselors get reimbursed for outpatient substance abuse services. In the other states, in order to get reimbursed for outpatient substance abuse services, practitioners must be at the masters level or above. Substance abuse respondents pointed out that this requirement excludes the majority of certified substance abuse counselors because, typically, they are not master's level professionals. Two states reportedly were taking innovative approaches to enhance the inclusion of certified substance abuse counselors in the provider networks.

- In **Vermont**, the state substance abuse agency and a local college collaborated in the development of a master's degree program in substance abuse. The state provides discounted tuition and scholarships for certified substance abuse counselors working in nonprofit or publicly funded substance abuse treatment programs. The program offers flexible class scheduling to help accommodate working professionals.
- **Pennsylvania** has been encouraging providers to become dually licensed. The mental health providers are encouraged to obtain licensure in substance abuse and vice versa. Respondents hope that the net effect will be dual capacity and expertise, and more holistic care for children, adolescents and their families.

Structure and Organization of Providers

Hypothesis: There will be a trend toward new structural and organizational arrangements among providers resulting from managed care reforms.

Finding: Upheld

Substance abuse respondents reported a number of positive changes associated with provider restructuring precipitated by managed care reforms. Reportedly, a major by-product of managed care reform has been substance abuse provider networking and the "rationalizing" of services. With the institution of managed care, providers have begun to dialogue with one another about ways to enhance their capacities and improve their attractiveness to MCOs and BHOs.

Reportedly, providers also have begun to discuss mergers in order to provide a greater continuum of services, and to benefit from one another's ability to refer across the continuum of services created by the merger. The smaller providers in mergers are able to access the infrastructure capabilities of the larger agencies that smaller providers could not afford as stand-alone programs. Managed care reforms also have forced providers to decrease their

emphasis on inpatient and residential care, to convert these programs to day treatment programs, and to identify and develop more intermediate levels of care, such as IOP. Managed care reform also reportedly has prompted providers to develop nontraditional partnerships with other community based-service agencies to offer an expanded service array.

Respondents also noted that managed care has enhanced the management and fiscal operations of substance abuse providers. Provider practices have had to change from a grant-based and relatively stable source of funding to the development of open-market business practices. These practices include changes in the roles of management, more attention to fiscal matters, and improved data and financial systems. In most states, providers who have adapted their operations to the new business climate engendered by managed care reform have fared best.

VII. Impact on Cultural Competence

Analysis of the Needs of Culturally Diverse Groups

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

Finding: Upheld

In the majority of states, respondents reported that there was a lack of inclusion of cultural competence issues in the planning, design and implementation of managed care reforms. Substance abuse respondents in five of the seven reforms reported that managed care has not affected the overall level of cultural competence on way or another in the adolescent substance service system. However, in several states, reportedly, managed care has had an unintended negative impact on culturally specific and nontraditional programs. In one state, for example, respondents reported that a Native American program was on the verge of closing its doors because of the low reimbursement rates paid by managed care. Respondents in other states reported that culturally specific and nontraditional programs opted not to pursue credentialing because of the requirements necessary to participate in provider networks.

However, respondents in some states did report some attention to issues of cultural competence.

- Philadelphia County in **Pennsylvania**, which includes the city of Philadelphia, reportedly has incorporated strong requirements and performance indicators related to cultural competence in its contracts with the MCO. The same county incorporated a specific billing code in order to recognize certain nontraditional services that would have normally been excluded from the benefit package. Other counties in Pennsylvania reportedly required targeted outreach to culturally diverse providers and consumers in their contract language.
 - In **Oklahoma**, a BHO implemented a new data system that can identify culturally diverse providers and pay these providers on a case-by-case basis.

VIII. Accountability of Managed Care Systems

Tracking Service Utilization, Quality, Cost and Outcomes for Adolescent Substance Abuse Services

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

Finding: Upheld

As was the case in the 1997 Impact Analysis, respondents in most states in the 1999 sample reported that they were in the early stages of tracking and capturing data related to utilization, quality, costs, and outcomes pertaining to adolescent substance abuse services.

Based on the information gathered from respondents during the site visits, Pennsylvania reportedly is the only state in the 1999 sample that is able to disaggregate adolescent substance data. All the other states either could not or did not disaggregate their data. In several states, respondents reported they were not sure the data were available, or that data may be available, but no one had requested that data set specifically. Many substance abuse stakeholders were not sure what level of data and information the MCOs could make available, in order to better manage the adolescent substance abuse system.

Respondents identified a number of problems relative to data on adolescent substance abuse services. Several of the MCOs reported that there were problems with the accuracy and timeliness of the data submitted by providers for analysis. Providers acknowledged some difficulty adjusting to the reporting requirements of managed care systems. In the majority of states, respondents reported that data from the MCOs is sent to the state purchaser who may or may not separate out the substance abuse data and report it to the state substance abuse agency. Reportedly, there are few data provided to state substance abuse agencies that documented the quality of services, and there are virtually no data on treatment outcomes. Consequently, the state substance abuse agencies reported that they receive little information from the managed care system that is useful in resource allocation and service development decision making for the adolescent substance abuse treatment system. To further complicate the issue, state substance abuse respondents were generally not sure what data they want or in what form they want it. These issues are identical to those raised in the 1997 Impact Analysis.

Reportedly, monitoring activities by state substance abuse stakeholders is minimal. Outside of the data that are reported to the state substance abuse agency and to the providers, respondents in only one state (PA) reported the use of organized and structured monitoring processes for adolescent substance abuse services.

- In **Pennsylvania**, reportedly, consumer monitoring committees have been implemented under the managed care reform. The committees include substance abuse stakeholders, including persons in recovery. In addition, reportedly, there are family satisfaction teams that conduct annual surveys and some face-to-face interviews with consumers and families.

IX. Overall Stakeholder Assessment

This section provides, *from the perspective of substance abuse respondents*, an overall assessment of managed care reforms. Discussed are the most positive effects and most serious problems cited by these respondents. In addition, where respondents offered recommendations, these are captured as well. The effects, problems, and recommendations cited do not represent universal agreement among substance abuse stakeholders in all states, but, rather general consensus among respondents across states in this sample.

Stakeholder Perceptions of Most Positive Effects

- Highlighted the need to address the problems of the adolescent substance abuse treatment system.
- Increased initial access to substance abuse services, primarily outpatient and/or short-term intensive treatment options for adolescents.
- In the integrated designs, improved somewhat linkages between physical health and substance abuse services.
- Increased ability of substance abuse providers to participate in the Medicaid program.
- Spurred development of more intensive outpatient adolescent substance abuse treatment programs, which has increased treatment capacity.
- Improved collaboration and networking among substance abuse providers.
- Decreased focus on “time-based” treatment (i.e., 28-day programs), and increased focus on individualization of care.
- Standardized decision making through the use of patient placement, continued stay, and discharge criteria.
- Increased accountability of providers and increased infrastructure development with respect to data and fiscal management issues.
- Increased interaction with other child serving agencies, such as child welfare, and juvenile justice.
- Motivated providers to enhance the level of competence and professionalization of staff to respond to the credentialing requirements of managed care reforms.

Stakeholder Perceptions of Most Serious Problems

- Lack of significant involvement and input from substance abuse stakeholders in the planning, design and implementation of managed care reforms.
- Lack of advocacy within managed care systems for substance abuse, especially for adolescent substance abuse.
- Need for training and education of managed care organizations on adolescent substance abuse.
- In the integrated systems, a lack of training on substance abuse issues for primary care physicians.
- Lack of staff with knowledge and/or expertise in adolescent substance abuse at the MCO level.
- Insufficient resources and lack of investment to expand adolescent substance service capacity, as well as serious shortages of available treatment options throughout states, particularly in rural areas.
- Lack of aggressive oversight and monitoring of adolescent substance abuse services within managed care systems.
- Lack of family involvement in managed care planning and implementation.
- Need for education and training for providers on managed care.
- Difficulty for providers to transition from grant-based funding to more fee-for-service reimbursement approaches, causing some providers to opt not to participate in managed care reforms or struggle to participate.
- Decreased access to extended care and to inpatient and residential services.
- Inadequate reimbursement rates.
- An absence of knowledge about best practice in the field of adolescent substance abuse treatment.
- Failure of providers, MCOs and states to take advantage of the potential flexibility in managed care reforms to design and implement new or innovative substance abuse services for adolescents.
- A lack of focus on adolescents with co-occurring mental health and substance abuse disorders.

Stakeholder Advice for Future Reforms

Substance abuse respondents offered the following advice to others who are planning, implementing, or redesigning managed care reforms that affect adolescents with substance abuse problems.

- Plan specifically for the adolescent substance abuse population prior to the implementation or redesign of managed care.
- Focus in planning on how to take advantage of managed care to expand the adolescent treatment system, with particular attention to critical service components.
- Include more input from providers, consumers, and those with expertise in adolescent substance abuse in the planning, implementation and monitoring processes, which will also increase their investment in the system.

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- Disaggregate data on adolescent substance abuse services to better plan for services, allocate resources inside and outside of managed care reforms, and assess the quality of services being provided.
 - Include patient placement, continued stay and discharge criteria endorsed by the single state substance abuse agency in managed care contracts and train and monitor MCOs on their use.
 - Develop accurate cost data on adolescent substance abuse services to assist in negotiations of adequate reimbursement and capitation rates.
 - Engage in a significant level of effort to educate MCOs, providers, consumers and other stakeholders on the implications of managed care reforms for adolescent substance abuse service delivery.
 - Maximize the reporting capabilities and requirements of MCOs and providers so that the state substance abuse agency can analyze data that will assist stakeholders in responding to the challenges of managed care for adolescents with substance abuse treatment needs. ■

Maturation Analysis

Introduction

Background

The Health Care Reform Tracking Project was initiated in 1995 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 (SAMHSA) in the Department of Health and Human Services and the National Institute on Disability and Rehabilitation Research in the Department of Education. The Tracking Project is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida in Tampa, the Human Service Collaborative of Washington, D.C., and the National Technical Assistance Center for Children's Mental Health at Georgetown University. A special analysis of the effects of managed care on children in the child welfare system was made possible by supplemental funding from the David and Lucile Packard Foundation.

The Tracking Project was undertaken at a time of significant changes within public health and human service delivery systems, as states implemented reforms involving 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. These public sector managed care reforms are the focus of the Health Care Reform Tracking Project, with investigation centered specifically on behavioral health services for children and adolescents and their families.

Methodology of the Tracking Project's 1997 Impact Analysis

The methodology of the Tracking Project has involved two major components—surveys of all states and impact analyses through in-depth site visit to a select sample of states. The state surveys have provided comparable data describing *what* all states are doing in their health care reforms, while the impact analyses have focused attention on a smaller sample of states and were designed to explore the *impact* of the reforms on youngsters with emotional and substance abuse problems, on their families, and on the systems of care that serve them.

For the first impact analysis (the 1997 Impact Analysis), site visits to a sample of 10 states were conducted in 1996-1997. Interviews on site were designed to obtain the assessments, perceptions, and impressions of multiple key stakeholders regarding a wide range of areas related to managed care reforms. The assessments and perceptions of multiple, key stakeholders comprise the primary source of data for the impact analysis component of the Tracking Project.

Each site visit for the 1997 Impact Analysis was conducted over a three-day period by a team of three or four individuals, drawn from a larger site visit team of 12 individuals. Each site visit team included individuals with expertise in children's mental health services, substance abuse services, and child welfare services, and all team members were knowledgeable about behavioral health managed care. A team leader was identified for

each of the 10 site visit teams. All site visitors participated in a training program during which the site visit purposes, processes, and interview protocols were detailed.

During the site visits, interviews were conducted with a wide variety of stakeholder groups, typically 13 to 15 groups per site, for a total of 75 or more interviewees in each state visited. A state liaison, usually the state children's mental health director, identified interviewees to comprise each of the stakeholder groups and organized the site visit schedule. Stakeholders interviewed in every site included groups from state mental health, substance abuse, Medicaid, child welfare, education, and juvenile justice agencies; managed care entities; local providers of mental health, substance abuse, and child welfare services; state associations and advocacy groups; families and foster families of children with behavioral health disorders; and other key informants identified through site visit planning. Semi-structured interview protocols were used with each group to guide the interview process and to ensure consistency in areas of inquiry across all sites.

After each site visit, site team members submitted written notes to site team leaders who prepared summary reports reflecting the findings from each of the site visits. Site visit reports were sent to states for review of factual accuracy. All team leaders then met to discuss trends and emerging issues and to synthesize findings. The 1997 Impact Analysis report presents an in-depth discussion of those trends, issues, and findings.

Methodology of the Maturation Analysis

The maturational analysis re-examined the 10 states included in the 1997 Impact Analysis sample to follow up on and update findings from the previously conducted site visits. The purpose of the maturational analysis was to identify changes that have been incorporated into managed care systems over time and to assess the effects of those changes. As state systems evolved, it was assumed that they would encounter problems, issues, and challenges related to the design of their systems, benefit design, management mechanisms, managed care organizations (MCOs), system planning and refinement processes, approach to serving high utilizers, rate structure, risk management approaches, and other areas. Many of those issues and challenges were identified in the 1997 Impact Analysis report. In response to those issues, changes and refinements in various features of managed care systems seemed likely. Through telephone interviews with key stakeholders in each of the 10 states comprising the 1997 sample, such changes were identified and described, reasons for the changes explored, and their impact discussed.

Team leaders from the original site visits recontacted the state liaison to request their assistance in the maturational analysis. Teams were assigned to each state, each including three specialists (in mental health, substance abuse, and child welfare), with one designated as team leader. The team leader and state liaison identified appropriate stakeholders and together scheduled telephone conference calls. In all states, calls were conducted with at least the following six stakeholder groups:

- State children's mental health group
- State substance abuse group
- State Medicaid group
- Families of children and adolescents with behavioral health problems
- State child welfare group
- Local mental health and substance abuse providers group

Team leaders conducted most telephone interviews, with the substance abuse specialist and the child welfare specialist each conducting those respective interviews. All interviews followed a protocol designed to identify changes in the managed care systems and the effects of those changes. The areas explored corresponded with areas explored during the 1997 Impact Analysis, with the addition of interview questions related to SCHIP (State Children's Health Insurance Program, federally-supported health insurance for uninsured children) implementation. Available data related to access, utilization, and quality and outcome measurement were requested during interviews.

Team leaders prepared summary reports containing the findings from each state's telephone interviews, detailing changes and their impact as described by interviewees in each targeted area. The information gathered from the telephone interview process across the 10-state sample was then synthesized, resulting in this report detailing maturational changes in managed care systems and the perceived effects of those changes. The results of the maturational analysis also have been incorporated throughout the overall report.

In general, the maturational analysis did not reveal substantial, major changes in most managed care systems. Rather, most systems are moving forward and are making modest adjustments across a variety of areas. Problems described in the 1997 Impact Analysis report generally continue to be problems, according to stakeholders, and many of these problems predated the managed care reforms themselves. Attention to behavioral health care for children, adolescents, and their families continues, and incremental improvements were noted in a number of areas.

I. Changes in Planning and Design of Managed Care Systems

A significant change that occurred in one state affects this entire report. On July 1, 1999, North Carolina's *Carolina Alternatives* (CA) ceased functioning, and publicly funded children's mental health and substance abuse services across that state returned to a fee-for-service funding mechanism. At the time of the interviews, an active planning process was underway to determine how the system would operate, and individuals interviewed expressed various beliefs about the goals, design, functions, and other attributes of the new system, but a variety of areas targeted in this maturational analysis could not be addressed in the absence of Carolina Alternatives. Only changes relevant to managed care systems are presented through the rest of this report, resulting in relatively few notes about North Carolina.

Inclusion of Individuals with Expertise in Children's Behavioral Health in Planning and Refinement of Managed Care Systems

Interviews revealed a mix of changes in the inclusion of individuals with specific children's behavioral health expertise in decision-making processes for managed care systems. Three states reported an increase in the involvement of parents of children with behavioral health needs in planning processes (DE, MA, and UT). For example, in Massachusetts, the state child mental health staff have become involved in managed care system policy planning, with respondents describing this as an important advancement. In other states, however, follow-up interviews showed that the concern identified in the 1997 Impact Analysis — "in most states, those with knowledge about children's behavioral health issues were not involved in the initial design of managed care reforms" — continues, with many stakeholders raising questions about the lack of involvement of appropriately knowledgeable people in decision-making processes.

Policymaking or Advisory Structures

Follow-up interviews revealed a significant trend in the development of new, state-level policymaking or advisory groups. Six of the 10 states reported creation of new structures, including high level “work groups” (AZ and DE), a Leadership Roundtable focused specifically on children with special needs (RI), operations or decision-making policy groups of multiple state agencies and other stakeholders (MA and OR), and a newly integrated behavioral services advisory committee (IA). In all six states, multiple child-serving systems are included in these new structures, reflecting implementation of the system of care value placed on interagency coordination. Interviewees universally described the creation of these groups as improvements, with many expressing hope for positive change from these new entities. Anecdotal information from interviews suggests that state Medicaid agencies have become more involved in these types of work groups and advisory structures in some states, engaging more comfortably in stakeholder input processes.

In a seventh state (NC), respondents indicated that substantial planning has taken place to determine how best to meet the behavioral health needs of those who depend on publicly funded services and supports following the termination of Carolina Alternatives, and that stakeholder participation in the planning has greatly increased as compared with their involvement in previous planning processes.

Process for Problem Solving and Making System Refinements

States appear to have implemented a variety of tools in the ongoing processes of problem solving and system refinement. Arizona has begun regular meetings of the child and adolescent service directors from Regional Behavioral Health Authorities (RHBAs), their MCOs; Connecticut has experienced problem solving through legislative advocacy; the Delaware Medicaid agency has adopted a work group approach to problem solving with MCOs; the Oregon child welfare system established new managed care liaison positions to improve the interface between that system and the Oregon Health Plan; and the Rhode Island Medicaid agency hired a family advocate to incorporate the family perspective into problem solving processes.

Goals of the Reform

Interviews in all 10 states indicated that the goals of state reform efforts have remained very consistent, with a few perceptions expressed of changed emphasis within stated goals. A few interviewees in two states reported that the emphasis of managed care system goals had shifted towards cost control and away from service quality, but other interviewees in those same states believed that goals had remained unchanged. As noted earlier, the managed care reform initiative ended in North Carolina.

Design of the Managed Care System (Carve Out and Integrated Designs)

The basic system design has remained in place in all states, except North Carolina. Respondents in two states reported an active focus on integrating mental health and substance abuse managed care programs, including the Iowa Plan under which the benefits of the formerly separate benefit plans were merged, enabling the MCO to better integrate its

management of mental health and substance abuse services. Another state (MA) has changed to a mixed design, with major HMOs now allowed to compete for behavioral health care for 25% of the eligible population, thereby having an opportunity to integrate the management of physical and behavioral health care; a behavioral health carve out continues to manage care for most of the eligible population.

Coverage for and Approach to Provision of Acute Care and Longer-Term Extended Care Services

Three states reported changes that impact the dynamics between acute and extended care. In Arizona, a lawsuit, filed in 1990 on behalf of children eligible for Medicaid who need long-term, intensive services, resulted in several system improvements, including a shift in emphasis from acute, episodic treatment towards longer-term planning for children with serious emotional disorders. Washington had begun the planned shift of management responsibilities for behavioral health inpatient services to the regional service networks (RSNs), which previously managed only outpatient services; and in Oregon the responsibility for managing extended care, always outside the Oregon Health Plan, was reported to have devolved to local child welfare and juvenile justice entities, changing the dynamics of negotiating the boundary between acute and extended care for children.

Processes for Determining When Acute Care Responsibilities End and Extended Care Responsibilities Begin

Respondents in three states reported changes in these processes. The Delaware entities responsible for acute care (MCOs) and extended care (state) have deliberately increased their communication around this transfer of responsibilities, with reported improvement in case-by-case decision-making. As noted above, Washington RSNs were in the process of assuming responsibility for short- and long-term behavioral health care, integrating management responsibilities within one entity, which was positively perceived by many. Negotiations around acute and extended care responsibilities in Oregon reportedly now take place locally between the MCO providing acute care under the OHP and child welfare and juvenile justice entities recently given extended care management responsibilities, which many respondents identified as a positive change.

II. Changes in Managed Care Organizations (MCOs)

Types of MCOs

Generally, the types of MCOs described in the 1997 Impact Analysis remain in place, although several states have made adjustments:

- **Arizona** — Whereas the reform originally utilized nonprofit, quasi-governmental regional behavioral health authorities (RBHAs), experience in Maricopa County led the state to contract with a for-profit organization in that region, opening up the process to greater competition and potentially taking advantage of superior private sector financial and data management systems.

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- **Connecticut** — The reform used multiple, statewide commercial MCOs, with 11 in operation at the time of the site visit. Two years later, only four statewide MCOs and one regional MCO are in operation, as the result of competition and some mergers in the industry.
 - **Massachusetts** — At the time of the site visit one statewide, commercial behavioral health organization (BHO) managed behavioral health care for all eligible citizens. Two years later, the state has allowed commercial HMOs to assume responsibility for the behavioral health care of 25% of the state's eligible citizens. The impact of this change was not yet known, but the HMOs reportedly were to be held to the same standards as the BHO.
 - **Washington** — At the time of the site visit, regional service networks (RSNs) had assumed management responsibilities for outpatient behavioral health services. Since then, most RSNs have added responsibilities for inpatient psychiatric services, necessitating some changes in RSN functioning.

Number of MCOs Used

Four states reported a decrease in the number of MCOs in their program: Connecticut began with 11 but reported only five in follow-up, including four statewide MCOs; Delaware reduced from four to three, but all three are now operating statewide; North Carolina no longer has MCOs operating; Rhode Island had two previously separate MCOs merge.

One state (OR) reported an increase in the number of MCOs, an increase attributable to reform implementation expansion from 25% of the state (at time of site visit) to the entire state. In Massachusetts, the single statewide BHO that managed all public behavioral health benefits has been joined by HMOs, now allowed to compete to provide behavioral health benefits for up to 25% of the state's eligible population. For all but North Carolina, these changes were universally described as increasing competition among entities while maintaining choice for consumers.

Standards or Requirements for MCOs

The maturational analysis suggests that states are adjusting their expectations and monitoring of MCOs, based on their experience. A number of states are adding new standards and requirements for MCOs. Arizona reportedly has added a variety of very specific requirements, such as performance bonds, capital reserve limits, access and timeliness requirements, primary behavioral health professional (PBHP) designation for each enrollee, and management of specialty providers. In Connecticut, new requirements include requiring a behavioral health director at MCOs, mandatory training, and requiring MCOs to meet department of insurance requirements. Massachusetts HMOs have now been allowed to compete for the behavioral health benefit, but in order to do so they must meet the same requirements as the statewide BHO, a substantial change in HMO management requirements. Utah has moved towards use of a standardized contract between the state and its multiple, regional MCOs.

Changes in MCOs Due to Competition or Other Reasons

The minor changes reported during the follow-up process all appeared to reflect discrete realities within each state. In Arizona, the change to allow a for-profit MCO to compete for and ultimately win the contract in Maricopa County reflected failure of the nonprofit entity in an area considered challenging to serve. One MCO dropped out of participation in Delaware to avoid the possibility of losing money on the contract, according to one respondent; two MCOs in Rhode Island merged, integrating management of their previously separate programs and enrollee groups. The inclusion of commercial HMOs in behavioral health management in Massachusetts was reported to reflect political dynamics that pressed for increased competition, while ensuring that all participating entities would be held to the same standards of care.

III. Changes in Capitation and Risk

Capitation/Case Rates

Changes were reported in the actual payment rates in many states, mostly minor adjustments based on inflation or better information about service cost and utilization. Three states reported slight rate increases (AZ, CT, and IA). Two states reported rate adjustments that resulted in both increases and decreases (DE and UT) as they attempted to improve the equity of resource distribution across disparate state regions.

The only other reported change in capitation/case rates was that benefit payments for behavioral health services for Native Americans in Arizona have been removed from total population capitation rates and returned to a fee-for-service payment arrangement.

Methods Used for Setting Capitation or Case Rates

Changes in the methods used to set capitation or case rates were reported in two states from this sample. In Delaware, a variable was added to recognize differences in service delivery costs between southern, rural areas and more urban, northern portions of the state. Utah engaged in a process to “equalize” rates across the state, deliberately shifting some Medicaid resources into rural areas to overcome historic unevenness in the distribution of child mental health funds. Otherwise, states appear to have stayed with the methodologies noted at the time of the site visits. As stated earlier, North Carolina has returned to a non-managed care, fee-for-service approach.

Risk Adjustment Mechanisms

Arizona is the only state where a change was reported in risk adjustment mechanisms. A 10% risk corridor was established for RBHAs, allowing the state to adjust capitation rates in either direction mid-year, if necessary. At the time of the interviews, only one use of that tool had been made, in an instance in which a RBHA earned more than the 10% allowed. This risk corridor was reported to have lowered anxiety in the system about future payment structures and rates.

Changes in or Development of New Risk Adjusted Rates for Children with Emotional Disorders, Adolescents with Substance Abuse Disorders, or Children in the Child Welfare System

No changes were reported in any of the 10 states in the development or use of risk-adjusted rates for any categories of children. Respondents in Delaware indicated that consideration was being given to establishing risk adjusted rates based on disorders, although no action had taken place by the time of interviews. The 1997 report indicated that Connecticut was, at that time, considering a risk adjusted rate for children in the child welfare population, but follow-up revealed that it was not implemented.

Risk Structuring Arrangements

Only two changes were reported in risk structuring arrangements for children with behavioral health care needs. In Connecticut, the respective responsibilities for inpatient psychiatric care were structured so that the MCO holds the risk for the first 15 days, the MCO and the state share the risk for days 16-60, and the state assumes full risk for day 61 and all subsequent days. In Washington, at the time of the follow-up interviews, RSNs were partway through the process of assuming risk for inpatient services – previously, RSNs were at risk only for outpatient behavioral health services. The first example describes a system response to a problem area, while the second change was planned from the reform inception.

Approach to Paying Providers and Rates Paid to Providers

At the time of the site visits, few systems in this sample of states paid providers through subcapitation arrangements, thus sharing risk with providers. In those states where subcapitation was found, it was generally employed by only one of several MCOs. One trend identified during the follow-up interviews was that even fewer subcapitation arrangements now appear to exist, with virtually all providers paid on a fee-for-service basis by MCOs and BHOs. The only exception to this finding occurred in Arizona, where two of the RHBAs were utilizing subcapitation arrangements and a third was exploring that approach.

Only two states reported changes in the approach to setting rates paid to providers, with Arizona moving to market-based rates (some increased, some decreased) and Delaware lowering some rates, based on service/payment data accumulated under the reform. No other changes were reported.

IV. Changes in Clinical Decision Making and Management Mechanisms

Prior Authorization Processes

A developing trend noted in prior authorization processes was that several states have attempted to aid service access by streamlining or removing prior authorization requirements, at least for certain services and/or populations. Arizona reported movement towards pre-approving service packages related to the needed level of care and away from authorization requirements for each individual service. Iowa reported elimination of prior authorization processes for outpatient behavioral health services, now relying on a sophisticated retrospective review process to identify areas where attention and improvements are needed.

Likewise, Massachusetts replaced prior authorization for outpatient services with an automated voice approval system using a 1-800 number, where all services consistent with diagnosis-driven service protocols are approved, in preset amounts. Providers described the Iowa and Massachusetts changes as positive, while families in those states perceived no resulting change. A change was reported within Oregon's substance abuse treatment program, where the requirement to be referred to substance abuse services by the primary care practitioner (PCP) was dropped, streamlining access to those services.

Other Management Mechanisms

As experience with reform lengthens, several states reported increased sophistication in utilization review practices. In Delaware, utilization review has been made more systematic, focusing reviews on very specific issues considered particularly important (e.g., psychotropic medications for children) and standardizing service protocols across MCOs; the Iowa MCO replaced prior authorization for outpatient services with a retrospective review process that identifies outliers and drastic changes in types/amounts of services provided; and in Rhode Island, the Medicaid agency has intensified its review of MCO functioning, with increased monitoring of MCO utilization review processes.

Other management mechanisms newly applied or changed since project site visits include: contracting with a third party for utilization review (NC); joint service planning protocols implemented between two or more responsible entities (DE and IA); and liaison positions with specific coordination and linking responsibilities (IA).

Level of Care or Patient Placement Criteria

Two areas of change were identified in the use of level of care or patient placement criteria—development and application of new or revised level of care criteria and development and application of clinical standards or practice guidelines for specific diagnoses and/or services. Four states described the application of new or changed level of care criteria to drive clinical decision making (AZ, DE, RI, UT). In one state it was reported that the commercial MCOs chose not to implement the state criteria for the highest level of care after they were developed. Four states (AZ, CT, MA, and UT) reported the development and implementation of practice guidelines for specific services and/or diagnostic groups, as exemplified by new guidelines for treating children with autism and those with both behavioral needs and developmental disabilities in Arizona. Massachusetts implemented a change in continued stay criteria aimed at shortening inpatient lengths of stay.

Medical Necessity Criteria

Three states (AZ, CT, and DE) reported the development and dissemination of improved or standardized medical necessity definitions, with reported improvements in general understanding of benefit package boundaries. Iowa added a "Keep Kids Safe" clause to the medical necessity determination process to ensure that no child can be discharged from an inpatient setting unless and until a "safe" environment for discharge has been assured.

Grievance and Appeals Processes

Interviews with this set of states revealed that several states are attempting to address concerns about the utility of grievance and appeals processes, although various stakeholders in most states indicated that this is an area of continuing problems. A deliberate effort to expedite the grievance and appeals process was described in Arizona, creating an avenue for quick appeals directly to the Medicaid agency. In Delaware, a guidebook for families was created and is distributed, including information about grievance and appeals processes. Utah was reported to have focused on increasing awareness of the grievance and appeals process through distribution of written material, inclusion of material on grievances and appeals in orientation information, and requirements for agencies to offer consistent information at intake. It is noteworthy that, in four of the 10 states, parents who were interviewed reported substantial problems with grievance and appeal processes, while state mental health respondents for those same states reported that the processes were working quite well.

V. Changes in the Service Array

Range of Services Covered

There appeared to be a continuing trend towards broadening of the array of mental health services, with one state reporting a formal change in the range of services previously covered by the managed care system, and several states reporting changes in emphasis within the array of previously covered services. The actual change occurred in Washington, which initially established the benefit package managed by RSNs as an outpatient benefit, with inpatient care handled outside the managed care system. Since the site visit, RSN management of inpatient services has been phased in (five RSNs were not yet “on line” with this benefit at the time of follow-up interviews). Although actual coverage has not changed, other states appear to be focusing on increasing the availability and use of a variety of types of home and community-based services. Two plans in Connecticut have added extended day treatment; Delaware is attempting to increase availability of therapeutic foster care and therapeutic group care, both of which are managed outside the plan; Iowa has attempted to increase the use of intensive outpatient services, previously covered but little used; Massachusetts has focused on increasing the use of home-based services and intensive case management for those with the most serious needs; and Utah has focused attention on utilizing an appropriate service mix for consumers with dual diagnoses. It was reported that the range of services in North Carolina expanded following termination of Carolina Alternatives, with the addition of “family interventions,” but long waiting lists were reported for most services, reflecting capacity that appears inadequate to the need.

Investment in Service Capacity Development

There were indications in follow-up interviews that states are devoting continuing attention to investment in service capacity development, with a particular focus on capacity in home and community-based services. Utah reported that resources previously invested in adult inpatient care had been redeployed to increase respite, day treatment, home-based, and case management services. Oregon reported that one region was developing a county-based sub-acute care level between inpatient and residential treatment in intensity. Services for persons with dual diagnoses (mental health and substance abuse) were the focus of service capacity

development resources in Arizona. Intensive outpatient services for mental health and substance abuse needs were being developed in Delaware. Massachusetts focused on developing intensive case management services targeted at children in the child welfare system with serious behavioral health needs. Several RSNs in Washington were building regionally-based professional parent homes to provide therapeutic foster care and respite. As it did at the time of the original site visits, Iowa continues to include requirements for reinvestment in service capacity in the contract between the state and the MCO, leading to 37 separate service development projects around the state during the past two years.

Incorporation of Prevention Services or Activities

Follow-up interviews identified no changes in the incorporation of behavioral health prevention services and activities in managed care systems. This reportedly was not an area of focus in most systems.

Provision of Transportation Services

The only state that reported a change in this area was Utah, where capitation rates were increased to add transportation services under the benefit package. Local centers responded by utilizing a variety of approaches, including purchased vans, contracting for taxis, and using case managers to provide transportation. One county in Arizona was reported to have improved procedures for obtaining consumer transportation.

Services or Service Delivery in Rural and Frontier Areas

The termination of Carolina Alternatives in North Carolina was reported by many to have negatively affected service access for persons living in the many rural areas of that state, because some providers were reportedly unable to survive under the fee-for-service system and went out of business or moved. It was noted by respondents from Delaware that the rate restructuring that took place slightly decreased payment rates for services in the rural, southern portion of the state, although the restructuring was reported to better reflect the actual cost differences of delivering services in regions of the state.

Several states reported adopting or expanding the use of specific strategies to improve service delivery in rural and frontier areas. For example, Arizona has expanded its telemedicine approach into additional rural areas. Utah has increased outreach by outstationing mental health staff with child-serving system partners to better identify behavioral health treatment needs among their populations; a program of psychiatric consultation to rural physicians was also initiated in Utah. Utah further reported receiving a federal grant from the Comprehensive Community Mental Health Services for Children and their Families Program grant that will target service development in a three-county frontier area.

VI. Changes in Access

Procedures or Guidelines for Accessing Services

This area of focus appeared to be one in which evaluation and adjustment have been important for system improvements.

- Respondents in **Delaware** reported multiple strategies within a broad plan to improve access to services, including school-based K-3 screening for behavioral health needs, formal liaisons between schools and the state agency, and in-court screening to identify adolescent substance abuse needs.
- The **Massachusetts** BHO (the Partnership) implemented an automated, voice-activated authorization process, accessed through a 1-800 number, which pre-approves all services within published protocols for specific diagnoses; it was reported to have greatly improved timeliness of access to needed services.
- Modifications in two states (**AZ** and **RI**) shortened eligibility and access timelines to speed connections between families and providers.
- **Rhode Island** has created an extraordinary “lifeline” arrangement with the telephone company that enables eligible parents to access RiteCare’s 1-800 number, even if their telephone has been turned off for unpaid bills.
- **Oregon** reported the hiring of regional managed care specialists through the child welfare system to facilitate relationships between those local agencies and the HMOs and MCOs managing care in order to improve access to services.

Despite these types of changes, parents interviewed in four different states reported that access to services had decreased since the site visits, although most of the concerns voiced were related to access to extended care services for children with the most serious and complex needs, rather than initial access to behavioral health care.

Serving Children Who Are Not Eligible for Medicaid

The 1997 Impact Analysis found that, in four states, managed care reforms had exacerbated pre-existing problems in providing services for non-Medicaid children and adolescents, with increasing amounts of state resources devoted to the Medicaid group. The maturational analysis found reports from stakeholders in six states that access for children not eligible for Medicaid had worsened for the same reasons identified in the 1997 analysis (AZ, CT, MA, NC, UT, and WA).

In two states, respondents suggested that the reform had improved service access for this group (OR and RI). It is interesting to note that Rhode Island had already accomplished, through RiteCare, much of the purpose of SCHIP (extending health care coverage for children previously uninsured), which left only a small population of uninsured children in that state. Oregon implemented SCHIP as an upward extension of its Medicaid program eligibility, and this was cited as the reason that access to non-Medicaid children had increased.

SCHIP is seen as a vehicle in many states to increase access to physical and behavioral health care services for many uninsured children who are not Medicaid eligible. In some states, SCHIP was designed as an expansion of Medicaid, while others created a separate insurance

program. In this sample of states, access to behavioral health care for the non-Medicaid population was not reported to have improved significantly with SCHIP implementation, and, in some respects, was considered worse. The primary reason cited was the inclusion of a limited behavioral benefit in the state's SCHIP program; the service limitations in these systems reportedly have made it more difficult to provide care for children with more serious and complex needs (who are not Medicaid-eligible but who are eligible for SCHIP). Generally, respondents in several states suggested that increased accountability for Medicaid funds through managed care has reduced the overall resources available in community systems to serve persons not eligible for Medicaid coverage.

Access to and Discharge from Inpatient Hospital Services

Respondents in Utah reported a change characterized as an improvement in this area, with the implementation of an interagency effort to improve the functional linkage between inpatient services and community-based care systems. This reportedly has resulted in a decreased average length of stay for children and adolescents accessing the inpatient level of care and better connections with community services.

Generally, however, the maturational analysis suggests that problems associated with access to inpatient care have continued and perhaps worsened over time. Respondents in four states reported that access to inpatient services had deteriorated further since the site visits and that children were being prematurely released, leading to an increase in near-term re-admissions, also referred to as “cycling.” In response to problems around access to inpatient care, Iowa's contract with the MCO now requires follow-up within 72 hours when inpatient admission is denied to ensure service responses to psychiatric crises, and Connecticut has established a risk sharing arrangement with MCOs for hospital stays needed by children in the child welfare system. Respondents in Rhode Island reported an increase in the average length of inpatient stay as less intensive alternatives have filled to capacity.

Access to and Use of Residential Treatment Services

Some respondents in four states indicated that access to residential treatment had become more difficult since the site visits (AZ, NC, RI, and UT). In two states, it was reported that community-based, step-down alternatives were limited, forcing up the length of stay in residential treatment centers and, thus, limiting access to available beds (MA and RI). The 10 states in this sample continue to reflect considerable variance in how they assign and manage responsibilities in the relationship between acute behavioral health care and extended services for those children with the most serious and complex needs, particularly with respect to residential treatment services.

Development of New Services or Levels of Care as Alternatives to Hospitalization

Most stakeholders agreed that capacity in alternative levels of care is necessary to appropriately manage the most intensive services, such as hospitalization, and although five states reported activity in this area, most efforts were either focused on a limited service or were still early in stages of development at the time of the follow-up interviews. Arizona stakeholders reported efforts to develop therapeutic foster care, respite, wraparound teams, and partial care programs at schools. Utah stakeholders indicated that emphasis had been

placed on developing 48-hour stabilization and 30-day residential treatment environments as alternatives to psychiatric hospitalization, along with attention to therapeutic foster care, in-home, respite, and mentoring services. Interagency case conferences were reported as the primary tool to develop new alternatives in Iowa, while Massachusetts was reportedly considering development of short-term, acute residential and therapeutic foster care models. Finally, several Washington RSNs were promoting the development of therapeutic foster care homes with professional parents to provide respite and short-term stabilization.

Coverage of Prescription Medications

Stakeholders reported continuing concerns with coverage of psychotropic medications in three of the 10 states, and few changes were noted. Massachusetts had reportedly developed and implemented guidelines for prescribing and purchasing psychotropic medications through the Partnership (the primary statewide BHO) and all HMOs serving as BHO for a portion of the eligible population. Respondents in Delaware indicated that the state's process for authorization of medications (for consumers served in long-term care through the state's functions, not contracted to the MCOs) has been improved based on stakeholder feedback.

VII. Changes Related to Children With Serious Disorders and Systems of Care

Benefits or Special Provisions for Children and Adolescents with Serious Disorders

One change was noted in Utah, where a "rapid response team" has been created at the state level, with Medicaid participation, to manage complex care for children whose needs cross systems and for whom services are not readily available or are too costly. North Carolina respondents indicated that the special level of care criteria developed under Carolina Alternatives have remained in place for children with serious emotional disturbances following the termination of the managed care system and the return to a fee-for-service payment structure, although payment rates reportedly have decreased.

Planning Processes for Children with Serious Disorders

Two states reported changes in planning processes for children with the most serious disorders. In Arizona, a lawsuit filed in 1990 has more recently triggered a significant increase in state-level planning attention given to children with serious emotional disorders, which was described by most respondents as a positive change. Rhode Island has responded to an increase in the number of hospital placements for children with autism by convening a workgroup focused on children with serious behavioral disorders, although no tangible changes had yet resulted at the time of follow-up.

Using Managed Care Reforms as Strategic Opportunity to Further the Development of Systems of Care

No changes were reported in this area.

Incorporation of System of Care Values and Principles

A formal change with respect to the incorporation of system of care values and principles in managed care systems was noted in one state. In Connecticut, a Memorandum of Understanding was established between the state and the health plans that includes language affirming system of care values and principles. Stakeholders in most other states indicated that system of care values and principles continue to be incorporated to some degree and that changes primarily reflect increased understanding and strengthening of this philosophy. For example, Massachusetts stakeholders reported strong improvements in family involvement and input into system management and design, with the expectation that their participation will help to improve the service system. North Carolina stakeholders indicated that system of care values are incorporated in their public systems in many ways, and that new initiatives (post-Carolina Alternatives) will strengthen that commitment. In Oregon, many local respondents stated that their managed care reform is synonymous with system of care values and principles. In Delaware and Rhode Island it was also noted that system partners (such as Medicaid, juvenile justice, and child welfare) have improved their understanding of the system of care philosophy, which was reported to have improved system relationships.

Requiring the Use of Organized Systems of Care

No changes were reported in this area, and few requirements of this type exist.

Coordinating Managed Care and System of Care Reforms

The only change in this area reported in follow-up interviews was from Utah, where the newly awarded federal Comprehensive Community Mental Health Services for Children and their Families grant was predicted to have a future impact on the design and function of the managed care system.

VIII. Changes in Family Involvement

Inclusion of Families at the System Level in System Planning and Refinement

This follow-up process obtained reports from respondents in eight of the 10 states in the sample indicating that family participation in system level planning and refinement had improved. Family respondents offered that perception in seven of the eight states reporting such improvement; stakeholders in four stated described deliberate actions towards that goal.

- The **Massachusetts** state children's mental health staff made family participation in decision making one of its highest priorities, and all respondents from that state indicated that the efforts have been effective, with more parents contributing meaningfully to more meetings than ever before.
- Multiple changes in **Rhode Island** policies enhanced family involvement, including: a statewide Leadership Roundtable comprised 50% of parents; hiring a parent advocate within the state Medicaid office; creation of a Consumer Advisory Council including parents, with an honorarium for meeting participation; and creation of an ongoing dialogue with foster parents.

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- **Utah** has increased family participation by training families at the local level to serve on committees, hiring regional family consultants to support local families, and including family advocates on all local interagency councils.
 - **Washington** changed RSN operating requirements to ensure that advisory boards include at least 51% representation by consumers and parents of children currently in the system, while also hiring a parent advocate in the state office.

It was noted that family respondents in two states offered opposite perceptions from the state and/or MCO representatives, with parents seeing decreased opportunities for participation and others seeing increased opportunities.

Requirements for Family Involvement at the System Level and at the Service Delivery Level

A change in requirements for family involvement at the system level was reported in Utah, where state statute was changed to require family participation on local operational groups, including councils and quality review teams that monitor MCO functioning. Changes in requirements for family involvement at the service delivery level were reported in four states (AZ, UT, IA, and DE). New contract requirements were set for family involvement in Maricopa County, Arizona, and it was reported that the requirements would likely move statewide in the future. Utah has provided MCOs with training and technical assistance around family involvement in service planning, and the state Medicaid office monitors MCO compliance with family involvement requirements. Iowa's contract with the BHO now ties incentives to a high rate (96%) of family involvement in treatment planning meetings regarding children with the most complex or severe needs. Delaware trained primary care physicians in child abuse and the roles of natural and foster families, leading to increased involvement of both groups of parents.

Preparation of Families for and Facilitation of System-Level Involvement

State agencies and/or MCOs in five states were reported to have hired or funded parent positions expressly to increase system support for parental involvement in system processes. A parent advocate was hired by the MCO in Iowa, Massachusetts funded a new position in the family advocacy organization, and parents were hired in state agencies in Rhode Island, Oregon, and Washington—all to prepare and support parents for their participation in decision making. Stakeholders in two states reported that financial support for parent participation was added (RI and UT), and two states (DE and UT) reportedly have conducted training in support of parent involvement.

Funding of Family Organizations to Play Roles in the Managed Care System

New funding support to family organizations was reported in three states, all reportedly achieving the intended effect of increasing family input into managed care system operations. The state mental health office in Delaware initiated a contract with the Parent Information Center to increase the organized flow of system information to and from families. Massachusetts funded a new position in the parent advocacy organization specifically to support parent participation in decision-making processes. Utah reported contracting with two

parent advocacy organizations and placing parents on system quality review teams. Respondents also reported that the Connecticut statewide parent advocacy organization had ceased to function, a change unrelated to the managed care reform.

Training of MCOs

Few changes were reported in the training of MCOs to fulfill responsibilities towards children with behavioral health needs and their families. Three states reported that they have increased the amount of information and training that the state system provides to MCOs (AZ, OR, and WA), particularly to help them succeed in their management responsibilities, but no specific changes were reported in training related to issues specific to children and families.

Family Involvement in Treatment Planning for Their Own Children

Action was reported in four states (IA, AZ, UT, and DE) that enhanced the expectations for providers to include families actively in service planning and delivery for their children. The Iowa MCO offered incentives to providers that meet a high performance expectation for family involvement (96%) in service planning. Changes in rules were reported in Arizona to strengthen the expectations for family involvement in planning and delivering their child's care. New contract requirements were incorporated addressing family involvement in Maricopa County, Arizona; the requirements are likely to be applied statewide in the future. Training and technical assistance related to family involvement in service planning has been provided in both Utah and Delaware.

Services to Entire Family in Addition to Identified Child

Respondents in four states related strategic interventions to improve system accessibility and responsiveness to the needs of families of children with behavioral needs. Since the ending of Carolina Alternatives, North Carolina added a "family intervention" billing code to its fee-for-service Medicaid system, enabling providers to recoup some of the costs of these important interventions. When Rhode Island implemented SCHIP, it included an increased eligibility category (185% of Federal Poverty Level) for parents of SCHIP-eligible children. Utah has implemented a parent mentor program to match new parents with experienced parents at intake, enabling a better, quicker understanding of the family's needs. In Delaware, it was reported that MCOs have become more willing to serve the entire family, due to the realization that a family focus is likely to lead to better outcomes.

Inclusion of Family-Run or Youth-Run Programs

Respondents in the 10 states in this sample reported no changes since the site visits, when this project found little or no evidence of family-run or youth-run programs prior to managed care reforms or within managed care systems.

Use of Family Members as Paid Staff

Follow-up interviews revealed some change in this area, as a number of states have hired parents as paid staff, as mentioned above, specifically to increase system support for parental involvement in system processes. A parent advocate was hired by the MCO in Iowa, Massachusetts funded a new position in the family advocacy organization, and parents were hired in state agencies in Rhode Island, Oregon, and Washington, all to advocate for and

support parental participation in decision making. Utah respondents reported several significant efforts to hire family members in paid staff roles, indicating that a group of parents was in training (at the time of the follow-up interviews) to become paid case managers within the state managed care system, that parents were being hired at the new federal Comprehensive Community Mental Health Services Program for Children and their Families grant site as evaluators, and that community mental health centers were being encouraged by the state to hire parent consultants.

Financial Burden on Families

Family respondents in four states reported that the financial burden on families for care of their children was increasing. In two of these states, parents indicated that the managed care system had incorporated co-payment requirements that were high enough to render some services unaffordable. Stakeholders from the other two states noted that the financial burden on families has increased primarily with respect to extended care, as benefit programs have focused on acute care. Incidentally, where they had comments about this issue, state and MCO respondents in the same four states indicated that they did not perceive the financial burden on families to have changed.

Practice of Giving Up Custody of Children in Order to Obtain Services

The 1997 Impact Analysis found that managed care reforms had exacerbated problems of custody relinquishment in order to obtain services, a problem which pre-existed managed care reforms, and follow-up suggested that little has changed. Respondents in two states in this sample described increasing numbers of families having to give up custody in order to access services for their children, and those in five other states indicated that this continues to be a problematic area. Interviews suggested two related trends: 1) as Medicaid managed care reforms have been implemented, fewer resources appear to be available for persons not eligible for Medicaid coverage but without other resources to purchase services, thus increasing the number of non-Medicaid families giving up custody; and 2) many of the managed care systems have focused on acute care and brief therapies, forcing parents whose children need extended or longer-term care to do whatever they must to get that care. It was noted by state child mental health respondents in four states that the need to give up custody has decreased since the site visits, and it was reported that in two states that parents could now make “voluntary” placements without losing custody.

XI. Changes in Early Identification and Intervention

Identifying and Treating Behavioral Health Problems at an Earlier Stage

Changes or improvements designed to identify and treat behavioral health problems earlier were reported in five of the 10 states in this sample. Arizona has implemented a new EPSDT screening tool that includes more attention to behavioral and developmental issues. PCPs in Arizona are now required to utilize the “Pediatric Symptom Checklist” in EPSDT screens at every visit; Connecticut implemented a system of incentives to get primary care providers to conduct EPSDT screens. In Delaware, the state agency is funding K-3 case managers in the

schools, seeking to increase the number of children whose behavioral needs are first identified in earlier grades. Massachusetts has added a mechanism to ensure that children entering foster care receive a screening that includes behavioral health questions within seven days of entering that system. Utah has established nine “traveling clinics,” bringing medical and behavioral health expertise to more remote communities otherwise without access to services. Each of these changes has targeted a strategic point in the identification process for improvement.

Services to Infants, Toddlers, Preschoolers and Their Families

Respondents in three states reported changes or active work in this area: Arizona used a grant opportunity to increase awareness and expertise related to behavioral health services for the 0 to 3 population; Connecticut has one health plan exploring the development of a standardized, multidisciplinary assessment approach for infants; and Utah implemented a new screening tool to identify behavioral health needs in very young children. These initiatives were described by respondents as positive improvements.

X. Changes in Service Coordination

Interagency Treatment and Service Planning

When the site visits were conducted, several states in this sample were found to be using interagency treatment and service planning processes to enhance coordination between child-serving system partners at the individual child and family level, and follow-up interviews revealed some evidence of advancements in this area. Arizona has expanded an Interagency Case Management Project which emphasizes joint case planning, and the child welfare system in that state has hired “behavioral health liaisons” to increase the effectiveness of case planning between systems. Delaware has mandated interdivisional team case planning for children requiring services from multiple divisions, with MCO participation on the teams. Iowa added joint treatment planning sessions to its benefit package after experiencing success in an initial joint planning pilot. Utah has created a state-level “rapid response team” that uses integrated service planning to manage care for children whose needs cross systems and for whom services are not available or are too costly.

Case Management and Service Coordination

Follow-up interviews included reports that adjustments have been made in case management services in four states, generally aimed at improving service coordination. Arizona has implemented in Maricopa County a requirement that all children be assigned to a Primary Behavioral Health Professional (PBHP), a role that can now be held by professionals with a range of qualifications or education, fixing the responsibility for service coordination with that person. It is anticipated that this approach will be applied in other areas as contracts with RBHAs are renewed or re-awarded. Massachusetts has initiated an intensive case management pilot program aimed at children in the child welfare system with serious and complex needs, with some hope of expanding the program in the future. In Utah, the state has established training for case managers, while also increasing the availability of case management for children with serious needs who are not identified as having serious emotional disturbances. Delaware’s management information system includes a records management

component that supports quality assurance processes and enhances coordination of services for individual consumers. In contrast, it was reported that the termination of Carolina Alternatives has greatly reduced the availability of case management for children with serious emotional disturbances in North Carolina.

Coordinating Mental Health and Substance Abuse Services

A substantial change in the coordination of mental health and substance abuse services was reported in Iowa, where the Iowa Plan reflects a merging of mental health and substance abuse responsibilities under one contract with one MCO. Previously, Iowa had established separate contracts and requirements, even though the same MCO held both contracts. Respondents from the state, the MCO, and providers described this change as very positive, enhancing coordination across mental health and substance abuse services. No other changes were reported in other states.

XI. Changes in Physical Health Care–Behavioral Health Care Linkages

Linking Physical Health Care Providers with Behavioral Health Care Providers

A design change related to this area occurred in Massachusetts, where HMOs were recently allowed to compete to function as the BHO for a portion of the Medicaid-eligible population, joining the Partnership, which had previously functioned as a single, statewide BHO. State and BHO respondents expected increased linkages between behavioral health and physical health care to result from this change.

Other changes directing at improving coordination between physical health and behavioral health providers were reported in three states. Arizona has designed and employed a standardized release for the appropriate sharing of necessary information between behavioral health and physical health providers. Arizona and Delaware have both implemented a physician notification process when a child is admitted to specialty behavioral health care. Iowa reported that responsibilities for payment for psychotropic medications have been clarified between HMOs (physical health care) and the MCO for behavioral health, thus improving coordination.

Preparation of Primary Health Care Practitioners to Identify and Refer Behavioral Health Problems

Respondents in three states reported some changes in the preparation of primary health care providers for identifying and referring individuals with behavioral health problems (CT, DE, and UT). In Delaware, for example, a “pocket screen” was created and distributed for use by primary care practitioners to assist them to identify behavioral health needs in their patients.

XII. Changes Relevant to Cultural Competence

System Response to Culturally Diverse Children and Adolescents and Their Families

Stakeholders in two states reported that strategic steps have been taken to improve system response for diverse families. In Massachusetts, the Department of Mental Health determined from system satisfaction data that cultural issues needed to be addressed more effectively and established in the department an Office of Multicultural Affairs to begin systematically addressing this area. In Utah, a cultural competence specialist was hired in the Division of Mental Health to be the lead person for improvements in cultural competence, and specific programs of outreach to three tribal nations were cited. Two states were reported to have translated outreach materials into Spanish.

Inclusion of Culturally Diverse Providers in Networks

Reports from three states (AZ, DE, and UT) described specific efforts to recruit bilingual providers (English/Spanish), although they are meeting with varied levels of success. No other changes in the inclusion of cultural diverse providers were reported.

Inclusion of Special Services Needed by Culturally Diverse Populations

Two reports of changes relevant to this area were reported in follow-up interviews. The new for-profit RBHA in Maricopa County, Arizona has included Native American healing approaches in its rate schedule, and Delaware has begun utilizing two parent empowerment curricula, specifically designed for African American and Latino groups, to improve the cultural sensitivity of its services.

Requirements for Cultural Competence

Changes in requirements for cultural competence were reported in three states in this sample. In Maricopa County, Arizona, provider contracts require that intakes be conducted in the language most appropriate for the consumer/family. Rhode Island has incorporated specific cultural competence requirements into its RFPs and system contracts. Utah MCOs are now required to identify providers with skills relevant to culturally diverse populations, and they must develop long-range cultural competence plans.

XIII. Changes in or Affecting Providers

Types of Providers and Programs Included in Networks

Respondents in five states reported additions to the types of providers included in their behavioral health networks. In two states (IA and UT), deliberate efforts to add specialty providers have expanded the number of providers offering specialized care (such as sex abuse treatment). In two other states (AZ and OR) it was reported that MCOs in a few locales have expanded the local network to include more private practitioners. In Delaware, the MCO has mandated that all network providers have the capability of conducting both mental health and substance abuse assessments, effectively adding substance abuse providers to networks.

A decrease in types of providers included in provider networks was reported in Delaware, where one of the three statewide MCOs was reported to have stopped using professional counselors in its network.

Mandates for Inclusion of Providers

No changes were reported in this area during follow-up interviews.

Inclusion of Smaller and Non-Traditional Provider Agencies

Providers in one state reported that some smaller agencies had dropped out of the managed care system because they were unable to meet quality management requirements, but no other changes were reported in this area.

Inclusion of School-Based Behavioral Health Providers

Increased use of school-based providers was a change noted by respondents in three states in the maturational analysis sample. Providers in Utah reported that more community mental health centers are offering services at schools, as negotiated locally. Delaware has placed case managers in schools serving K-3, primarily to identify needs and refer for services. Change was reported in Iowa, where the MCO hired a psychiatric nurse working in the schools to help move children out of day treatment programming and into appropriate, less restrictive settings. Those aware of this process described it as achieving good results for the children helped. Difficulty in providing school-based services was reported by respondents in Connecticut who indicated that school-based clinics are hampered in obtaining payment by a requirement that they must seek reimbursement through a behavioral health organization.

Credentialing Requirements for Providers

Three changes were reported in discrete credentialing requirements across the sample of 10 states. RBHAs in Arizona are now required to establish “privileges” for certain services; one (of three) MCOs in Delaware has dropped professional counselors from its provider network; and in Massachusetts, where HMOs recently began to contract for behavioral health services for a portion of the eligible population, some of those HMOs were reported to be establishing wholly private provider networks (e.g., private practice psychiatrists and psychologists). In addition, issues related to credentialing and use of substance abuse providers surfaced in two states. Connecticut recently conducted a survey to determine whether substance abuse providers were included in MCO provider networks, finding that they were. Delaware has focused on improving the substance abuse treatment capabilities of mental health provider agencies by encouraging them to hire certified addictions counselors.

Use of National Standards

The only reported activity in the use of national standards was that one RBHA in Arizona was seeking NCQA accreditation, and one was preparing for a JCAHO site visit.

Credentialing of Agencies or Programs as Well as Individual Practitioners

No changes were reported during follow-up interviews with stakeholders in any of the 10 states.

Inclusion of Culturally Diverse and Indigenous Providers

Few significant changes were reported during follow-up interviews. Arizona now requires that provider networks conduct intakes in the language appropriate to the individual (one county first, probably followed by others) and has added mandates around cultural competence training for providers. Rhode Island respondents indicated that an earlier change in credentialing requirements, aimed at enabling more providers of color to join the network, did not have a significant impact on provider diversity. Utah reported the addition of bilingual therapists in some areas of the state.

Front-Line Clinical Practice

Many respondents expressed their perceptions regarding changes in front-line practice with children and adolescents with emotional and substance abuse disorders and their families, creating a mixed picture in several states, and revealing more changes characterized as negative than those viewed as positive.

In the 1997 Impact Analysis, respondents in all 10 states reported moves to briefer treatment models. In follow-up, stakeholders in three states reported that the increasing emphasis on brief therapies in their managed care systems (AZ, CT, and MA) were creating greater difficulties in accessing longer-term, extended care. It was interesting that in three states, state and/or MCO respondents, as well as families, described the same specific changes in front-line practice, with the former describing them as improvements, while the families identified them as negative, particularly in terms of making access to longer-term services and supports more difficult.

One or more respondents in six of the 10 states in this sample reported that front-line service providers were seeing children with more serious, difficult needs at the community level, attributed to the shorter lengths of stay in inpatient and residential treatment settings that have resulted from managed care reforms. Respondents in two states reported an increase in intensive outpatient services (DE and UT), designed to strengthen the system's ability to successfully maintain children in the community.

Training of Child and Adolescent Mental Health Substance Abuse Providers

Three targeted programs of provider training were described during follow-up interviews. Arizona focused training on mental health services for the 0-3 population; providers in Massachusetts have received training on symptom resolution; and one RSN in Washington trained providers in the system of care model for serving children and their families, with positive effects reported by parents.

Inclusion of Certified Substance Abuse Counselors

Two states have made specific changes in this area, one fostering greater inclusion of certified substance abuse counselors and the other making it more difficult for them to participate in the managed care system's provider networks. In Delaware, the Behavioral Health Care Coalition is moving toward ensuring that all network providers have basic competencies in mental health and substance abuse assessment and referral processes, opening the door for greater inclusion of providers with substance abuse expertise. Utah recently changed the licensing law to require that mental health therapists conduct assessment and diagnosis of both mental health and substance abuse disorders. The same change excluded substance abuse counselors from those functions, while requiring that they receive mental health supervision in order to provide services.

Administrative Burden for Providers

Providers in four states reported that their paperwork burden, particularly in responding to quality management and data demands, has steadily increased during reform implementation. Respondents in two states described specific efforts to decrease the administrative demand placed on providers: the paperwork burden for Connecticut providers has decreased because there are now only five plans (compared to 11 at the time of site visits), and the state now requires the use of consolidated forms; and Arizona has attempted to streamline data reporting requirements for network providers.

Structure and Organization of Provider Agencies

Respondents in three states (AZ, CT, and UT) reported some changes in the structure and organization of provider agencies in response to managed care reforms, including the formation of provider networks, a statewide organization, mergers, and the like. In Utah, the Utah Behavioral Health Care Network was organized, which is a non-profit advocacy and lobbying organization created by mental health and substance abuse providers. Interviews in two states (AZ and CT) raised reports of smaller agencies merging to integrate service and administrative functions. Reports in two other states suggested that smaller, more rural providers were going out of business at an increasing rate.

XIV. Changes in Interagency Relationships

General Trends in Interagency Collaboration

Respondents from many of the states in the maturational analysis sample described various areas or activities reflecting continued evolution of collaborative processes among the many child-serving systems and agencies, regardless of the overall structure of such systems or of the managed care reforms. In many reported instances, activities were in response to a variety of pressures, some contributed by managed care reforms in behavioral health or child welfare systems, but others emanating from areas unrelated to those reforms. In particular, several states in this sample have established new, high-level state groups (work groups,

leadership groups, problem solving teams, etc.) which bring combinations of systems together. More have also established places within such groups for representatives of the Medicaid agency, MCOs, and HMOs with major roles in the managed care system. Generally, changes or improvements resulting from these collaborative processes continue to be described as incremental improvements in system relationships.

Clarifying Responsibility for Services and Paying for Services Across Child-Serving Systems

A variety of changes in the clarification of respective responsibilities held by child-serving systems were identified during follow-up interviews. Respondents in five states described specific strategies to address at least one aspect of the complex responsibilities held by the various systems. Arizona's behavioral health system, in the context of the managed care reform, has drawn clearer boundaries around the behavioral services and supports that the managed care system will cover, giving other systems better articulated limits against which to negotiate. Delaware state respondents noted improved agreement about the respective responsibilities of behavioral health, child welfare, and juvenile justice systems in long-term care, especially in therapeutic group settings, and improved coordination of substance abuse services for juveniles in the justice system. In Iowa, partially in response to data showing that 11.6% of the population served by the behavioral health managed care system also had a DHS case worker, the MCO has created regional "care teams" to improve functional relationships with juvenile justice and child welfare entities around long-term care decisions. Oregon has created a high level "operations" group as a forum for clarifying responsibilities and system needs, and in Utah, state agencies have agreed upon an approach to sharing the cost of care when children come into state custody with significant treatment needs.

Cost Shifting to Other Child Serving Systems

Respondents in five states reported recognition of cost shifting between systems, particularly around long-term care, but, as during the site visits, no interviewees provided verification or data supporting these perceptions. Delaware has begun tracking behavioral health care costs specific to children in the child welfare system, but data were not yet available at the time of follow-up. The MCO in Iowa was also reported to have begun tracking costs for serving the child welfare population, and it was reported likely that cost shifting to the MCO was taking place.

Monitoring the Impact on Other Child Serving Systems

Respondents in Delaware and Iowa indicated that efforts were recently begun to monitor the cost of behavioral health care for children in the child welfare system, but data were not yet available. Delaware is specifically tracking services, spending, and outcomes under managed care for children in custody of the child protection system. The Iowa MCO is gathering and analyzing data regarding children in its care who have DHS caseworkers.

XV. Changes in Financing Behavioral Health Services for Children

Ability to Use Medicaid as a Funding Source for Children's Mental Health and Adolescent Substance Abuse Services

The only change reported during follow-up interviews took place in Utah, where a Memorandum of Agreement between the mental health and education agencies led to expanded Medicaid coverage of mental health services specified in Individualized Education Plans (IEPs).

Use of EPSDT

Changes in the use of EPSDT to finance behavioral health care services for children were reported in two states. North Carolina implemented a joint mental health/child welfare assessment and planning process to improve mental health services for the child welfare population, and respondents suggested that EPSDT would be used to pay for the assessments. In Rhode Island, the EPSDT service approval process was simplified by removing the requirement for the child welfare agency to authorize prescriptions and disenrollments, thus making it easier for EPSDT to fund services.

Blending or Pooling of Funds Across Agencies

The only reported change in blending or pooling funds across agencies took place in Utah. An agreement reached between state agencies enables copayments from system partners when a child comes into state custody with significant treatment needs. No other changes with respect to blended funding were reported in this sample of states.

Reinvestment of Saving or Profit Back in the Child and Adolescent Behavioral Health System

Few changes were reported with respect to reinvestment. Delaware has redirected some resources (not described as "savings" per se) in an interagency effort to expand therapeutic foster and group care; and one MCO in Oregon was reported to include "reinvestment targets" in contracts with providers. It was noted that the Iowa contract with the MCO continues to include specific and significant performance expectations regarding reinvestment in service capacity.

XVI. Changes in Accountability Of Managed Care Systems

Management Information Systems (MISs)

A few notable trends regarding MISs emerged in the follow-up interviews. Reports from many states indicated that agencies and MCOs were having difficulty collecting data for analysis and decision making, which depends first on receiving good data from front-line agencies. In two states (CT and DE), discussions were underway regarding the implementation of financial consequences for not submitting data according to contract timelines. Reports from two other states (MA and WA) indicated that data were being collected, but that adequate use

of the data was not yet being made, in one instance “because most people don’t know how to use the data,” and in the other because providers suggested that data only flow one way, with no subsequent access to information about their own performance or overall system performance.

It was also reported that Delaware state children’s divisions (mental health, child welfare, and juvenile justice) were discussing a possible merging of outcomes tracking and quality improvement processes, driven by improvements in the department’s management information system.

Tracking of Utilization for Children and Adolescents for Mental Health and Substance Abuse Services

Overall, follow-up interviews suggest that work in this area is taking place, but few reports of concrete progress were recorded. Reports from three states (OR, RI, and UT) indicated that usable utilization data had only recently become available, in some cases with child/adolescent data not yet separated out. Stakeholder in Oregon reported that they were focusing on high-end service utilization in their data analysis. At the time of the site visits, Delaware was carefully tracking utilization data for children and adolescents under state care, and follow-up interviews indicated success and continuation of that approach—a variety of Delaware changes noted elsewhere in this report resulted from utilization analysis and tracking to determine the impact of changes. One Arizona focus is matching functional levels of consumers against utilization, cost, and impact data. The Iowa MCO has begun tracking utilization patterns for children and adolescents in the child welfare system as one basis for strengthening their relationship with that system, but data were not yet available at the time of the interviews.

Service Utilization Patterns

In Massachusetts, it was reported that home-based service utilization had significantly increased as a direct result of incentives from the MCO. It was reported in Utah that inpatient services (state and private) for children and adolescents had decreased, while utilization of community-based services had increased. Utah respondents indicated that the service culture was evolving towards a greater focus on community-based care and away from longer-term, institution-based care. No other changes were documented during this follow-up process.

Measurement of Quality

Some progress and activity in this area was reported during follow-up interviews. Utah has put monitoring teams in place, including a children’s team, that visit each region annually to review records and interview stakeholders regarding the quality of services. The children’s team includes professional, state, and family representation. Arizona created a Quality Management Committee and added quality assurance staff at the state level. State respondents in Delaware reported that the state system for children with more serious needs was using the Child and Adolescent Functional Assessment Scale (CAFAS) to monitor functional changes in response to system services, and raised the prospect that MCOs managing acute care would eventually use the same tool.

Development of Quality Measures Specific to Child and Adolescent Behavioral Health

No changes were reported in this area in any of the states in the sample.

Measurement of Clinical and Functional Outcomes for Children and Adolescents

Some efforts to build or refine outcomes measures were reported. As noted, Arizona is beginning to match functional levels over time against use, cost, and impact data to improve system management. Two states (DE and MA) have begun to use the CAFAS for children served under the state system with the most serious and complex problems, with hope of ultimately employing the same tool in acute care. Utah reported progress in developing a clinical and functional outcomes tracking system, but no data were yet available.

Focus on Children and Adolescent Behavioral Health Services in Evaluations

Follow-up interviews did not reveal significantly increased attention to children in evaluations since the site visits. Basic evaluations were described in five states in this sample, but most had little specific focus on children and adolescents. Respondents in two states (MA and WA) reported that outside evaluations by university- and consultation-based organizations were predominantly focused on the adult consumer experience in the reforms, offering little if any useful information to the children's system. An exception was noted in Iowa, where a study of the highest need subpopulation, including children, is being conducted, with the CAFAS used to track child progress.

Measurement of Satisfaction

Some changes, characterized as progress, were reported regarding the measurement of satisfaction in four states in this sample. Arizona implemented statewide use of the Mental Health Statistics Improvement Program (MHSIP) consumer perception survey, including a family version, administered through the RBHAs. Delaware, at the time of follow-up, was piloting a satisfaction system, anticipating decisions about full implementation in the near future. In Massachusetts, the Department of Mental Health reported the hiring of adult consumers to gather consumer satisfaction feedback regarding MCO-managed services. Utah reported implementation of two new tools—the Utah Family Perception of Care Scale and the Utah Burden of Care Scale—measuring family satisfaction among other things, including family stress.

Measurement of Cost

Stakeholder reports suggested that total Medicaid spending for child mental health and adolescent substance abuse services had decreased in at least two states as a result of managed care reforms, but no data were provided.

Cost per Child Served, Cost per Eligible Child

The 1997 Impact Analysis found little information available in this area, and follow-up interviews in all 10 states revealed that data on cost per child served or cost per eligible child remain unavailable.

Proportion of Funds Spent on Hospital/Residential Treatment versus Outpatient, Home, and Community-Based Services

State mental health respondents in Connecticut described newly available Medicaid information showing a 70% reduction in psychiatric inpatient spending and a 50% reduction in outpatient mental health spending for children between 1995 and 1997. North Carolina respondents offered data regarding Carolina Alternatives, a program terminated in 1999, suggesting that Medicaid spending on institutional care diminished from 74% of total (in Carolina Alternatives sites) in 1992 to 12.3% of total (system-wide) in 1997. ■

Summary of Special Analysis: Child Welfare

Introduction

Background and Purpose of the Special Analysis

In 1996, The David and Lucile Packard Foundation provided supplemental funding to the Health Care Reform Tracking Project to explore more fully the impact of public sector managed care reforms on children and families served by the child welfare system who need mental health and substance abuse services. These funds, along with funding from the Administration for Children and Families in the U.S. Department of Health and Human Services, enabled the Tracking Project to incorporate a focus on child welfare issues throughout the project's activities. The purposes of the child welfare focus of the Tracking Project are:

- To determine the impact of behavioral health managed care approaches on children and adolescents with behavioral health disorders who are involved with the child welfare system, and their families.
- To identify strategies that states use, within managed care initiatives, to meet the mental health and substance abuse treatment needs of children in the child welfare system, and their families.
- To identify and describe managed care initiatives within the child welfare system.

Accordingly, a specific focus on child welfare issues was incorporated into the following project activities:

- **Impact Analyses** — The 1997 Impact Analysis included site visits to 10 states, and the 1999 Impact Analysis included site visits to eight new states¹ with the purpose of assessing the impact of behavioral health managed care reforms through interviews with a wide range of stakeholder groups. During the site visits for the 1997 and 1999 Impact Analyses, consultants with expertise in child welfare interviewed a range of stakeholders involved with child welfare systems, including state and local child welfare administrators; child welfare supervisors and caseworkers; child welfare providers; and birth, foster and adoptive parents.

¹ In one state, Maryland, two design types were studied, a mental health carve out and an integrated physical health/substance abuse design. Thus, the number of managed care reforms studied on site for the 1999 Impact Analysis total nine reforms in eight states.

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- **Maturational Analysis** — The Maturational Analysis tracked, through telephone interviews, changes that have occurred in the 10 states from the 1997 Impact Analysis. A child welfare consultant was involved in the telephone interviews in each of the 10 states, and interviewed a child welfare stakeholder group including both state and local child welfare system representatives.
 - **State Survey** — The 1997–98 State Survey including a special study of child welfare managed care² activity across the country, in addition to tracking behavioral health managed care reforms³.

How This Summary Is Organized

This summary of the findings from the Special Child Welfare Analysis focuses on the perceptions of child welfare stakeholders regarding behavioral health managed care initiatives in the eight states visited for the 1999 Impact Analysis. When helpful, these findings are contrasted with findings from the first round of site visits in 1997 to the 10 states in the initial sample, the follow-up telephone interviews that were conducted as part of the maturational analysis in 1999, and the 1997-98 State Survey.

The summary initially discusses the involvement of child welfare stakeholders in behavioral health managed care and what the child welfare system hopes to gain from managed care. The remainder summarizes issue areas that are discussed in the full report and outlines the most positive aspects and most serious problems associated with managed care from the perspective of child welfare respondents. Key findings related to each issue area are highlighted in italics, and positive examples of individual state strategies can be found in boxed text.

A more detailed Special Child Welfare Analysis that presents important contextual issues and includes descriptions of child welfare managed care initiatives undertaken by three states in the 1999 Impact Analysis sample is available as a separate, longer document that can be obtained from the National Technical Assistance Center for Children's Mental Health at Georgetown University Child Development Center.

² Child welfare managed care refers to a type of child welfare reform in which states or communities apply some managed care tools to the organization, provision and funding of child welfare services. Child welfare managed care reforms focus primarily on funds allocated to the child welfare system, and may or may not include some behavioral health services.

³ Behavioral health managed care, as used in this document, refers to reforms within state Medicaid and/or state mental health programs that apply managed care technologies to the administration and delivery of behavioral health services.

I. Involvement of Child Welfare Stakeholders in Behavioral Health Managed Care

Level of Child Welfare Stakeholder Involvement

Child welfare stakeholders, in response to issues around their involvement in behavioral health managed care, noted broad national policy shifts in the child welfare system that impact the nature of the interface between the child welfare system and behavioral health managed care at the local and state levels. The passage of the Adoption and Safe Families Act (ASFA) in late 1997 maintains the basic goals of the child welfare system – safety, permanency, and well-being for children and families. It also pressures the child welfare system to achieve outcomes more quickly, to be accountable for better results for children, and to promote adoption and other permanency options, if reunification is not possible. Respondents affirmed that, for many children and families, these goals cannot be achieved without effective behavioral health services. ASFA reaffirms the need for the child welfare system to forge linkages with other systems of support for families, including the behavioral health system.

Finding: Involvement of child welfare system stakeholders in behavioral health managed care policy deliberations and implementation is steadily increasing.

Respondents in both the 1997 and 1999 Impact Analyses indicated that, as problems occur within managed care systems that relate to services for children in the child welfare system, mechanisms for resolving the problems are developed, which increasingly involve child welfare system stakeholders. This occurs at the system level, as child welfare administrators take a more active role in planning behavioral health managed care reforms, as well as at the lineworker level, where social workers function as case managers, advocating for service authorization, monitoring the service delivery, and adjusting the service package when necessary to obtain desired results.

Respondents often described the current role of the child welfare system in behavioral health managed care as that of a very large, vocal, and influential consumer, seen by many MCOs as the representative of a major group of children with serious health and behavioral health care needs who consume large amounts of services. The 1997-98 State Survey confirmed that most public sector managed care reforms (60% nationally) are including children in state custody. This was reconfirmed in the 1997 and 1999 Impact Analyses – in the 1997 sample, nine of the 10 reforms included children in custody. In the 1999 sample, eight of the nine reforms included children in custody. The 1997-98 State Survey also indicated that 48% of reforms nationally included a discrete planning process for children in the child welfare system.

How Child Welfare Stakeholders Participate in Planning and Implementation

Finding: A variety of mechanisms are used to ensure involvement of child welfare system stakeholders in managed care reforms.

- **System Level Liaison** — Some states (for example, MA, MD, NM, and OR) have designated one or more persons to serve as a managed care specialist and system-level liaison between the child welfare agency and the managed care organization(s). This liaison may negotiate specialized treatment and enhanced capitation rates, clarify service responsibility, address service gaps and the creation of new services, and provide a central contact for resolving problems between systems.
- **Clinical Liaison** — Some states (such as NM and OR) also reportedly have created clinical liaisons at the service level, who assist local child welfare agencies and behavioral health organizations in resolving disagreements about services or levels of care that are appropriate for individual children, usually those with serious disorders.
- **Advisory Groups** — Participation in standing advisory groups and in formal work groups that have been created to resolve problems are other reported vehicles for child welfare system involvement.
- **Training** — Child welfare agencies have worked with Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs) to provide cross-system training that prepares each for working in and with the other system.
- **Collaboration** — In some states (such as CO and MA), local or regional child welfare agencies have formed strong collaborative relationships with community mental health centers that serve as behavioral health organizations. This has led to coordinated service planning, blending funds, sharing staff, and/or developing flexible services.

■ Example

Child Welfare Involvement in Behavioral Health Managed Care

- Child welfare respondents from **Oregon**, a state included in the 1997 Impact Analysis sample, indicated, during the Maturational Analysis interviews, that the state legislature has authorized funds for the state child welfare agency to hire four regional specialists who are charged with making managed care work for children and families in the child welfare system. The regional specialists will assist field-level caseworkers to resolve problems, negotiate with the Health Maintenance Organizations (HMOs) and the Mental Health Organizations (MHOs), and understand enrollment choices. They also will address payment responsibilities for children who move across county lines and strategies for meeting special service needs.

What The Child Welfare System Hopes To Obtain From Behavioral Health Managed Care

Finding: According to child welfare respondents, if behavioral health managed care is to work positively for children and families involved in the child welfare system, it is essential that the following occur:

- Easy access to appropriate behavioral health service.
 - Behavioral health services for family members, as well as for the identified child.
 - Coordinated and continuous care, especially when children change placements.
 - Commitment of the managed care initiative to meet the needs of children and families in the child welfare system.
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Child welfare stakeholders also stressed the importance of:

- Organizing provider networks that include providers who have the skills and expertise to work effectively with children and families in the child welfare system and to offer specific services, such as therapeutic foster care, sex offender treatment, and treatment for children who have been sexually abused.
- Preventing cost shifting from the behavioral health system to the child welfare system.
- Maximizing the use of Medicaid funding to provide behavioral health services for children and families in the child welfare system (cited especially by child welfare administrators).
- Creating a managed care system that can be “navigated” and understood by child welfare staff and parents.

II. Key Issue Areas – Impact on the Child Welfare System

Stakeholders indicated that some of the most challenging issues raised in managed care are related to meeting the needs of children and families in the child welfare system – children who have proportionately higher physical and behavioral health needs than the Medicaid child population as a whole and who experience greater difficulty in obtaining needed care. This is especially important in that eight of the nine reforms studied in the 1999 Impact Analysis include children who are in the custody of the child welfare agency. This section provides a summary of critical issues related to behavioral health managed care that were identified in discussions with child welfare stakeholders throughout the study.

Design of the Behavioral Health Managed Care System

Carve Out Designs and Integrated Designs

Finding: Child welfare respondents generally concurred with others in noting that states with carve out designs⁴ provided significant advantages for children with behavioral health problems as compared with states with integrated designs.⁵

Although child welfare stakeholders rarely noted the advantages or disadvantages of a behavioral health managed care system based solely on its design, the Tracking Project found that significant advantages for children with behavioral health problems were noted more frequently in states with carve out designs, while significant disadvantages were noted more frequently by respondents in states with integrated designs.

Advantages described in the states with carve out designs included: goals consistent with system of care principles, a wider array of behavioral health services, more home and community-based services, more flexibility in service delivery, and more child welfare and other agency involvement in planning and in ongoing interagency structures to implement and monitor the system. These advantages were noted despite specific findings from the eight states in the 1999 Impact Analysis sample demonstrating little difference between carve out and integrated reforms in the adjustment of capitation rates to meet the needs of children in state custody (two of the five carve out reforms increase capitation rates for children in custody; two of the four integrated reforms also increase these rates).

The disadvantages cited by child welfare stakeholders with respect to behavioral health services integrated managed care systems were tempered in some cases by some positive responses to the physical health services received through these systems. Respondents emphasized that for a child in the custody of the child welfare system, access to a primary care physician who coordinates all of the child's health care is extremely important. The benefits of a medical home and primary care physician can accrue to children in child welfare regardless of how behavioral health services are managed. In the 1999 Impact Analysis sample, three of the four states with integrated physical — behavioral health designs included children in custody in the reform. Although many child welfare respondents expressed concerns similar to other stakeholders about behavioral health services available through the integrated designs (especially related to the strict interpretation of medical necessity criteria that restricted access to behavioral health services), child welfare respondents in two of these three states with integrated designs were pleased with the provision of *physical* health care that foster children could receive through the integrated reform, but expressed concerns about the coordination between physical and behavioral health care. In the third state, stakeholders were not

⁴ A carve out design is defined as one in which the financing and administration of behavioral health services are separated from the financing and administration of physical health services.

⁵ An integrated design is defined as one in which the financing and administration of physical and behavioral health services are integrated.

pleased with the integrated system and noted multiple problems in access to *both* physical and behavioral health care. In general, across all states in both the 1997 and 1999 samples, coordination between physical and behavioral health care was cited as problematic regardless of design.

Acute and Extended Care Services

Finding: Respondents generally felt that including both acute and extended care services in the managed care system has the potential to reduce service gaps and disagreements about payment responsibility; however, this requires attention to special safeguards to ensure access for children in the child welfare system.

Seven of the nine reforms in the 1999 sample include both acute and extended care services. This represents an increase from the 1997 Impact Analysis in which only four of the 10 states studied included extended care in the managed care system. This issue is of great significance to the child welfare system. Forty-five percent of the reforms described in the 1997-98 State Survey listed the public child welfare system as primarily responsible for providing extended behavioral health services when the managed care system was limited to acute care services only.

Child welfare respondents also indicated the importance of ensuring that the capitation rate paid to the MCO is adequate to cover extended care services and that the provider network includes those who can offer extended care to the child welfare population.

Managed Care Organizations

Finding: Generally, child welfare respondents in all phases of the Tracking Project have noted the following concerns about MCOs:

- Unfamiliarity with the needs of children and families involved with the child welfare system (especially among commercial MCO).
- The negative impact on service continuity and coordination caused by the use of multiple MCOs within a state.
- The need for training for the child welfare system about managed care and for MCOs about the child welfare system.

Unfamiliarity with Families and Children Served by the Child Welfare System

Several states complained about MCOs' lack of familiarity with the service needs of children in the child welfare and juvenile justice systems. Commercial MCOs (used by seven of the nine reforms in the 1999 Impact Analysis sample) were charged with not understanding: the trauma experienced by the children; the extent of health and behavioral health needs and thus the need for additional services; the necessity of working with multiple agencies and families; and the policies and dynamics of working with children in state custody, for example, the role of the court and state laws that govern the child welfare system.

Some respondents noted, however, that although the child welfare population was at first largely misunderstood and ignored, there appear to be an emerging understanding between MCOs and the child welfare system and that MCOs are finding that advice and input from the child welfare system is proving to be reliable.

■ Example

Collaboration between the Child Welfare System and the MCO

- In **Vermont**, the child welfare and Medicaid agencies have worked with MCOs to familiarize them with the needs of the child welfare population. Interagency agreements are in place with child welfare, monthly meetings are held to resolve issues, and weekly calls between child welfare liaisons and MCOs reportedly are held.

Impact of Multiple MCOs on Continuity and Coordination of Services

The perspective of child welfare respondents in all phases of the Tracking Project regarding the disadvantages of using multiple MCOs statewide or within regions conforms to the perspectives of most other stakeholder groups. The multiple moves experienced by many children in the child welfare system make use of multiple MCOs especially problematic.

Through the various phases of the Tracking Project, several patterns regarding the number of MCOs and/or BHOs operating within a state have emerged. Each of these patterns presents different advantages and disadvantages for the child welfare system.

- **Multiple MCOs operating statewide or within regions** — Foster families who have children enrolled in different MCOs, each with different authorization procedures, interpretation of medical necessity criteria and providers, have found particular difficulties with this model. Birth parents, who have some children living at home and some in foster care or residential treatment, experience similar difficulties with multiple plans.
- **Multiple MCOs or BHOs assigned to different regions of the state** — In this model, only one MCO or BHO operates within each region, but as consumers move from one region to another, they must change MCOs. As children move from their own homes to foster homes, from one foster home to another, or from family

homes to residential placements, they often change MCOs. This can mean a change in services, providers, benefit structures and authorization procedures. It often requires extensive paperwork to disenroll with one MCO and enroll with another and can cause delays in obtaining services.

■ **Example**

Strategy for Retaining Same Provider

- To reduce the impact on a child who moves from one county to the next, **Pennsylvania** found a partial solution by creating multi-county zones and requiring behavioral health MCOs and providers to be able to serve children wherever they live within a particular zone. However, problems related to responsibility for payment and changing providers still exist when a child moves outside of the zone.

- **Single MCO or BHO that operates statewide** — A single statewide MCO or BHO eliminates choice of MCO. However, in the 1999 Impact Analysis sample, respondents in all nine reforms cited the choice of providers as more important to consumers than the choice of MCO. Respondents from states with this model have noted, in previous phases of the study, the advantage of consistency and continuity of care for children in the child welfare system as they change placements.

The Need for Training

In some states, respondents felt that the learning curve was higher with commercial companies than with nonprofits or government entities that serve as the MCO. However, most agreed that all management entities need additional training, education, and experience to serve the child welfare population effectively.

Respondents also noted the need to train child welfare workers in the workings of managed care. Training about authorization requirements, utilization review procedures, and the use of results-based bench marks in service planning were cited as critical to successful navigation of a managed care system. Cross-training initiatives were described by several respondents.

Efforts to prepare MCOs and BHOs that were noted included: large training efforts by the public child welfare and mental health system for MCO administrators, clinical staff, and care coordinators; education at monthly planning meetings; and use of every appeal or grievance about individual children as a “teachable moment” about the dynamics of the foster care system.

■ Example

Familiarizing the MCO with the Child Welfare System

- Child welfare stakeholders in the counties in **Colorado** with strong partnerships between the behavioral health managed care entities and the local child welfare agencies reported that they have worked together in work groups to problem solve and plan. Through these processes, the managed care entities have learned more about the child welfare system, and, together, they have developed specialized treatment programs to address sexual abuse issues and attachment disorders, and have moved toward treating whole families rather than individual children.

Capitation And Risk

Finding: More states are beginning to establish risk adjustment mechanisms, such as enhanced capitation rates, for children in the custody of the child welfare agency.

In the 1997 sample of 10 states, only one state (OR) had a higher capitation rate in place for children in custody. In the 1999 sample of eight states, half (CO, NE, NM, VT) incorporated risk adjusted rates for the child welfare population, and another state (PA) indicated that it was considering doing so. Two of the states from the 1997 sample (DE and CT) also indicated through the maturational analysis that they are considering risk adjusted rates. Connecticut, through another study, recently determined that children in the custody of the Department of Children and Families, who constitute 5% of the Medicaid population, account for 60% of the behavioral health expenditures.⁶ Pennsylvania also is engaged in a study to determine behavioral health service utilization by the child welfare population to inform its rate-setting.

Findings from the 1999 Impact Analysis highlight the need for special attention to the financing and delivery of services for children in the child welfare system. Respondents noted the higher prevalence of both physical and behavioral health problems in the child welfare population and, therefore, the need for higher capitation or case rates as one way to guard against denial of service or underservice. However, even with the use of enhanced rates, many stakeholders believe that underservice is occurring. Data to document underservice typically are not available in states.

Clinical Decision Making And Management Mechanisms

Finding: As in previous phases of the Tracking Project, child welfare respondents in the 1999 Impact Analysis noted difficulties with the criteria used by MCOs to authorize treatment and to determine levels of care received.

⁶ Child Health and Development Institute of Connecticut, *Delivering and Financing Children's Behavioral Health Services in Connecticut, A Report to the Connecticut General Assembly*, February 2000, p. ES-3.

Medical Necessity Criteria

The divergence between child safety concerns and medical necessity criteria that was noted in the 1997 Impact Analysis continues. Respondents in the 1999 sample indicated that medical necessity criteria often are too narrowly defined to authorize appropriate types, levels, and duration of services for children in the child welfare system and do not allow for consideration of psychosocial and environmental factors in clinical decision making.

An example cited by child welfare respondents is that restrictive level of care criteria in some states have led to real or perceived premature discharge from hospitals without adequate step-down services or safe placements arranged. Child welfare respondents in one state charged that children were discharged with recommendations for levels of care that the BHO knew did not exist. This reportedly led to placements in child welfare emergency shelters that could not provide the needed therapeutic services. Premature discharges also were cited as creating a revolving door, with children returning to hospitals more frequently, and often in worse shape than during a previous admission.

Prior Authorization

Child welfare workers noted the need to learn the language of managed care in order to get services authorized. For example, requests for placement had to be reframed as seeking treatment, i.e., a placement that offers a specific level of care for a child.

In several states, child welfare stakeholders were not familiar with or had misconceptions about prior authorization policies. Authorization processes for substance abuse services were of particular concern as they related to parents of children in the child welfare system. Respondents felt that any delay in obtaining substance abuse treatment, both for adolescents and for parents, could discourage participation in a treatment program.

In some states, utilization review presented significant problems by requiring repeated reviews at intervals considered by child welfare respondents to be too frequent. For example, in one state, reauthorization for therapeutic foster care was required once a week after a child had been in placement for six months. Some respondents felt that child welfare workers had been disenfranchised around clinical decision making due to lack of involvement in and control over treatment decisions.

On a positive note, child welfare respondents were pleased that MCOs generally are able to track children and families by service and Medicaid eligibility category, thus providing information about service utilization specific to those served by the child welfare system. However, many noted that although the ability to do this tracking exists, the data have not yet been made available, nor analyzed.

■ Example

Use of Data from Utilization Review

- In **Pennsylvania**, utilization data will be used in a study of residential care to determine who pays for care, the pattern of use, and the movement of the children involved. Pennsylvania also is doing a study on the percentage of children in child welfare who are at higher risk for physical and behavioral health problems.

Grievance and Appeals

Respondents in all states in the 1999 Impact Analysis sample saw the grievance and appeals process as problematic. Child welfare respondents noted that they often did not know how the process worked and rarely used it. Disputes and disagreements were more often addressed through liaisons appointed to work with managed care organizations, through interagency committees, and at the agency head level. They also expressed concern for families who did not have access to liaisons and advocates to assist with the grievance and appeal process.

Service Array

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- Finding:** Child welfare respondents in the 1999 Impact Analysis identified several areas of concern regarding needed service capacity within the managed care reforms:
- Hospital step down services, particularly therapeutic foster care.
 - In-home support services for children in foster care.
 - Sex offender treatment.
 - Sexual abuse treatment services.
 - Specialized post adoption services for families receiving adoption subsidies.
-

As noted previously, children served by the child welfare system, and their families, require an intensive level and wide array of services. From the child welfare perspective, the availability of home and community-based mental health services in managed care systems reportedly is highly dependent upon the development of good working relationships with the MCOs or BHOs and a history of using a system of care approach in the community.

In the 1999 sample, four of the five reforms with carve out designs reportedly included coverage of a broader array of child mental health services than pre-managed care, while only one of the four reforms using an integrated design reportedly included a broader array.

Some respondents indicated that the development of services that are responsive to the needs of families involved with child welfare can be expected to increase as the child welfare system becomes more sophisticated in its dealings with managed care systems, in controlling

cost shifting and in asserting its presence as a major consumer of behavioral health services. As noted, interviewees identified a number of instances in which child welfare systems were joining with managed care systems and managed care entities in joint program development initiatives.

Access Issues

Finding: Respondents in the 1999 Impact Analysis indicated that access problems reported in the 1997 Impact Analysis continue, especially at the high end of the service spectrum around admission to hospital, residential care and other extended care services. However, some of the reforms studied illustrate how child welfare organizations are becoming more effective in accessing behavioral health services for their clients.

Initial Access to Services

Child welfare respondents tended to concur with other stakeholder groups in the 1999 Impact Analysis about initial access to services. The four reforms with carve out designs reportedly increased initial access to behavioral health services, attributed to including more providers in the network and pre-approving a set number of outpatient visits without requiring prior authorization. However, even initial access was felt to be compromised in five of the nine reforms, a finding different from the 1997 sample in which stakeholders in most states felt managed care was improving initial access.

Access to Extended Care

Stakeholders in all but one of the states visited in 1999 indicated that managed care aggravated access to extended care services. Given the complexity of the needs of children in the child welfare system, the most significant problems faced in accessing extended care related to the difficulties in obtaining admission to intensive levels of care and to reduced lengths of stay. Respondents from seven of the nine reforms affirmed increased difficulty in accessing inpatient hospital services, and in eight of the reforms, respondents indicated that children are being discharged prematurely. Many respondents indicated managed care systems do not account sufficiently for children needing more than brief treatment, and that too often children are placed inappropriately in lower levels of care that are not equipped to adequately care for them.

Child welfare respondents complained that inpatient and residential treatment admissions took more time to arrange post-managed care reforms. Further, when a youth was discharged prematurely, the previous placement setting often was unwilling to take the child back because they could not adequately deal with the child's behaviors and were concerned about the safety and well-being of the other children in the program.

Accessing Substance Abuse Services

Stakeholders in five of eight reform initiatives including substance abuse services concurred that managed care made it more difficult to access adolescent substance abuse treatment in long-term settings, citing such contributing factors as fewer residential treatment beds for substance abuse services available statewide and authorization and length of stay requirements that have become more stringent. Child welfare respondents indicated they frequently used child welfare funds to obtain long-term adolescent substance abuse treatment for children in foster care.

Dealing with Concerns about Access

Child welfare stakeholders confirmed that they are beginning to confront and deal with access issues through the appointment of system-level and clinical-level liaisons and also by participating in system-level advisory, planning, and implementation groups.

Family Involvement

Involvement at the System and Service Planning Levels

Finding: Although findings from the 1999 Impact Analysis demonstrated that family involvement is slowly increasing at the system level, and also that seven of the nine reforms require providers to involve families in serving planning for their own children, respondents had no data to demonstrate if, or how, families served by the child welfare system are involved at either level. No targeted efforts to involve child welfare families were described by any respondents. The general consensus among child welfare stakeholders was that states and communities continue to struggle to adequately involve families from the child welfare system.

Family Focused Approach

Finding: A critical finding for families served by the child welfare system is that, in all nine reforms, the focus of treatment planning and services reportedly is on the child, rather than on the entire family.

In the 1997 Impact Analysis sample, stakeholders in five of the 10 states reported that their managed care systems focused primarily on the identified child and not on broader family needs. This was attributed to the interpretation of medical necessity criteria and to Medicaid policy and reimbursement practices, predating managed care reforms, that present barriers to a family focus. Many respondents in the 1999 sample reported similar concerns.

In both the 1997 and 1999 samples, child welfare stakeholders pointed out that prevention of placement and reunification of parents and children depend upon adequate services for both the children and parents. Some stakeholders indicated a hope, reportedly not realized, that managed care would provide the flexibility needed to meet the service needs of the whole family. However, several states did describe some strategies for strengthening a family focused approach.

■ **Examples**

Family Focused Services

- In **Delaware**, in the area of substance abuse treatment, MCOs are recognizing that they can obtain better outcomes for children and reduce costs when they focus on the whole family. The mental health reform in **Maryland** has created a fiscal code for family intervention (without the child present) and a code for multifamily groups to provide education and support to families. Also, the rate differential incorporated in the Maryland system for many children's services is based upon the additional indirect work that clinicians must do with families and other child-serving agencies. In one region in **New Mexico**, the reform covers home-based services and automatically authorizes several family sessions when individual therapy is approved for the child.

Relinquishing Custody to Obtain Services

Finding: Only two of the states studied in the 1999 Impact Analysis reported that managed care has exacerbated the practice of parents' having to relinquish custody to the child welfare system in order to obtain long-term or costly mental health treatment services for their children. In contrast, five of the 10 states in the 1997 Impact Analysis sample reported that managed care had exacerbated this practice.

It is important, however, *not* to misinterpret this as significant progress toward resolving the practice. Respondents in the two states where this practice has worsened due to managed care reforms cited strict interpretation of medical necessity criteria and denial of services for children on Medicaid as factors. Of the remaining six states, three indicated that relinquishment of custody remains a problem in their states, although not influenced by managed care. The other three noted that parents in their states are not forced to give up custody to access services.

Even in some states that prohibit relinquishment of custody to access services, parents' perspectives on actual practice differed significantly from what was allowed in law. In spite of the legal option to allow service provision through voluntary custody, some local agencies reportedly would not accept a child for placement without a custody order. In one state, parents described losing control of their children's lives and having difficulty extracting them from the system, even though they were placed voluntarily.

■ Example

Minimizing the Practice of Relinquishing Custody

- Several strategies were noted by respondents for minimizing the practice of custody relinquishment. Three states (**VT**, **PA**, and **IN**) from the 1999 Impact Analysis sample allow voluntary placement for services, so that, although children are placed, parents do not lose their custody rights. In two other states (**MD** and **NM**) a child can become eligible for Medicaid as a family of one when *residential placement* is required. Although this is helpful for children who need this level of care, it does not impact children ineligible for Medicaid who need intensive *community-based* services. Three states in the 1997 Impact Analysis sample (**OR**, **RI**, and **CT**) also allow voluntary placement.

Early Identification And Intervention

Finding: Most stakeholder groups in six of the nine reforms in the 1999 Analysis sample reported that managed care has had little or no effect on the early identification of and intervention in mental health and substance abuse problems in children and adolescents at an earlier stage. Child welfare respondents generally echoed comments made by other stakeholders; however, some indicated that managed care reforms have improved early identification for the child welfare population due to requirements in some states that children coming into foster care must receive both a physical and a behavioral health screen within 72 hours.

Physical Health — Behavioral Health Linkages

Finding: Although respondents in all but one of the 1999 reform initiatives (eight of nine) identified problems with primary care practitioners (PCPs) identifying and referring children to specialty health care (a problem that predates managed care), some child welfare respondents saw advantages in the role of the PCPs.

Linkages between physical health and behavioral health providers were described as weak by most stakeholders in both the 1997 and 1999 samples, including child welfare respondents, and there was a strong consensus across states in both samples that PCPs often are not well prepared or not skilled at identifying behavioral health problems in children and adolescents and referring them for appropriate specialty care.

Despite problems related to behavioral health care, child welfare respondents noted advantages for children in child welfare to having an assigned PCP to coordinate their health care. As mentioned previously, the PCP concept that is inherent in managed care establishes a single point of information and accountability for children's health care, a locus of health accountability that the child welfare system historically has not been able to achieve under fee-for-service systems. When children experience several placements over a relatively short period of time, their health records can be lost or lag so far behind the child that they are of little value. Although not yet realized in all of the managed care reforms, some child welfare officials see the creation of a medical home and the role of the PCP as an opportunity to improve physical health care for foster children.

Cultural Competence

Finding: Respondents in all nine reforms in 1999 indicated that managed care has had little to no effect on increasing cultural competence in the service delivery system. This lack of adequate attention to and impact on cultural competence in managed care has a particularly significant impact on the child welfare system.

Other studies have shown that for numerous reasons, children of color, particularly African-American children, are over represented in the child welfare system. In 1995, African-American children represented 15% of the U.S. population and 49% of the children in foster care and group care.⁷ African-American children come into care at greater rates, remain in care longer, and are more likely to be served in out-of-home placements than are Caucasian children.

Culturally competent managed care systems can provide the opportunity to lessen the problem of over representation by:

- Promoting early identification of children in need of mental health services.
- Providing services tailored to each child's cultural context.
- Offering culturally appropriate services to parents affected by mental illness or substance abuse.
- Initiating mental health and substance abuse services in communities that have historically underserved people of color.⁸

On the other hand, however, the absence of culturally competent behavioral health services can contribute to inappropriate disruption of families and a continuation of a disproportionate number of children of color in out-of-home placements.

⁷ Morton, Thomas D., *The Increasing Colorization of America's Child Welfare System: the Overrepresentation of African-American Children, Policy and Practice of Public Human Services*, the American Public Human Services Association, 12/99, p. 23.

⁸ McCarthy, Jan; Meyers, Judith; and Jackson, Vivian. *The Adoption and Safe Families Act: Exploring the Opportunity for Collaboration between Child Mental Health and Child Welfare Systems*, Georgetown University Child Development Center and Washington Business Group on Health, 7/99, p. 27.

Provider Issues

- Finding:** The most critical provider issues identified by child welfare respondents in the 1999 sample (also confirmed in other activities of the Tracking project) include:
- Whether child welfare provider agencies are included in the BHO provider network.
 - Whether provider rates paid by the BHO are comparable to those paid by the child welfare system.
 - Whether strategies for a child to continue with the same provider when he/she moves from one placement to another are incorporated into managed care systems.
 - Whether the behavioral health provider network has the capacity to meet the special needs of the children and families involved in the child welfare system.
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In seven of the nine reforms in the 1999 Impact Analysis, providers of behavioral health services to the child welfare population reportedly are included in the provider networks.

■ Example

Including Child Welfare Providers in the Behavioral Health Network

- **El Paso County, CO** (studied in the 1999 Analysis) and **Massachusetts** (from the 1997 sample) provide examples of strategies used by BHOs to include child welfare providers in the network. In El Paso County, CO, the Department of Human Services entered into an agreement with the public/private county behavioral health organization to provide the mental health services for all children in foster care. Current child welfare provider agencies can provide services by joining the BHO network. If a child welfare provider cannot meet the credentialing requirements, the BHO offers technical assistance. In Massachusetts, the statewide BHO credentials all the providers referred by the Department of Social Services (DSS), and has done clinical training for outpatient providers; DSS participated in the development of the clinical training curriculum.

In the 1999 sample, respondents in some states indicated that the rates paid through managed care systems were lower than those paid in the previous Medicaid fee-for-service arrangement, causing some child welfare providers to stop offering certain services or to go out of business. In at least one state, the rates offered through the managed care system also are lower than the rates offered by the child welfare system for similar services. This has discouraged child welfare providers from joining the managed care system's provider networks. The child welfare system in this state is seriously considering reducing its rates in order to encourage providers to join the network and enable the system to rely on Medicaid reimbursement to a greater extent.

Therapeutic foster care (TFC) providers seem to be particularly impacted by managed care reforms. Respondents in one state for example, noted that reduced rates, repetitive and frequent utilization review, and reduced lengths of stay in TFC had forced some providers to stop providing TFC. In another state, the BHOs generally do not pay for therapeutic foster care.

Although respondents from six of the nine reforms in the 1999 sample reported that managed care reforms had not disrupted ongoing relationships between providers and the children and families they serve, such disruption was more of a problem for children in the child welfare system who move frequently. Several states have implemented strategies to reduce the impact on a foster child whose placements change frequently.

■ **Example**

Preventing Forced Changes in Providers

- **Vermont** requires that each child be allowed a six-month transition period with his/her existing provider. In addition, if a child changes from one MCO to another, the child's therapist can be added to the new MCO network. In **New Mexico**, providers can be grandfathered into a new network to avoid a forced change in providers. The decision about becoming a permanent member of the network occurs later. As mentioned, providers in **Pennsylvania** must be able to offer services throughout each multi-county zone, so that children moving between counties, but within a zone, do not have to change providers.

Respondents in seven of the nine reforms in the 1999 sample indicated that managed care reforms have resulted in the inclusion of more individual private providers in the Medicaid networks. For the child welfare system, this reportedly has expanded the number of available Medicaid providers and thus reduced the waiting time for some. In some states, child welfare respondents were pleased to note less dependence on community mental health centers as the main source of mental health care for children in the child welfare system as a result.

Interagency Relationships

Finding: Respondents generally indicated that:

- Managed care reforms have contributed to increased collaboration among agencies due primarily to the need to problem solve.
 - Tension concerning who pays for various services has increased.
 - Cost shifting to child welfare and juvenile justice services is occurring.
-

Collaboration across Child-Serving Systems

Stakeholders in six of the nine reforms in the 1999 sample reported that challenges related to managed care reforms are forcing child-serving systems to increase collaboration and joint problem-solving at both the state and local levels. This is consistent with findings from the 1997 Analysis.

Generally, the child welfare system plays an active role in the collaborative process, reportedly meeting regularly with MCOs and Medicaid agencies in several states around policy issues. Local-level collaboration tends to be around resolving issues concerning specific children. Sometimes these cases escalate to the state level where a child welfare liaison, in states with such liaisons, meets directly with other involved agencies and the MCO to resolve service and payment issues.

Payment Responsibilities and Cost Shifting

In seven of the nine reform efforts in the 1999 sample, managed care implementation reportedly has exacerbated the age-old issue of which system is responsible for paying for which services. In addition, respondents from all but one of the managed care reforms in the 1999 sample indicated that cost shifting to other child-serving systems (such as child welfare and juvenile justice) is occurring, particularly in inpatient and residential costs. Child welfare providers in one state, for example, believed reductions of length of stay in inpatient care and residential treatment were resulting in cost shifting to other systems, such as child welfare, who either had to pick up the costs of longer unauthorized stays or serve children in their own programs. Providers also cited a lack of therapeutic foster care in managed care provider networks, so that other systems paid for children needing that level of care. Stakeholders in another state cited a cost shift to juvenile justice services as judges increasingly used juvenile justice funds to pay for residential care not accessible through the managed care system.

Disparate views about cost shifting were reported by some stakeholders. For example, in one state, child welfare respondents indicated that they expected some child welfare costs to shift to managed care systems, so that limited child welfare resources could be used more creatively.

There was a general belief among respondents that managed care reforms offer an opportunity to identify where and how cost shifting is occurring and to ensure that systems pay for what clinically is in the best interest of the child, but that this goal has yet to be attained, according to stakeholders. There were some reports (PA, IA, NE, and CO), however, of MCOs or BHOs working closely with child welfare and juvenile justice systems at the local level to resolve payment responsibilities and, in some cases, to co-fund service provision.

Financing

Finding: On the positive side, many child welfare system respondents in the 1999 Impact Analysis sample reported that managed care reforms provide an opportunity to obtain additional Medicaid support for behavioral health services that previously had been largely supported with child welfare resources. On the negative side, respondents noted the shortened length of stay in inpatient and residential care, and, therefore, an increased financial burden on the child welfare system to pay for extended stays.

Accountability Issues

Finding: Child welfare respondents in the 1999 Impact Analysis sample indicated that when resources for behavioral health services are accessed through managed care, it is critically important to be able to track service utilization, treatment outcomes, and costs specifically for children and families involved in the child welfare system.

Service Utilization

Stakeholders noted that state and local child welfare agencies are accountable for the safety of children, for achieving a permanent placement for children in custody, and for attending to the well-being of each child. They pointed out that carrying out these responsibilities requires access to adequate resources and data.

In six of the nine 1999 reforms (five carve out states and one integrated reform) managed care initiatives reportedly track service utilization across the full continuum of services for children and adolescents; however, respondents indicated behavioral health encounter data submitted by MCOs had not been analyzed to determine if children receiving child welfare services had a different service utilization profile than other children being served.

Child welfare respondents generally agreed with other respondent groups in all nine reforms that MIS systems were inadequate to meet the demands of the managed care system. They also cited lack of coordination between managed care and the State Automated Child Welfare Information System (SACWIS).

Outcomes

Two states in the 1999 sample reported that measurement systems for clinical and functional outcomes were in place, but even in these, and in three additional states reporting work on outcomes measurement, the efforts to assess clinical and functional outcomes were still characterized as being at early stages of development. Several respondents suggested that the development of behavioral health clinical and functional outcome indicators should include consideration of child welfare outcome indicators.

Measuring Cost

Data on the impact of reforms on the cost per child served, cost per eligible child, and the impact on the costs of behavioral health services to other child-serving systems also generally were not available from most of the states in the 1999 sample. The 1999 findings regarding whether managed care has increased or decreased aggregate Medicaid costs are mixed (two states reported increases, two reported decreases, and one reported decreasing the rate of growth). However, child welfare respondents were more concerned about the perceived cost shift to the child welfare system than the increase or decrease in Medicaid costs.

III. Summary of Issues to Consider in Planning and Implementing a Managed Care System

This section provides a summary of issues cited as important by child welfare stakeholders along with their perceptions regarding the most positive and negative aspects of managed care reforms.

Critical Issues

Parallel Systems

The availability of parallel behavioral health services within child welfare systems influences how the child welfare system stakeholders view managed care systems. Many child welfare systems have been reluctant to blend their resources with the behavioral health managed care systems for fear of being held ultimately accountable for services that they would have to access through another entity. As a result, they maintain “parallel” behavioral health services within child welfare. However, several states in the 1999 Impact Analysis sample have taken steps to blend child welfare and behavioral health resources under the behavioral health managed care system. To the extent that these initial steps are successful, broader, more encompassing steps can be expected.

Impact of Managed Care on the Role of the Child Welfare Worker

The child welfare system is legally responsible (and under public scrutiny) for the care of children in its custody as well as for appropriate decisionmaking and services for children and families needing child protective services due to abuse or neglect. Traditionally, child welfare workers have directly provided or purchased behavioral health services for children. They controlled who provided the service, in addition to the type,

level, and duration of services. When dependent upon a managed care system for services, the child welfare worker's role changes significantly. Respondents in the 1999 Impact Analysis sample felt this change even more than those in the 1997 sample. The responsibility for understanding and navigating managed care systems that have become even more complex has increased. Workers described being "at war" with MCOs in some states, frequently fighting to obtain services. The time involved in enrolling children in MCOs, requesting authorization and re-authorization, responding to utilization review requirements, settling disputes about payment responsibility, and justifying requests for service was noted as a time consuming burden by many respondents.

Tracking Utilization

Respondents pointed out the importance of being able to track service utilization, outcomes, and cost for the children and families served by the child welfare system. States are increasingly gaining the capacity to track by service category, and some have identified children in custody as a separate category to track. However, there were few, if any, results as yet.

Continuity of Care through Frequent Moves and Transition

Respondents described several situations that increased the problems related to continuity of care often experienced by children in the child welfare system, specifically, the use of multiple MCOs, delayed eligibility determinations, and cumbersome enrollment processes. These have created time lags in obtaining services and forced changes in providers, and sometimes even in MCOs, as children have moved from one location to another. Multiple strategies are being tried to reduce these problems, including requiring providers to serve larger geographic zones, securing agreements about service responsibility as children move from one area to another, and specialized enrollment processes for children in foster care.

Service Boundary Issues

Demarcations and boundaries within the system related to eligibility, responsibility, and services create operational problems. As in the 1997 Impact Analysis sample, determining responsibility for providing and paying for services, particularly at points where one system stops a service and another is to pick it up, continues to be difficult to address. Disagreements about medical necessity criteria and whether a service is treatment focused, or whether it is simply a placement, continue to exist between MCOs and child welfare agencies. However, several states described some success in clarifying some of these service boundary issues.

Capitation Rates

States are beginning to set enhanced capitation rates for children in custody to ensure access and to entice MCOs to enroll them and to develop appropriate services.

Service Array

The tightened timelines for decisions about reunification or other permanent placements that resulted from passage of the Adoption and Safe Families Act (ASFA) in 1997 have made it even more important to ensure that appropriate behavioral health services are in place for children and families served by the child welfare system. Treatment for sex offenders and for children who have been sexually abused, therapeutic foster care, step-down services from residential treatment or from inpatient hospitalization, and post-adoption behavioral health services were among the services reported by respondents as lacking in some behavioral health managed care systems. These services are in high demand for the child welfare population.

Court Ordered Services

A number of states reported that behavioral health managed care plans were reluctant to authorize as medically necessary many of the services ordered by courts. This was particularly true with regard to psychological evaluations, which are often not judged to be medically necessary unless specific mental health questions are raised. General assessments associated with placement issues are not usually authorized.

Education and Training

Respondents cited multiple training and education needs on the part of MCOs and providers to familiarize them with the service needs of children and families involved in the child welfare system. Education also was needed for child welfare workers, who frequently lacked adequate information about the managed care system to make appropriate decisions and to secure needed services. The need for systematic ways to offer cross-system training was highlighted by many respondents.

Relinquishing Custody

As described in detail in the section on family issues, many states are still struggling with parents having to relinquish custody to the child welfare system in order to obtain long-term or costly mental health treatment services for their children. Two states felt that managed care had exacerbated this practice due to strict interpretation of medical necessity criteria and denial of services for children on Medicaid.

Coordination of Child Welfare Managed Care and Behavioral Health Managed Care

Three of the states visited in 1999 were engaged in implementing or developing child welfare managed care reforms. In two of the three states, the child welfare reforms were closely coordinated with behavioral health managed care. Respondents in these two states cited numerous advantages to close coordination between the two systems.

Major Positive Effects

Although opinions about the most positive effects of behavioral health managed care were not unanimous across the nine reforms studied in the 1999 sample, there was some degree of consensus among child welfare stakeholders across states with respect to the following benefits:

- Managed care reforms have proven to be a new resource for initial, basic mental health services for children in the child welfare system in some states. Access has been improved in these states by covering more children, by expanding the number of providers, and by allowing individual licensed mental health counselors and social workers to participate in provider networks.
- Managed care has led to a greater choice in providers in some states.
- Several states have included requirements to ensure that children entering foster care receive behavioral health screens within a specified number of days. Also, in at least one state with an integrated reform, both physical and behavioral health screens are required.
- Child welfare stakeholders have cited the advantages of having a primary care physician for each child in custody to coordinate physical health, although not necessarily behavioral health, care.
- Increased flexibility in service delivery was noted in a few states. Capitated rates have provided the opportunity to provide more flexible and individualized services.
- Dealing with managed care reforms has generated greater discussion across systems for planning, problem solving, clarification of payment and service responsibilities, and cross-system training. In some states, this has led to improved interagency relationships.

Most Serious Problems

Child welfare respondents across states noted a number of concerns about the impact of behavioral health managed care reforms on the child welfare system:

- With few exceptions, managed care continues (as did Medicaid fee-for-service systems) to focus on services for the identified child and to deny services for other family members unless they are eligible for services in their own right. This is especially problematic for the child welfare system where prevention of placement and reunification of parents and children depend upon adequate services for *both* the children and the parents.
- MCOs and providers continue to lack familiarity with how the child welfare system operates and with the service needs of the children and families involved.
- Insufficient service array, including such specific problems as the lack of specialty services such as treatment for sex offenders, therapeutic foster care and step-down services from inpatient hospitalization and residential care; lack of mid-level services between regular foster care and residential treatment services; and lack of focus on post adoption mental health services.

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- Cumbersome authorization and utilization review processes and limited authorization of services resulting in such problems as the need for frequent and burdensome reauthorizations; reduced lengths of stay in inpatient care; and “level of care creep”, a term coined by a respondent to describe how managed care initially focused on reducing the length of inpatient care, then residential treatment, then therapeutic foster care, and now intensive home based services.
 - Very short-term placements, especially in therapeutic foster care, that force unnecessary moves and exacerbate the attachment problems from which many children in the child welfare system suffer.
 - Funding for services for children with special needs remains fragmented across managed care, mental health, and child welfare agencies, making accountability unclear and service delivery confusing to families.
 - Although some states have increased the number of providers available, others have lost providers primarily due to reduced rates and increased administrative burden.

Recommendations For Future Reforms

Recommendations and advice derived from interviews with child welfare stakeholders are listed below.

- Address the special needs of the child welfare and juvenile justice populations in planning and implementing managed care systems with respect to: the design of the managed care system; contracts and agreements; higher or risk adjusted capitation and/or case rates; the makeup of the provider network; and special provisions and services to meet the special needs of children and families involved in these systems.
- Provide adequate education and training for all child welfare stakeholders in the operation of the managed care system, including the grievance and appeals process.
- Provide adequate education and training for MCOs and providers regarding the service and system requirements of child welfare.
- Offer a specialized enrollment process for children entering foster care so that they do not have to wait for service provision or change providers once they have been enrolled.
- Ensure that medical necessity criteria allow for consideration of psychosocial and environmental factors.
- Reduce the use of prior authorization for outpatient services and make authorization and reauthorization processes less burdensome.
- Create mechanisms for resolving ongoing problems that will inevitably occur.
- Develop the array of intermediate services before phasing in populations of children with more serious and complex needs.
- Create methods for tracking outcomes for children and families involved in the child welfare system.

IV. Child Welfare Managed Care

In addition to their behavioral health managed care reform initiatives, three of the eight states visited by the Tracking Project in 1999 also had initiated or were considering child welfare managed care reforms: Colorado, Indiana, and Baltimore, Maryland. In these child welfare reform initiatives, states and/or communities apply some managed care tools to the organization, provision, and funding of some child welfare services. Child welfare managed care reforms primarily address the use of funds allocated to the child welfare system, although some include behavioral health services and funds.

For summaries of the three initiatives studied in the 1999 Impact Analysis (Colorado, Indiana, and Baltimore, Maryland), see the full report of the child welfare special analysis:⁹

- McCarthy, J., and Valentine, C. (2000) *Special Analysis: Child Welfare Managed Care Reform Initiatives — The 1999 Impact Analysis*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

For complete descriptions of other child welfare managed care initiatives that have been tracked by the Health Care Reform Tracking Project, see:

- Schulzinger, R., McCarthy, J., Meyers, J., Irvine, M., and Vincent, P. (1998) *Special Analysis: Child Welfare Managed Care Reform Initiatives — The 1997/98 State Survey*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. ■

⁹ These documents are available from: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, 3307 M St., NW, Suite 401, Washington, DC 20007. 202/687-5000 voice, 202/687-1954 fax, Attention: Mary Deacon, deaconm@gunet.georgetown.edu

Family Reflections

Introduction

The Health Care Reform Tracking Project began in 1995 to track and analyze public sector managed care initiatives as they affect children and adolescents with emotional, behavioral, and/or substance abuse disorders (together referred to by the Tracking Project as *behavioral health disorders*) and their families.

Equal and respectful partnerships between service providers and families have been at the heart of the system of care reform movement since 1985 when the federal Child and Adolescent Service System Program (CASSP) mandated state grantees to forge equal partnerships with families. Through a program of grants to states, CASSP focused on state-level, system building activities and on providing assistance to states and local communities to build *community-based systems of care* for children and youth with serious mental health disorders. These systems of care feature comprehensive and individualized services, full participation of families, coordination among child-serving agencies and programs, and cultural competence. The system of care philosophy and approach emphasize providing services to support families and to help children remain at or close to home, and viewing families as “allies” and “full partners” in all aspects of the planning and delivery of services.

Since its inception, the Tracking Project has explored issues of family involvement in managed care initiatives and has solicited the perspectives of families about the effects of these reforms. For the 1999 Impact Analysis, the Tracking Project intensified its focus on family involvement issues by expanding its team of investigators to include four family consultants—the authors of this special analysis. Each family consultant has had extensive experience at the community level in planning and service delivery for her own child and involvement at the national and state levels influencing policy related to public service delivery systems. Family consultants participated in each of the site visits conducted for the 1999 Impact Analysis and, in addition to contributing to the analysis of findings for the full 1999 Impact Analysis report, prepared this special report on the perceptions of families on public sector managed care reforms.

Process

The Tracking Project has involved two major activities: 1) surveys of all states (the 1995 State Survey and the 1997-98 State Survey) to identify and describe state managed care reforms affecting children and adolescents with emotional disorders and their families, and 2) impact analyses involving in-depth site visits to a sample of states to assess the impact of managed care reforms on children and families. The 1997 Impact Analysis involved site visits to a sample of 10 states; the 1999 Impact Analysis studied a new sample of eight states, including Colorado, Indiana, Maryland, Nebraska, New Mexico, Oklahoma, Pennsylvania, and Vermont.

Each site visit was conducted over a three-day period by a team of three to four individuals drawn from the larger study team of 12 individuals, each team including individuals with expertise in family involvement, children’s mental health, adolescent substance abuse, and child welfare services. As noted, a family consultant participated as a team member for each of the eight site visits.

During the site visits, interviews were conducted with a wide variety of stakeholder groups, typically 13-15 stakeholder groups in each state, including a total of 75-100 interviewees per state. One of the stakeholder groups interviewed in each state was comprised of family members of children and adolescents with emotional and substance abuse disorders. Through this process, the team interviewed numerous family members, including: representatives of statewide family organizations; representatives of parent support groups; families receiving services from the managed care system or from other parts of the public system; families involved with the child welfare system; and, in a few cases, family members functioning in paid staff roles within managed care systems. Families interviewed included those who were Medicaid-eligible, as well as families that had exhausted their private insurance and had become involved in the public system as a result. A few of the families interviewed had previously been involved in system of care reforms.

Following the site visits, family consultants participated with site team leaders in the analysis process that led to the development of the full 1999 Impact Analysis report. In addition, family consultants held a day-long meeting to discuss the sites they visited and to share what families reported about their involvement in public sector managed care, their relationships with other system reform stakeholders, and their perceptions about the effectiveness of managed care systems. This information forms the basis for this special analysis, reflecting the family perspectives captured in the interviews across states. In addition, strategies are offered for increasing the family voice in public sector managed care decision making processes regarding services, supports, systems, and policies that affect children and adolescents with mental health and substance abuse problems and their families.

I. Family Involvement

Although the family voice in public sector managed care is growing, the Tracking Project's 1997-98 State Survey found that *significant* family involvement in the planning, policy development, implementation and evaluation of public sector managed care initiatives was reported in only 38% of state managed care reforms nationally. The site visits for the 1999 Impact Analysis revealed that many stakeholders (including state policy makers, managed care organizations, community-based programs and individual family members) are still unsure about how the concepts and principles of family involvement can be incorporated and implemented in managed care systems.

Family Involvement at the Service Delivery Level

When interviewees were asked about family involvement at the service delivery level, there was often a period of silence and bewilderment. After team members probed further, questions often emerged from the interviewees, such as:

- How do you meaningfully involve families in the decision making process about what services and support they need?
- How do you forge equal and respectful relationships?
- How do you engage families as peer supports and mentors, and also as paid providers of services, leaders, and advocates?

A representative from a statewide family organization who was interviewed explained the following:

- “When you ask families, ‘Were you involved in the development of your child’s plan? Did you feel that you were a *full* partner in the process?’ they respond with, ‘They asked me to sign it.’ Families think if they were asked to sign off on their treatment plan, they were involved, but, when you ask further, ‘Were you involved in its *development*? Were you assigned equal decision-making power regarding the services and supports your family needed?’ they responded, ‘*NO!*’.”

Family Involvement at the System Level

Typically, family involvement at the system level consists of participation on state-level advisory groups, and this involvement tends to be sporadic. The following response from one of the state Medicaid agency representatives interviewed was a fairly typical characterization of family involvement at the state system level in those states in which there was family involvement occurring: “We have a few family members involved in drafting Requests for Proposals (RFPs), reviewing managed care bids, and participating on quality improvement teams.”

Again, when team members inquired about family involvement, this time at the system level, many interviewees responded with questions:

- How do you support and encourage families to stay involved in decision making at the system level?
- What infrastructure changes are needed to create meaningful opportunities for parents to contribute to managed care reform policy deliberations?

Families expressed frustration at not understanding the politics or issues discussed by professionals in policy and planning meetings. As one family member told us, “They talk above me. I can’t figure out what’s going on.”

Representatives from a family organization related that, because they were not “at the right table” when decisions were made about behavioral health managed care design, options, they could not influence the state’s decision to create two parallel managed care systems—one an acute care model, *not* using the system of care approach, and the other a flexible, individualized wraparound model—both of which serve children with serious disorders.

Requirements for Family Involvement

While a growing number of states are including the *language* of family involvement in Requests for Proposals (RFPs) and managed care contracts, very few states monitor this or earmark funds to family organizations or family advocates to monitor implementation. As a result, there is a disconnect between contractual requirements and practice.

A director of a statewide family organization gave the following example:

- “Managed care agencies were charging families co-payments in our state. Due to our participation in the RFP process, we knew they couldn’t do this. When our office got a

call from a family complaining about being charged a co-pay, we went to the managed care agency and said, 'It is in the RFP and in your contract that you are responsible for the co-pay.' They agreed to pay. However, because the state does not fund family organizations to track the activities of the managed care plan, we know they only meet terms of their contractual agreement when we call them on a particular case. And, by the way, our organization receives no financial support to assist or to support families to negotiate their child's care in this managed care environment."

Another story related about the disconnect between contractual requirements for family involvement and actual implementation was the following:

- "Children are placed in these traditional settings that operate by traditional rules; managed care, which has the ability to apply more elastic rules to help families, does not make the transition. For example, a child needed a crisis center. The staff at the center placed him in a room and isolated him from his family. The family stated: 'We want to be with him.' The family was denied access to that room, and a decision was made to move the child to a regional center. A physical transfer was arranged on paper — what we call a 'paper placement' — without considering the *whole* family or even involving the family in the decision, in spite of contractual requirements for family involvement."

II. Managed Care Organizations (MCOs) and Management Processes

Managed Care Organizations

Families interviewed for the 1999 Impact Analysis indicated that MCO management processes are cumbersome and difficult to understand. For example, families in one state with an integrated physical/behavioral health design told us that there was no identified process for accessing behavioral health benefits. Families said that MCO personnel speak to them using language and terms that are difficult to understand. Families in a number of states also reported that they are not given a list of services, have few choices, and are driven to make decisions about their child while on the phone. Concerns also were expressed about the inability of families to talk with child psychiatrists.

In several states, families talked about the large amount of paperwork that families and providers must complete. To solve this problem, parents and the provider community in one state successfully advocated as partners to streamline the paperwork process.

Other families talked about the attitudes of the people they talked with in MCOs. One family member stated:

- "Theoretically, they are being paid to provide this coverage for me, and, yet, their attitude is an antagonistic one. I requested some materials, and, when I received them, I did not understand any of it, so I called back and was told: 'That is the wrong paper; you shouldn't even have that paper.' That was her tone of voice. She was mad at me, and she had mailed me the wrong forms."

A family advocate stated:

- “If you are a family member who is not very assertive and does not have good negotiation skills or even conflict resolution skills, you are probably going to give up. What happens to those families who do not have phones in their homes and have to use the corner pay phone? Imagine being a migrant worker in a rural community who speaks no English.”

Prior Authorization Processes

Families did not speak kindly about MCO “gatekeepers.” They described the gatekeeping and prior authorization processes as lengthy, time consuming, and difficult to navigate. Families often do not understand the roles of MCO gatekeepers, or the language they use, or the concepts to which they refer. One family member told us:

- “It should be about results. [If] I’m in crisis, I need help, not to be put on hold or told to call this one or that one. How can you find somebody who can give you a result so that you can get on to the next result? We need systems to work and to talk together for the sake of our children. I am the case manager for my child. I manage the child’s care, and no one is paying us; in fact, we are losing our jobs over caring for our children.”

Communication and Coordination With Other Systems

Both providers and families who were interviewed reported that managed care is a time consuming process with too many players. In addition, findings suggest that, to manage services across the multiple service delivery systems in which this population of children is involved, managed care systems need to develop intensive and multi-level care coordination capabilities, which are now lacking.

Family advocates talked about this population of children being involved, typically, in no less than three systems. As one family member told us:

- “If they are in child welfare, they are in mental health and education. I would say the average (number of systems) is five. I currently am involved in seven systems with my kid.”

Parents reported that they are finding it difficult to work and to arrange for and coordinate care for their child. “Making phone call after phone call to arrange for my child’s care takes away from my time on the job,” one parent told us, a complaint heard time and again from families. Families talked about losing their jobs because the time spent arranging care for their children requires an inordinate amount of time away from work.

Grievance and Appeals Process

A majority of families interviewed indicated that were not informed about the right to appeal the denial of services, nor were they told they could refuse any services, supports or treatments for their child that they did not feel were appropriate. When questions were asked families in one state about the grievance and appeals process, one mom said, “The grievance process is, you pack up and move.”

When families were asked in another state, “Are you aware of the grievance and appeals process?”, they responded with: “The what?” Family members in some states knew about the process, but did not know how it operated.

III. Services and Support

What Is Needed and What Is Available

Families interviewed believed that a majority of families who have a child with a serious behavioral health disorder need a care coordinator or case manager, but most interviewees did not feel that appropriate case management services were available from MCOs. In one state it was reported that a managed care provider made a decision that it would be more cost effective if all the case managers were moved to one location in the state. As a result, all the families that need a care coordinator reportedly have to travel across the state to receive care, and there is no transportation reimbursement.

On the other hand, in another state, families reported that there is a statewide family organization with which the state contracts as part of the managed care reform. In this state, parents can call requesting transportation to attend treatment meetings. Staff are available to drive them to their treatment meetings, and child care is available at no cost to the families. Families reported that staff from the family organization treat them with respect and acknowledge their expertise concerning their children.

Crisis intervention services were also identified as a major need. Most family members interviewed reported that there were few crisis services available. Families talked about driving up to three hours, with other children in the car, to obtain crisis services.

In some states, respite care reportedly is now considered a crisis service, not a family support service. With respite being used as a crisis service, families reported that ongoing respite needs are going unmet.

In most states, families reported that there was no systematic, identifiable process to inform them of what services were available. As one family member put it:

- “I find my way into managed care and discover that I can get this benefit or that service. I have no idea if there is anything else that my family could use.”

Families often talked about having to make quick decisions about services on the phone.

The services and supports approach that families raved about was the flexible, wraparound individualized model. This model, families say, is not a *cookie cutter*, “*one size fits all*” approach. The wraparound approach, as one family member described it, is “responsive to my families’ needs, values and strengths.” In the wraparound approach, some of the services families described as being provided included: emotional support, skills training, aides in schools, job coaches, big brothers and big sisters, and help with such daily living needs as groceries, bills, and clothing. There were very few managed care systems, however, providing these types of wraparound services among the states visited for the Tracking Project.

Access

Families reported to the Tracking Project family consultants that the authorization process is so cumbersome that access to behavioral health services takes too long. One state reportedly has set up a mental health review committee to process access applications for particular services. One mother involved in this process was told it could be up to four months before her case would be heard. She reported that she was passed from agency to agency and, finally, placed numerous calls to the State Mental Health Department requesting help, and no one returned her calls.

When families were asked about access to services, they said: “We have to run around to find services.” An example given by family members in one state is the following:

- A single mother, who works full time, has a 12 year old child with learning disabilities and a serious emotional disorder who is enrolled in the Medicaid managed care system. Her child had been on fee-for-service Medicaid seven months prior to the start of the managed care reform. The mother reported that she received a letter telling her to choose a managed care plan or the state would assign one for them. The mother did not understand that the managed care plan was Medicaid, and the mother was not familiar with EPSDT as another possible route to services. The mother reported having trouble accessing a psychologist for her child through the managed care plan in which she became enrolled, and that she was not happy with the services she was receiving from the psychologist ultimately assigned to her child. In addition, her managed care plan limited visits to one per week, although the mother felt her child needed more. The mother reported that she called the behavioral health unit in her plan and asked for a list of providers. They said they did not have one, nor did they connect her with anyone else. Eventually, she located a parent organization and explained their situation, and they made a call on her behalf. The family organization got help for the mother, and her child has a new therapist. This therapist is willing to accommodate the mother's working schedule, and all parties are now working to obtain respite services for her.

Denial of Services to Children with Dual Diagnoses

In talking with stakeholders, it was reported that children with dual diagnoses in particular are falling through the cracks of managed care systems, and that it is very difficult to obtain even the most basic level of mental health services or substances abuse services for these children in some states.

Family respondents related many examples of denials of services related to children with mental retardation, substance abuse problems, and cerebral palsy who also have an emotional disorder. Stakeholders in most states reported that there are few inpatient or partial hospitalization resources for these children. In several states, family advocates stated:

- “There is no clarity as to when a child with a dual diagnosis should be in or out of the managed care system.”

Families also reported that managed care providers do not understand nor take responsibility to ensure that families receive services stipulated by the Individualized Education Plans (IEPs) developed through the special education process, which is how many children with dual diagnoses are identified for services. Families in one state said:

- “If the IEP calls for a basic mental health service, families cannot get the authorization through the managed care system, or it takes a long time to go through the process.”

IV. Family Information, Education and Advocacy

Need for Information and Education

With all of the families interviewed, the Tracking Project found that lack of information and education about managed care reforms and how managed care systems operate is an enormous issue. Without an identifiable resource or place to turn for information and assistance, families struggle with many unanswered questions about managed care systems. How do I get the services I need? What does my plan cover? Who are the providers of services to help my child? How do I know who is *family friendly* and knows about children like mine? How can I shape what the system has to offer? Which plan best meets my needs as a family? Which providers and plans have trouble communicating in plain English? Where do I go in an emergency? Is there a toll-free number to call with complaints?

Without education and information, families do not know how to get an *individualized* plan, how to access services, how to find a parent support group, and how to be the best parent that they can be to help their child. Most of the families interviewed did not even understand that there was a managed care reform occurring, even though they may have been involved in a parent support group and enrolled in the managed care system. Findings from the Tracking Project suggest that, without consistent, ongoing information and education efforts in states, families within the same state have different levels of knowledge and understanding of the services and supports available to them.

Family advocates shared their concerns about the need for ongoing information about service and support options when they are trying to negotiate care for children. Families in one state used the following example to illustrate the importance of reliable information when trying to access and negotiate care with MCOs:

- A single mother, who works full time, with a family of four, had her 11-year old child diagnosed with clinical depression and a second child diagnosed with oppositional defiant disorder. The family was enrolled in the Medicaid managed care system. Her second child was admitted to a clinic for one week for emergency stabilization. Upon discharge, it was recommended that the child be placed in a highly structured environment that only a residential facility could provide. The only program in the network was unavailable due to long waiting lists. The child was released home. The mother was told that, if she gave up custody of her child to the child welfare system, her child's needs would be better met. The child began to show signs of remanifestation of severe behavioral problems within one week after discharge. The mother began her own search for residential placement and found a good private placement. However, the managed care system said that it would not pay. The mother took on a second job to

defer costs and asked her church to help pay. Her managed care organization said that it did not cover residential treatment facilities for long term care, but covered acute care only. However, *according to the state*, her child should have been able to move through a system of care within the managed care system, which was supposed to cover both acute and extended care. When the mother asked about wraparound care using EPSDT, which also was part of the benefit package in the managed care reform, and which could have served as an alternative to longer term residential treatment, the managed care representative had no idea what she was talking about.

Families also indicated that information and education around the issue of medications is very limited. In many states, families were concerned that psychiatrists are prescribing too much medication, after having spent *only* 15 minutes at the initial visit. Families reported that they seldom received a list of possible side effects during this initial visit and that it was their responsibility to monitor their child's medication.

Other requested informational needs heard from families included:

- "I don't know how to fight for my child." "We have had four different therapists in a year and a half." "How can I find another family member facing the same challenges that I am?" "How can I develop better skills and confidence as a family member?"

Use of "Inside and Outside" Paid Family Advocates

Some of the states studied by the Tracking Project incorporate different approaches for the use of paid family advocates within managed care systems. In one type of approach, family advocates are employed by family-run organizations under contract to the state; in another approach, the state, county or MCO has directly hired a paid family advocate. (It should also be noted that most states are *not* using paid family advocates within their managed care systems, which families described as a problem.)

In those states that do utilize paid family advocates, site visit team members asked a number of questions about the approach being used. For example, questions were raised about the possibility of conflict of interest: For example, can it be considered family involvement if family members are employed and supervised by a government agency? Is a family member co-opted or inhibited if he/she is paid and works as a family advocate in a state/county agency? Does she become a "system person?" Whose interests do family advocates then represent? Can family members only be "real" advocates if they are paid by and work for a family organization?

The consensus among the families interviewed was that both approaches provide different learnings, benefits, and challenges, and both provide links to resources and tools that are essential in developing a family centered system of care. For example, the "outside" advocate employed by the family-run organization can be a player in the larger child's advocacy network and can develop relationships to assist in children's mental health issues at the state policy level. These "outside" advocates also can support and train family support groups at the local level as family support centers that provide a feedback loop to the state family organization and that educate child-serving agencies and other citizens about the needs of children and adolescents with serious behavioral health disorders and their families.

An “inside” advocate can work with individual families whose children are receiving services and work from the inside out in collaboration with “outside” advocates in defining policy issues. In addition, parent advocates who are staff may be able to participate more readily in the state/county agency’s decision making processes as a member of task forces, committees, and in staff meetings, bringing the parent perspective. By utilizing a parent advocate with experience raising a child with a behavioral health disorder, both approaches can help to reduce the stress of a family whose child is receiving public services by offering support, information, education, and advocacy services.

V. Accountability

Quality Improvement (QI) Process

Many of the families interviewed emphasized the need for a set of processes for the continual improvement of services provided by managed care. Family members talked about the need for standards to demonstrate that individual practitioners have specialty training, demonstrated competence, and expertise in diagnostic assessment and treatment of children and adolescents with serious emotional disorders. Families also were adamant about the need for involvement of families and family organizations in the QI process. As one group of family advocates put it:

- “If the stakeholders in this state want to strengthen partnerships with others and provide high quality care for our kids in this managed care system, then it is imperative that family-run organizations be funded to play a key role in monitoring and in complaint review.”

A countywide family organization in one state did report that the state had given them \$100,000 to ensure that the managed care system was consistent with the principles of the system of care. The stakeholders, including the family organization, in this county have been working as partners since the CASSP movement to develop a community-based system of care and now are using managed care technologies to enhance their system of care. Family members are employed by this family organization to profile the providers in the MCO networks and to plan more nontraditional service approaches in collaboration with providers and MCOs. Other staff family members serve on QI teams.

Accountability

Two different views were expressed by families regarding accountability. Some families felt that lack of accountability for children with serious mental health needs has been a huge problem over time, a problem that was pre-existing but that is being exacerbated by managed care issues. The other viewpoint is that, with managed care reforms, there is an opportunity and a promise to create greater accountability.

The major frustrations expressed by family members were that no one is tracking the activities of managed care plans and providing feedback to the state on issues that families face. For example, families said that no one would ever know what the “gatekeeper” is saying to families. One family member said:

- “Instead of having a psychiatrist behind a closed door in a crisis center talking with the child and family and to no one else, as was the case in the old system, we now have an entire managed care company where no one knows what anyone else said.”

On the other hand, families in some states believe that the promise in managed care lies in the potential (and, in some cases, the reality) of partnerships with providers, families, and other advocates in the community who share concern for improving the mental health services and supports available to children and youth with serious mental health needs. Working together in the decision making process can boost parents’ morale and promote family leadership in children’s managed care reforms. Another positive, families indicated, is the fact that managed care reforms are shaking up “*business as usual*” among professional partners and bringing in, hopefully, accountability tools that will improve services and allow for informed decisions to be made about what is working and what is not.

VI. Strategies to Increase Family Voice and Family Input

Our experience as family consultants and our involvement in the Tracking Project, listening to families involved in managed care systems, have led us to a number of recommendations with respect to increasing the voice and input of families in public sector managed care reforms:

Fund Family-run Organizations Focused on the Needs of Children and Adolescents with Emotional, Behavioral, Mental Disorders.

- Since the beginning of the system of care movement, there have been efforts to form *equal and respectful partnerships* between service providers and families in policy design, in planning, in implementation, and in monitoring. Federal, state and local grants have required *family involvement* and *family-professional partnerships*. Front line workers are asked to view families as “*allies*” and “*full partners*.” Yet, a majority of the families interviewed still do not feel they are viewed as the necessary link to develop and maintain an effective managed care system for children and adolescents with serious mental health disorders.
- Federal, state, and local governments need to *put their money where their mandates are*. The public sector delivery system needs to fund efforts to create equal partnerships among family members, direct service providers, and policymakers in designing children’s managed care systems. If they do not financially support this mandate, no one is going to do it out of the goodness of their heart. The result will be that our children will remain the “unclaimed children.”
- Government agencies at all levels need to see families as resources and involve them in planning, refining, and overseeing managed care systems.

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- If encouraged and supported to participate in state-level managed care decision making meetings, families will educate other child serving systems and other participants about the needs of families raising children with serious mental health needs. Families bring the voices of families from across the state “to the table” and help shape the managed behavioral health care system in ways that make sense to families. They know what services and supports help their children, so they can convincingly suggest how public officials can design the most effective and cost-efficient managed care systems for children. Having families at state level policy meetings allows them to reach officials in the Medicaid agency to help them understand family perspectives, concerns, and experiences so these can be incorporated into the managed care design.
 - The families interviewed talked often about the need for more communication and coordination between systems. Sitting at state policy tables, parents can help form new partnerships across the organizations working on the issue of managed care, including advocacy groups for low-income and Medicaid populations, family practitioners, and other alliances of primary care providers, protection and advocacy systems, mental health providers, adult mental health consumers, children’s advocates, child serving agencies, administrative staff, and others.
 - Families want trusting relationships with professional partners, in addition to their service provider, who will provide them with “inside” information that will help them to raise their children, to educate other families across the state and to make linkages with the professional partner’s counterparts at the local level.

Invest in Family and Youth Leadership

- Families need information and training to ensure that they can develop the skills needed to negotiate a managed care system. This includes: 1) information about managed care principles, practices, and systems design; 2) understanding of the concepts and principles of family involvement; and 3) education in the importance of and opportunities for influencing systems change.
- Development of youth leaders also is critical. Efforts must be made to provide effective outreach to youth and their families in rural and inner-city communities in order for them to have equal opportunity to access information and training.
- Front line workers must be well-trained in meeting family needs, and responsiveness to families has to be ingrained into the organizational culture.
- Family members will use their new skills and the information that they have learned to make an impact on the lives of their own families and on their communities. Family members will utilize personal power to create change within themselves and those around them, adding to their own bank of personal skills as they enter each new area of involvement.

Focus on Community Outreach

- Building relationships within the community and involving families and other stakeholders reflects the mission of the system of care movement—to bring together all those who are involved in caring for children and adolescents with serious emotional disorders. Involvement of families and the larger community makes the community more supportive of families, ensuring a better quality of life and reducing the stigma for children with mental health disorders.
- Family involvement at state as well as community levels increases the ability of families to understand both the state policy side and community-level issues related to managed care reforms. The most powerful tool for spreading the word about managed care reforms may not be an expensive public relations firm, but, rather, families themselves. Families are the force behind a well-designed and well-implemented managed care system. When families tell their stories, it is not difficult to listen.

Through increased funding of family organizations, investing in family and youth leadership and focusing on the importance of community outreach and involvement, we believe it is possible to develop a well managed system of care for children and youth with serious behavioral health disorders. ■

Glossary of Terms

Adapted in part from: *Managing Behavioral Health Care for Children and Youth: A Family Advocate's Guide* (1996, Bazelon Center); *Blueprints for Managed Care: Mental Healthcare Concepts and Structure* (Frank McGuirk, Andrew Keller, & Colette Croze); and "Children's and Adolescent's Mental Health: A Glossary of Terms" (Communities Together Campaign, SAMHSA-CMHS)

1. **Acute care services** – brief, short term treatment with, in some cases limited intermediate services also being provided
2. **Administrative Services Only (ASO)** – a contractual arrangement whereby a managed care organization (MCO) provides only the administrative services required by a health plan
3. **Behavioral Health Organizations (BHOs)** – organizations with specific experience in the management of behavioral healthcare plans who are often subcontracted with by MCOs for that purpose
4. **Behavioral health services** (also referred to as behavioral healthcare) – includes both mental health and substance abuse services provided to children and their families
5. **Capitation rate** – a fixed amount of money paid per person for covered services for a specific time period, usually calculated for each person per month
6. **Carve-out design** – an arrangement whereby behavioral health services are administered and financed separately from physical health services
7. **Case manager** – an individual who organizes and coordinates services and supports for children with behavioral healthcare problems and their families
8. **Case rate** – a fixed amount of money paid per person for covered services based on the number and type of persons who present for services (as opposed to per person per month, see capitation rate)
9. **Co-payment** – a set amount of money that an individual pays for health care services in addition to the amount paid by the private insurer or state agency (e.g., Medicaid)
10. **Cost shifting** – the practice of obtaining care for a child at the expense of another party (e.g., juvenile justice or child welfare)
11. **Crisis residential treatment services** – short-term, round-the-clock help provided in a non-hospital setting during a crisis
12. **Day treatment** – services typically last at least four hours a day and work with mental health, recreation, and education organizations
13. **Divided benefit** – an arrangement in which the financing and administration of selected behavior health services (typically acute care) are integrated with the physical health services. Other behavioral health services (typically extended care services) are split out for separate management and financing either through a partial carve-out or another arrangement

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14. **Early intervention** – a process for recognizing warning signs that individuals are at risk for behavioral health problems and taking early action against factors that put them at risk
 15. **Emergency and crisis services** – a group of services that are available 24 hours a day, 7 days a week, to help during a mental health emergency
 16. **Enabling services** – those services that assist children and families to learn about and access treatment and support services that they need (e.g., translation, transportation and childcare)
 17. **EPSDT (Early Periodic Screening, Diagnosis and Treatment Program)** – a Medicaid program that is designed to improve primary health benefits for children with an emphasis on preventive care. States must cover regular and periodic exams for all eligible children under the age of 21; and must provide any medically necessary services prescribed by the exams, even those not covered in a state's Medicaid plan.
 18. **Essential providers** – types of providers or provider organizations (e.g., physicians, community mental health centers) whose services are required by state or federal statute to be included in benefit plans
 19. **Extended care services** – care extending beyond the acute care stabilization phase, (i.e., care required by children with more serious disorders and their families)
 20. **Family support services** – services designed to keep the family together and to cope with behavioral health problems that affect them
 21. **Fee-for-service** – paying a specific amount for a specific service, such as an office or medication check
 22. **Gatekeeping** – the use of primary care clinicians, case managers or some other mechanism as the initial contact to ensure that only appropriate and cost-effective services are utilized
 23. **Grievance and appeals process** – a process by which families and providers can investigate complaints and resolve disagreements with a managed care company, typically related to issues or service denial or reduction
 24. **Health maintenance organization (HMO)** – an organized system of health care that provides directly or arranges a comprehensive range of basic and supplemental health care services for individuals who are enrolled to receive these services; the arrangement is primarily for each member to receive prepaid services on a fixed periodic basis
 25. **High utilizers** – children with serious or complex behavioral health disorders who are using large volumes of services
 26. **Home-based services** – help provided in a family's home to help prevent the child from being placed out of the home
 27. **Inpatient hospitalization** – behavioral health treatment in a hospital setting 24 hours a day with the purpose of (1) short-term treatment in cases where a child is in crisis and possibly a danger to self or others, and/or (2) diagnosis and treatment when the child cannot be evaluated or treated appropriately in an outpatient setting

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28. **Integrated design** – an arrangement in which the financing and administration of physical and behavioral health care are integrated (e.g., as in a HMO)
 29. **Level of care criteria** – guidelines employed to assist in the determination of the appropriate setting and intensity of behavioral health treatment
 30. **Managed care entity** – an organization that either directly provides or arranges managed health care by applying various strategies designed to optimize the value of provided services by controlling their cost and utilization, promoting their quality and measuring performance to ensure cost-effective outcomes
 31. **Managed care organization (MCO)** – an organization that provides or arranges managed health care; see managed care entity
 32. **Managed behavioral healthcare** – managed mental health and substance abuse benefits
 33. **Medicaid** – a federal program administered by participating state and territorial governments to provide physical and behavioral health benefits to specific groups of low income and/or categorically eligible children and families
 34. **Medical necessity criteria** – criteria used by the managed care entity to determine if requested interventions or services are medically appropriate and necessary to meet the needs for a particular individual; for example, in the case of inpatient hospitalization
 35. **National Alliance for the Mentally Ill (NAMI)** – a national association of advocacy and mutual aid groups for family members of people with a serious mental illness
 36. **Outcomes** – an assessment of the impact of health services in terms of improved quality of life and/or daily functioning
 37. **Part C (formerly Part H)** – the Early Intervention Program of the Individuals with Disability in Education Act (IDEA) that 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
 38. **Practice guidelines** – systematically developed descriptions of sound practice that assist clinicians in making appropriate decisions regarding healthcare provided for specific diagnoses or concerns
 39. **Preferred provider organization (PPO)** – a network of providers that agree to accept negotiated fees from a behavioral healthcare plan in return for prompt payment and a certain volume patients
 40. **Prior authorization** – the approval a provider must have from the managed care entity before providing certain services
 41. **Primary care physician (PCP)** – an internist, family practitioner or pediatrician who provides professional and related services on an outpatient basis
 42. **Provider networks** – group of agencies or providers that agree to provide and are reimbursed for services to members of a managed care plan
 43. **Psychosocial necessity criteria** – criteria used by the managed care entity to determine if requested interventions or services are necessary for a particular individual that include nonmedical, community, and family factors in addition to medical necessity criteria

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44. **Quality measurement** – systematic efforts to assess and improve the quality of the process of service delivery
 45. **Requests for proposals (RFPs)** – the process followed when companies or agencies want a specific job completed such as delivery of mental health services, usually for a set amount of money. People submit bids explaining how they would provide the requested services and how much it would cost
 46. **Respite care** – a service that provides a break for parents or other caregivers who are caring for a child with a serious emotional disturbance
 47. **Residential treatment centers** – facilities that provide treatment 24 hours a day on a longer term basis than inpatient hospitalization
 48. **Risk** – the difference between projected costs for services and the actual amount spent
 49. **Risk adjustment** – the determination of capitation rates that take into account patient characteristics such as age, sex, or previous utilization of health services
 50. **Risk sharing** – when the managed care entity assumes responsibility for services for a specific group but is protected against unexpectedly high costs by a prearranged agreement for higher payment for individuals who need significantly more costly services
 51. **Stakeholders** – people or groups of people with a vested interest in the design and functioning of a service or product (e.g., family members, providers, legislators)
 52. **Subcapitation** – an arrangement in which a capitated health plan pays its contracted providers on a capitated basis
 53. **Systems of care** – community-based networks of child-caring agencies that emphasize a broad array of services; collaboration among the various agencies; treatment in the least restrictive, most appropriate setting; individualized, flexible care; involvement of families in the planning and delivery of services; and services that are culturally competent
 54. **Utilization review** – a retrospective mechanism used to evaluate the use of and request for services on the basis of necessity, appropriateness and quality
 55. **Waiver** – Medicaid waivers are granted by the federal Health Care Financing Administration (HCFA) to allow a state to operate its Medicaid program in a way that does not comply with all requirements of federal law. There are two types of Medicaid waivers for managed care:
 - Section 1915(b), a more narrow waiver that permits the state to require individuals to enroll in managed care programs or to select a physician to serve as their primary case manager; often used when a state applies for a behavioral health care managed care plan separate from physical health care
 - Section 1115, a very broad waiver that allows states to add individuals to their Medicaid program and to operate managed care on a broad scale with few federal rules. ■

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