II. Design and Financing Issues

Integrated Versus Carve Out Reforms

Since 1995, the Health Care Reform Tracking Project has been studying the design characteristics of publicly-financed managed care reforms to ascertain whether certain design features seem to promote or hinder effective service delivery for children with behavioral health disorders and their families, particularly children with serious and complex disorders. A fundamental area of inquiry has focused on the extent and nature of differences between integrated and carve out designs in their effect on children with behavioral health disorders.

Consistently, the HCRTP has found that carve outs tend to encompass design features that, reportedly, are more advantageous to children with behavioral health disorders and their families than do integrated designs. Consider the findings reported in **Table 2**, for example. These differences between integrated and carve out designs were reported by state child mental health directors responding to the HCRTP's *2000 State Survey;* the sample includes 35 managed care designs, primarily large-scale, Medicaid-managed care initiatives in 34 states. Similar findings were reported as well by the more diverse group of stakeholders that included purchasers, managed care organizations, family members, providers, child-serving systems, and advocates that were interviewed for the HCRTP's impact analyses in a smaller sample of 18 states. Among the differences in design characteristics reported, carve outs were more likely than integrated designs to include: a broad, flexible benefit design for child behavioral health care; specific mechanisms for care coordination for children with serious emotional disorders; clinical management features that support provision of individualized care, such as flexible level of care criteria and individualized service planning teams for children with serious disorders; broad psychosocial medical necessity criteria; and a formal role for family organizations built into the design.

Table 2

Reported Differences Between Carve Outs and Integrated Designs
(Sample of 35 managed care designs in 34 states*)

Characteristic	Carve Out	Integrated
Cover an expanded array of behavioral health services	70%	13%
Increase case management or care coordination for children with serious emotional disorders	79%	42%
Support provision of individualized, flexible care	88%	50%
Incorporate broad, psychosocial medical necessity criteria	82%	40%
Involve families of children with behavioral health problems in planning and implementation in significant ways	48%	0%
Include specialized behavioral health services for culturally diverse populations	48%	0%
Provide training to MCOs on children with serious emotional disorders	62%	29%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

The HCRTP also found reported differences in the financing arrangements of integrated and carve out designs. Carve outs were more likely to utilize multiple funding streams from multiple sources, while integrated designs tended to depend principally on Medicaid dollars contributed by the Medicaid agency. While both integrated and carve out designs left significant dollars for behavioral health care outside of the managed care system, creating potential for fragmentation across systems, carve outs were more likely to include strategies for clarifying responsibility for paying for services across child-serving systems. Carve outs were more likely to use non risk-based financing and case-rates, while integrated reforms primarily used capitation, a "riskier" form of financing, particularly when high-need populations are involved, such as children with serious disorders. Carve outs were more likely to assess the sufficiency of rates for behavioral health services, and more likely to include bonuses or penalties tied to performance related to child behavioral health care.

There were even some significant differences reported between integrated and carve out designs in their fundamental goals, as **Table 3** shows. Survey respondents and key stakeholders reported that, with respect to behavioral health services for children, carve outs were far more likely than integrated reforms to encompass goals beyond cost containment, such as expansion of the service array for children's behavioral health care, improvement in accountability for child behavioral health care, and improvement in the quality of child behavioral health care.

Table 3

Reported Differences in Goals Between Carve Out and Integrated Designs

(Sample of 35 managed care designs in 34 states*)

Goal	Carve Out	Integrated
Cost containment	72%	100%
Expand service array	76%	38%
Improve accountability for children's behavioral health care	92%	38%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

At least as perceived by key stakeholders who responded to the HCRTP's state surveys and who were interviewed on site for the HCRTP's impact analyses, the differences in design and financing characteristics between integrated and carve out approaches were associated as well with differences in impact on children with behavioral health disorders. As **Table 4** shows, integrated designs were far more likely than carve outs to be perceived as having a negative impact across a number of indicators, including access to initial care, access to extended care for children with serious disorders, waiting lists, interagency coordination, the practice of families having to relinquish custody to access services, administrative burden on providers, and reimbursement rates.

Table 4

Reported Differences in Impact Between Carve Out and Integrated Designs

(Sample of 35 managed care designs in 34 states*)

Measure	Carve Out	Integrated
Initial access to behavioral health services is worse than before managed care	10%	33%
Access to extended behavioral health services is worse	4%	60%
Waiting lists are longer	15%	33%
Practice of having to relinquish custody to access services is worse	0%	17%
Administrative burden on providers is higher under managed care	56%	75%
Provider reimbursement rates are lower under managed care	25%	57%
Interagency coordination is worse	4%	14%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

Theoretically, an integrated approach should lead to improved service delivery for children because of the important linkage between primary and behavioral health care. The HCRTP found, however, that if this linkage does occur, it is regardless of integrated or carve out design and far more a function of whether coordination between physical and behavioral health care was attended to in planning, implementation, and financing (e.g., incentives for primary care and behavioral health providers to coordinate). Indeed, the *2000 State Survey* found that carve outs were actually slightly more likely to be reported as improving coordination between physical and behavioral health care than integrated designs (61% versus 57%).

The findings of the HCRTP should *not* be interpreted as suggesting that there is an *inherent* disadvantage for children's behavioral health care in an integrated design approach. Rather, primarily because integrated designs tend to focus almost exclusively on physical health issues, integrated designs end up being disadvantageous because they tend *not* to include design features that have been customized for children with behavioral health disorders, particularly children with serious disorders. In addition, they are less likely than carve outs to draw on or coordinate with the multiple financing streams that exist across child-serving systems for children's behavioral health care, thus aggravating service fragmentation to a greater extent.

The HCRTP found that, in comparison to carve outs, integrated designs were less likely to have had the benefit of involvement in planning and implementation of stakeholders who are knowledgeable about children's behavioral health care, such as family members, other child-serving systems, and behavioral health providers. In addition, the HCRTP found that state Medicaid agencies were the predominant players in designing integrated reforms, whereas carve outs were more likely to be designed jointly by state mental health and Medicaid agencies. The lack of involvement of stakeholders informed about children's behavioral health care, combined with an almost exclusive focus on physical health issues, makes it not surprising that integrated designs tend not to include design characteristics more favorably suited to children with behavioral health disorders.

Most of the promising design and financing approaches that were identified by stakeholders across the country for the *Promising Approaches Series* are carve outs; however, there are some integrated designs as well. What these promising integrated designs have in common with the carve outs are customized design and financing features for children with behavioral health needs, which reflect the expertise and input of key stakeholders with knowledge in this area.

Type and Number of Managed Care Organizations Used in Design

A basic design question concerns the type and number of managed care organizations (MCOs) to use. Stakeholders interviewed for the HCRTP's impact analyses cited pros and cons of using various types of MCOs. For example, commercial MCOs were seen as having managed care technical expertise in such areas as provider profiling, utilization management, and data systems. However, they also were perceived as lacking familiarity and expertise in serving children with serious disorders and other populations dependent on public systems. Nonprofit and government entity MCOs were perceived as having this expertise, but as lacking in experience with managed care. Stakeholders cited the importance of training and orientation for MCOs to understand issues with respect to children with behavioral health disorders, as well as populations involved in the child welfare and juvenile justice systems, where there is a higher prevalence of behavioral health disorders. The HCRTP's *2000 State Survey* found that approximately half of all publicly-financed managed care systems provide training to MCOs related to children's behavioral health and child welfare issues, and about one third related to juvenile justice issues.

The design approaches described in this paper, collectively, use a variety of types of MCOs, including government entities, non-profit organizations and commercial companies. What these MCOs have in common is an expertise in serving children with behavioral health disorders, particularly those with serious disorders, gained through prior experience, as in the case of government entities, and/or an active partnership with state purchasers and family members that encompasses training and orientation to create responsive systems.

Another design issue identified through the HCRTP concerned the problems created by the use of multiple MCOs, as opposed to one MCO statewide or one in each region. Stakeholders interviewed for the HCRTP's impact analyses noted that when there are multiple MCOs, each MCO develops different procedures for virtually every aspect of system operation (i.e., billing; credentialing; service authorization; utilization management; reporting, etc.; creating added administrative burden on providers; confusion for families in navigating different systems; and monitoring challenges for state purchasers). Stakeholders noted that families were not so much concerned about choice in MCOs, but, rather, choice in providers. The HCRTP also found that integrated designs were nearly three times as likely to use multiple MCOs statewide or within a single region as were carve outs.

The design approaches identified for the *Promising Approaches Series* utilize one managed care entity statewide or within a single region and do not use multiple MCOs.[2]

[2] Delaware, which uses an integrated approach with a partial carve out, is a kind of hybrid in that a single MCO is used for children with intermediate to extended care needs and multiple MCOs are used for children with only acute care needs.

Coverage of Acute and Extended Care Services

Stakeholders interviewed for the HCRTP's impact analyses strongly advocated inclusion of both acute and extended care in the design of managed care systems. *Acute care* is defined as brief, short-term treatment with, in some cases, limited intermediate care also provided. *Extended care* is defined as care extending beyond the acute care stabilization phase (i.e., care required by children with more serious disorders). The impact analyses found that inclusion of both acute and extended care creates the potential for more integrated service delivery for a total eligible population of children and reduces the potential for fragmentation and cost shifting.

All of the statewide approaches described in this paper, which are focusing on total eligible populations, that is, children with both acute and extended treatment needs, include both acute and extended care within the managed care design. The local approaches described in this paper are focusing on subsets of the total population that encompass only children with extended care needs (i.e., children with serious disorders), who, typically, have exhausted the resources of acute care systems.

Benefit Design

A tenet of effective service delivery for children with behavioral health disorders, particularly those with serious disorders, is that they require access to a broad, flexible array of services and supports, including especially home and community-based services.[3] The HCRTP's *2000 State Survey* explored the extent to which publicly-financed managed care designs are covering the following array of services and supports: assessment and diagnosis; outpatient psychotherapy; medical management; home-based services; day treatment and partial hospitalization; crisis services; behavioral aide services; therapeutic foster care; therapeutic group homes; residential treatment center; crisis residential services; inpatient hospitalization; care or case management services; school-based services; respite services; wraparound services; family support/education; transportation; and mental health consultation.

The HCRTP found that, at least in the case of carve outs, managed care designs are incorporating a broad, flexible benefit design. Seventy percent of carve outs reportedly cover a broad array of services, including "wraparound" services and supports,[4] but only 13% of integrated designs do.

All of the design approaches described in this paper incorporate a broad, flexible benefit design that includes home and community-based services and supports.

[3] Stroul B.A. & Friedman, R.M. (1986). *A system of care for children and youth with serious emotional disturbances* (rev. ed.). Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

[4] Wraparound services and supports are highly individualized, flexible services and supports, such as a behavioral aide, mentoring services, transportation, respite, often used to augment clinical treatment services. Wraparound also connotes an approach to service delivery that flexibly draws on and combines traditional and nontraditional services and supports to support individualized care planning and provision.

Individualized Care Mechanisms

Another premise of effective service delivery for children with or at risk for serious behavioral health disorders is that service design should support provision of individualized care.[5] The HCRTP *2000 State Survey* found that publicly-financed managed care, in general, and as compared to fee-for-service systems, is making it easier to provide flexible, individualized care in many cases. This was particularly, although not solely, reported to be the case with carve outs. An enhanced ability to provide individualized care was attributed to such design features as: more flexible financing arrangements, such as capitation, case-rates and designated pots of "flexible funds"; a broad, flexible benefit design; and required mechanisms for individualized care planning. Where managed care designs have not supported flexible, individualized care, stakeholders pointed to such design features as: rigid billing procedures and service codes; rigid service authorization mechanisms; narrow medical necessity criteria; accounting and reporting procedures that focus on single episodes of care or discrete services; and a narrow benefit design.

The design approaches described in this paper all incorporate a variety of design features that support provision of individualized care.

Care Management and Coordination Features

Children with behavioral health disorders, particularly those with serious disorders, often are involved or at risk for involvement with multiple service providers and multiple child-serving systems. Care management and coordination is important from the standpoint of both quality and cost of care, as well as family satisfaction. The HCRTP's *2000 State Survey* found that, in over a quarter of integrated designs, care management and coordination for children with behavioral health disorders had decreased in comparison to the previous fee-for-service system. This was not the case with carve outs, however, in which it was reported that care management and coordination had increased in over three-quarters of these initiatives. Increased care management and coordination was reported for nearly twice as many carve outs as for integrated designs (79% versus 42%).

All of the design approaches identified for the *Promising Approaches Series* incorporate customized care management features for children with serious disorders.

Clinical Decision Making and Management Mechanisms

Throughout the course of the HCRTP, stakeholders have complained about the impact of narrowly defined or interpreted medical necessity criteria on the ability of managed care systems to provide effective care for children with behavioral health disorders. The *2000 State Survey* found that, while there is some movement across states to broaden the definition of medical necessity criteria to include psychosocial and environmental factors, criteria continue to be interpreted narrowly within integrated designs, though not within carve outs.

The HCRTP also has been tracking the extent to which managed care designs incorporate clinical decision making criteria specific to children's behavioral health care. The *2000 State Survey* found that 70% of carve outs, but only 38% of integrated designs, reportedly incorporate criteria specific to children's behavioral health.

[5] Stroul, B.A. & Friedman, R.M. (op.cit.).

Stakeholders interviewed for the HCRTP's impact analyses often complained about the clinical management mechanisms built into managed care designs, such as prior authorization and concurrent and retrospective review procedures. These features were described as cumbersome, time consuming, confusing, and as creating barriers to access. The *2000 State Survey* found that, in many managed care systems, some steps were being taken to make clinical management mechanisms less rigid, such as pre-authorizing certain services or service amounts.

A common characteristic of the approaches described in this paper is that they all incorporate broad definitions of medical necessity, and they include clinical decision making criteria specific to children's behavioral health care. In addition, they have tried to build flexibility into their clinical decision-making and management mechanisms to support provision of individualized services for children with serious disorders.

Interagency Coordination Mechanisms

Because children with behavioral health disorders often are involved or at risk for involvement with multiple systems, such as the education, child welfare, and juvenile justice systems, in addition to the managed care system, coordination across systems is critical to effective care. The HCRTP found that, in most cases, insufficient attention was paid to cross-system issues in initial managed care designs. The problems that surfaced as a result have led states to focus more attention on improving interagency coordination in system redesign.

The approaches described in this paper incorporate a variety of interagency coordination features both at the systems and the services levels.

Family Involvement Strategies

Table 5 shows the extent to which the *2000 State Survey* found family involvement strategies built into managed care designs. Carve outs, reportedly, were far more likely than integrated designs to incorporate strategies for family involvement at systems and services levels.

Table 5

Extent of Family Involvement Strategies in Managed Care Designs

(Sample of 35 managed care designs in 34 states*)

Strategy	Carve Out	Integrated
Requirements in RFPs and contracts for family involvement at the systems levels	69%	0%
Requirements in RFPs, contracts and service delivery protocols for family involvement in planning and delivering services for their own children	62%	14%
Focus in service delivery on the family and not only the identified child	73%	29%
Coverage and provision of family support services	65%	29%
Use of family advocates	62%	0%
Hiring families and/or youth in paid staff roles	35%	0%
No strategies	0%	29%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

A characteristic of the approaches described in this paper is their focus on family involvement. Some go farther than others in building family partnership structures into the managed care design, but all recognize the importance of a design that incorporates opportunities for partnerships with families.

Provider Networks

Consistent with a broad, flexible benefit design and a goal of individualizing care, effective service delivery systems for children with behavioral health disorders also design provider network parameters to accommodate: nontraditional and culturally diverse providers; families in the role of providers; student interns and paraprofessionals; and providers from other child-serving systems, such as child welfare providers and school-based providers. As **Table 6** shows, the *2000 State Survey* found that many managed care systems are including various types of providers relevant to child behavioral health care, beyond traditional behavioral health providers, such as mental health clinics and psychiatrists. Again, however, carve outs are more likely than integrated designs to have diverse provider networks.

Table 6

Types of Providers in Managed Care Designs

(Sample of 35 managed care designs in 34 states*)

Provider Type	Carve Out	Integrated
Child welfare providers	65%	13%
School-based behavioral health providers	62%	63%
Certified addictions counselors	69%	63%
Culturally diverse and indigenous providers	88%	63%
Family members as providers	42%	0%
Paraprofessionals and student interns	62%	13%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

The design approaches described in the *Promising Approaches Series* all incorporate both traditional and nontraditional providers in their networks, and, in some cases, the range and flexibility built into provider network parameters are extensive.

Related to the issue of provider network design parameters is that of training to ensure that the provider network has the skills, attitudes, and knowledge necessary to serve children with behavioral health disorders, particularly those with serious disorders. **All of the approaches described in this paper incorporate training and technical assistance for providers into their managed care structures, again, in some cases, extensively.**

Accountability Systems

The adequacy of management information systems (MIS) and quality measurement and improvement systems has a critical impact on the effectiveness of managed care systems. The *2000 State Survey* found that over one-third of carve outs and over one-half of integrated designs reportedly did not have adequate data to guide decision making at both services and systems levels related to children's behavioral health care. In about a quarter of cases in which adequate data were not available, it was because the system was not designed to track data on children's behavioral health services. The *2000 State Survey* found that, while most managed care systems are incorporating quality and outcome measures related to children's behavioral health care, most also are in early stages either of development or implementation.

As a result of inadequate data systems and/or not fully developed or implemented quality and outcome measurement systems, a substantial number of publicly-financed managed care systems reportedly do not know the impact they are having on children's behavioral health care. The *2000 State Survey* found that, in over 40% of managed care systems, the impact on penetration rates, service utilization, cost, quality and satisfaction was unknown. In 63%, the impact on clinical and functional outcomes was unknown. While a major goal of managed care systems is to control costs, in nearly three quarters of integrated designs and over a third of carve outs, the impact on cost of children's behavioral health services was unknown. Where cost data existed, the impact was decidedly mixed, with cost increases reported for 24% of managed care systems, no effect one way or the other in 10%, and cost decreases in 7%.

The approaches described in this paper have designed data, quality and outcomes measurement systems specifically relevant to children's behavioral health care. In addition, a number of them have documented improved clinical and functional outcomes, along with cost savings.

Financing Structures

The *2000 State Survey* found that carve outs are more likely to draw on multiple funding streams contributed by multiple systems than are integrated designs, which tend to rely almost predominantly on Medicaid dollars contributed by state Medicaid agencies. In contrast, carve outs are drawing more on Medicaid, block grant, and general revenue dollars from state mental health, substance abuse, and child welfare systems, in addition to state Medicaid agencies.

The significance of the types of revenue and agencies financing managed care systems has to do with the fact that many of the populations of children enrolled in publicly-financed managed care rely on multiple funding streams and agencies for behavioral health services. This is true, for example, of children involved in the child welfare and juvenile justice systems, children receiving Supplemental Security Income (SSI), and those with serious disorders who do not quality for SSI. Historically, there has been fragmentation across these funding streams and agencies, creating cost inefficiencies and confusion for families and providers. Managed care as a technology creates opportunity to blend or braid dollars and "rationalize" the delivery system. The *2000 State Survey* results suggest that states with carve out designs are beginning to experiment with the use of multiple funding streams, engaging multiple agencies in this effort. This does not seem to be the case with integrated designs.

All of the design approaches described in the *Promising Approaches Series* draw on multiple funding streams contributed by multiple agencies.

An aspect of the design of managed care systems has to do, not only with the types of dollars used, but the types of financing arrangements involved. As **Table 7** shows, publicly-financed managed care systems are using a variety of risk-based financing arrangements, as one would expect in managed care. However, carve outs are far more likely than integrated designs to use "less risky" arrangements, such as case-rates and non risk-based administrative services organizations (ASOs); integrated designs are more likely to use full-blown capitation.[6] Less risky financing arrangements may be called for in the case of children with behavioral health disorders, particularly those with serious disorders, to guard against underservice and to give systems time to collect and analyze utilization and cost data to support realistic capitation models.

Table 7

Use of Risk-Based Financing

(Sample of 35 managed care designs in 34 states*)

Type of Financing	Carve Out	Integrated
Capitation	54%	88%
Case-rates	31%	13%
Neither (i.e., no risk)	27%	13%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

All but one of the approaches described in this paper are using either case-rates or non risk-based ASO arrangements or a combination of both, rather than full-blown capitation.

[6] Capitation financing pays MCOs or providers a fixed rate per *eligible* user of service, while case-rates pay a fixed rate per *actual* user of service, based typically on the service recipient's meeting a certain service or diagnostic profile. In a capitated system, a potential incentive is to prevent eligible users from becoming actual users. In a case-rated system, there is no such incentive, although case-rates do create an incentive, like capitation, to control the type and amount of service provided.