Overview

Promising Approaches 5: Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems

As noted, each paper in the series focuses on a specific aspect of publicly financed managed care systems. This paper focuses on promising approaches for serving youth with serious and complex behavioral health needs in managed care systems. The paper begins with a brief discussion of the issues and challenges related to serving youth with serious and complex behavioral health disorders and their families in the context of managed care. These issues and challenges have surfaced through all of the previous activities of the Tracking Project.

A number of promising approaches for meeting the needs of this population are then described. Identified through the state surveys and impact analyses that have comprised the Tracking Project, these approaches are perceived by key state and local informants to support effective service delivery to this most challenging population.

I. Serving Youth with Serious Behavioral Health Disorders in Managed Care Systems

Issues and Challenges

From the earliest stages of the Tracking Project, a specific emphasis has been placed on exploring the impact of managed care systems on the population of children and adolescents with serious behavioral health disorders and their families and on the systems of care that serve them. These are the youth with the greatest level of need, whose care most challenges their families and communities, who require intensive treatment and supports in multiple arenas of functioning, for whom significant resources are required, and whose problems are most likely to lead to school failure, substance abuse, suicide, and long-term impairments that continue into adulthood. Results from the state surveys and feedback from stakeholders interviewed through the impact analyses has led to the identification of a number of issues that affect the provision of appropriate services to youth with serious behavioral health disorders and their families in the context of managed care systems.

Planning for Youth with Serious Disorders

The need for specific, discrete planning processes for serving youth with serious and complex needs within managed care systems has been consistently found through all of the Tracking Project's activities. The early surveys and impact analyses confirmed a distinct lack of focused attention to the needs of children with serious behavioral health problems; most states did not distinguish this population from the total population of covered children, nor did they include any special benefits or provisions within their managed care systems to serve this group of high utilizers. The 2000 State Survey

revealed increased planning for children with serious behavioral health disorders. It is likely that the increased planning was attributable to states' growing experience with managed care, problems arising in implementation that led states to initiate planning processes and incorporate changes, and increased advocacy on the part of key stakeholders to better address the needs of this challenging population. While reports of discrete planning declined somewhat in 2003, this may be related to the more advanced implementation stages of managed care systems. Overall, attention to children with serious disorders in the managed care planning process has increased over time.

Table 1

Percent of Managed Care Systems with Discrete Planning for Children and Adolescents with Serious Behavioral Health Disorders

1997/98 State Survey	2000 State Survey	2003 State Survey	Percent of Change 1997/98 – 2003
57%	83%	74%	+17%

Extent of Coverage of Extended Care Services

Children with serious and complex behavioral health disorders are likely to need multiple services and supports, often at high levels of intensity and over significant durations of time. Thus, short-term, acute care services are not likely to be sufficient to provide for the treatment and support needs of these youngsters and their families; most will need longer-term, extended care. Acute care is defined as brief, short-term treatment with, in some cases, limited intermediate care also provided, and extended care is defined as care extending beyond the brief, acute stabilization phase, i.e., care required by children with more serious disorders and their families. Managed care in the commercial sector historically has focused on providing coverage for acute care, leaving the public sector to assume responsibility for consumers with serious disorders requiring extended care services and supports. The Tracking Project explored the extent to which extended care services are covered in managed care systems in addition to acute care, with obvious implications for children with serious and complex needs.

Early Tracking Project findings revealed that many public sector managed care systems were limiting their coverage to acute care. In leaving extended care out of managed care systems, states were both failing to take advantage of the potential of managed care to spread risk over a total eligible population of children, as well as its potential to manage service delivery and costs for the children who are the highest utilizers of behavioral health services – those with the most serious disorders. By the 1997–98 survey, a trend toward increased inclusion of extended care services in managed care systems was observed, and by 2003, 95% of the managed care systems reported covering extended care services, theoretically enhancing the likelihood of meeting the needs of children with serious and complex disorders and their families.

Table 2

Percent of Managed Care Systems with Coverage for Extended Care Services

1997/98 State Survey	2000 State Survey	2003 State Survey	Percent of Change 1997/98 – 2003
74%	88%	95%	+21%

Fragmentation of Responsibility for Behavioral Health Extended Care Services

Even though most managed care systems now include coverage for extended care services, other child-serving systems still retain both responsibility and significant amounts of resources for behavioral health services as well. The systems most likely to retain both responsibility and resources, in addition to the managed care system, are the public mental health system, the child welfare system, the juvenile justice system, and the public substance abuse system. All integrated managed care systems reported that these systems retain responsibility and resources, suggesting that although they report covering extended care, the extended care actually provided may be limited, resulting in a reliance on other child-serving systems for longer-term services.

Some stakeholders feel that leaving responsibility and resources in other child-serving systems creates a "safety net" for youngsters with serious disorders should managed care systems not authorize or deliver certain services and supports. However, most stakeholders agree that the multiple funding streams and overlapping responsibility for children's behavioral health care aggravate the historic fragmentation, duplication, and confusion characterizing children's services. Managed Care Organizations (MCOs) are forced to grapple with the complexities of multiple systems in the children's arena, including parallel delivery systems in other children's systems and resource and boundary disputes with these systems. In addition, this fragmentation may contribute to incentives for managed care systems to underserve children with serious disorders needing extended care services, since they potentially can be shifted to other systems with both responsibility and resources to provide behavioral health care. The potential for such shifting of children and costs to other systems is especially high when capitation or case rates are considered inadequate and/or when there are inadequate risk adjustment mechanisms for high utilizer populations, such as children with serious behavioral health disorders.

Table 3

Percent of Managed Care Systems with Other Systems Also Having Responsibility and Resources for Behavioral Health Extended Care

	2003 State Survey
Public mental health system	81%
Child welfare system	83%
Juvenile justice system	72%
Education system	58%
Substance abuse system	72%

Access to Extended Care Services

Stakeholders interviewed for the Tracking Project noted a widespread perception that it was more difficult to access services beyond a certain basic level in the managed care system compared with pre-managed care, thereby making it more difficult to obtain extended care for children with serious disorders and their families. Thus, coverage of extended care alone does not guarantee that youngsters with serious disorders will receive needed services and supports if there are substantial barriers to accessing care. A number of explanations for impaired access to extended care were offered, including: cumbersome and strict authorization processes; tighter controls and/or arbitrary limits and resulting reductions in admissions to inpatient, residential treatment, and other services; rigid interpretation of medical necessity and other clinical decision making criteria that limit both the type and duration of care; and lack of sufficient service capacity to meet the need for particular extended care services. Stakeholders also noted particular pressures and emphasis in managed care systems on a short-term, episodic approach to treatment, that is not sufficient for youth with serious disorders who are likely to need ongoing services and supports over time.

In further exploring this area, the 2000 survey found that access to extended care services was indeed compromised in managed care systems with integrated designs — access to extended care was considered to be worse in nearly two-thirds of the integrated managed care systems, as compared with only 4% of the managed care systems with carve out designs. For example, in some managed care systems, it reportedly was significantly more difficult to access hospital or residential treatment services for extended stays, even though, in some cases, children with serious disorders may need this care. The 2003 survey found improvements in this area, with only 6% of the managed care systems reporting worse access to extended care. Where access to extended care is difficult, youngsters with serious disorders reportedly experience more difficulty in obtaining needed services and supports at appropriate levels and durations, and children with higher acuity are served in lower levels of care that may not be equipped to respond to their needs.

Table 4
Impact of Managed Care Systems on Access to Extended Behavioral Health Services

	2000 Total	2003			Percent of Change 2000 – 2003
		Carve Out	Integrated	Total	
Access to extended behavioral health services is better	36%	71%	46%	62%	+26%
Access to extended behavioral health services is worse	14%	5%	5%	6%	-8%
No change in access to extended behavioral health services	50%	24%	46%	32%	-18%

Service Capacity for Broad Array of Community-Based Services

Stakeholders noted that underdeveloped service capacity for home and community-based services means that appropriate levels of care often are not available for youngsters with serious disorders. Similar to the issues around access to care, coverage for a broad array of services is necessary, but not sufficient to ensure that youngsters with serious disorders receive the treatment services and supports that they need. Although managed care reforms have expanded coverage, the actual availability of these services is a separate and distinct issue. Lack of sufficient service capacity for children's behavioral health is a systemic issue that predates managed care reforms. However, in many cases, the implementation of managed care systems has not resulted in improvements, and lack of sufficient capacity remains a barrier to serving youth with serious disorders. Stakeholders reported extensive wait lists for some services, pervasive shortages of particular types of services, and large gaps in the service array in rural and frontier areas. They also indicated that providers are reluctant to develop and offer new types of services as they lack start-up resources and particularly if they perceive the payment rates for them to be insufficient or if they perceive overly restrictive authorization practices among MCOs.

The 2000 and 2003 state surveys found that significant expansion of the availability of home and community-based services occurred in very few managed care systems (21% in 2003); 37% of the managed care systems resulted in very little or no expansion in service capacity for the types of services that youngsters with serious disorders are likely to require. Managed care systems with carve out designs have been far more successful in expanding service capacity. Further, ratings of the general level of service capacity in the states were higher for managed care systems with carve out designs, but mean ratings did not approach the level of "highly developed" regardless of managed care system design. Across all managed care systems, only 19% characterized service capacity in their state as highly developed in 2003. This indicates that lack of sufficient service capacity is a continuing problem that affects behavioral health service delivery, particularly for youth with serious disorders.

Despite this lack of service capacity, most managed care systems (68% in 2003) do not require that any savings from the managed care system be reinvested back into the system to expand capacity for children's behavioral health services. Only about half of the states reportedly are investing in service capacity development (53% in 2003), and impact analysis results suggest that stakeholders consider these investments to be inadequate in relation to the need.

Table 5
Service Capacity for Home and Community-Based Services

	2003 State Survey		
	Carve Out	Integrated	Total
Percent managed care systems with very little or no expansion of availability of home and community-based services	19%	62%	37%
Percent of managed care systems with significant expansion of availability of home and community-based services	36%	0%	21%
Mean rating of service capacity (1 to 5 scale with 1 being highest)	2.80	4.00	3.20
Percent managed care systems with highly developed service capacity (1 or 2 on 5 point scale)	32%	0%	19%
Percent managed care systems with poorly developed service capacity (4 or 5 on 5 point scale)	23%	40%	30%
Percent of managed care systems that require reinvestment of savings in service capacity development	57%	0%	32%
Percent of managed care systems with state investment in service capacity development	59%	53%	53%

Application and Interpretation of Medical Necessity Criteria

The Tracking Project found that nearly all states use medical necessity criteria in clinical decision making processes for authorizing care, including the types, levels, and duration of services and supports. Given their widespread use, the feedback of stakeholders about the barriers that may be created by medical necessity criteria that are too rigid or applied too stringently has been explored, particularly in view of the potential difficulties that could occur in obtaining authorization for services to children with serious and complex needs. Stakeholders noted that narrow definitions of medical necessity, based solely on a medical model, fail to account for the need to link treatment with the social and environmental supports so critical for children and adolescents with serious disorders. In addition, medical necessity criteria in some managed care systems may not "fit" the long-term nature of serious behavioral health disorders, making it difficult to obtain authorization for the more intensive services and supports over time. For example, some medical necessity criteria require the expectation of "continual improvement" in order to maintain eligibility for services. Maintaining stability, rather than improvement, may not be seen as meeting medical necessity criteria, though it may be a legitimate goal for some youth with serious disorders.

In response, many states have created broad definitions of medical necessity, or broadened their definitions to allow for consideration of psychosocial and environmental factors in clinical decision making and to consider the ongoing service and support needs of youth with serious disorders. The 2000 and 2003 surveys found that the majority of managed care systems (89% in 2003) now have criteria that consider psychosocial and

environmental factors. Even with broader criteria, however, stakeholders in some systems noted problems related to the application of medical necessity criteria — inconsistent application by MCOs and overly rigid interpretation and application by some MCOs that create barriers to service delivery, limiting both the types and duration of services. This has particularly strong implications for children with serious disorders and extensive service needs.

Table 6
Medical Necessity Criteria

	2003 State Survey		
	Carve Out	Integrated	Total
Medical necessity criteria allow consideration of psychosocial and environmental factors	91%	87%	89%
Medical necessity criteria are interpreted narrowly by managed care organizations (MCOs)	20%	27%	23%

Interagency Treatment and Service Planning

Interagency treatment and service planning is a process whereby representatives of all involved child-serving agencies and systems come together, in partnership with the youth and family, to jointly develop and implement a coordinated, individualized service plan for the child and family. This process, which is characteristic of systems of care and most often is convened by a case manager, typically is reserved for youngsters with serious and complex disorders who have multiple needs and are involved with multiple systems. The Tracking Project found a number of barriers to interagency treatment and service planning in the managed care systems in some states:

- Providers may not be able to bill for participating in service planning meetings; there may be no allowable billing code for this activity.
- The process is more complicated with the advent of managed care by the need to include yet another player — the MCO. 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 but that the MCO is not obligated to provide or pay for.
- Case managers to convene and coordinate the process may not be available, and in some states, their role may be shifted to a more service authorization and gatekeeper role rather than a broker, facilitator, and coordinator of care.

Table 7
Interagency Service Planning

	2003 State Survey		
	Carve Out	Integrated	Total
Interagency treatment and service planning is incorporated in managed care system	86%	38%	69%

By 2000, requirements for interagency treatment and service planning for youth with serious disorders reportedly were included in managed care systems through RFPs, contracts, service delivery protocols, and other key system documents in most systems, especially those with carve out designs. Over two-thirds of the systems reported incorporating interagency treatment planning in 2003. However, the impact analyses revealed that, even with such requirements, these processes may not be occurring to the degree necessary in some managed care systems, and that, according to stakeholders, MCOs are infrequent participants and are not required to provide or pay for the services and supports that are recommended by the service planning team.

Case Management/Care Coordination for Children with Serious Disorders

For youngsters with serious and complex needs, case management or care coordination services, often at intensive levels, are needed to plan, access, facilitate, and coordinate multiple services and supports, often from multiple agencies and programs. Thus, the availability of enhanced case management services is a critical variable in providing services to this population. By 2000, and again in 2003, the Tracking Project found that case management services for children with serious behavioral health disorders reportedly had increased as a result of the implementation of managed care. However, this was primarily found in managed care systems with carve out designs. Case management services increased in few of the systems with integrated designs, and, in fact, they reportedly decreased in some of the integrated managed care systems.

Table 8
Impact of Managed Care on Case Management/Care Coordination Services

	2003 State Survey		
	Carve Out	Integrated	Total
Case management services have increased as compared with pre-managed care	82%	21%	58%
Case management services have decreased as compared with pre-managed care	0%	7%	3%
No effect on case management services	18%	71%	39%

Fiscal Incentives

Unintended financial incentives to underserve consumers with the most serious and potentially most expensive service needs may compromise services to youth with serious disorders in the context of managed care. Some managed care systems attempt to mitigate the financial risk to MCOs and providers of meeting the needs of this group. Higher capitation or case rates for enrolled consumers with serious disorders and/or other risk adjustment mechanisms are used to protect MCOs and providers against financial losses from providing the needed high levels of care to this group. However the use of these approaches to manage the risk posed by high-need populations (in particular children with serious behavioral health disorders) is not extensive. The 2000 and 2003

surveys found that about 30% of managed care systems use risk adjusted rates for any high-need population at all. In 2003, only 13% use risk adjusted rates for youth with serious disorders, and even fewer for youth involved with the child welfare and juvenile justice systems. Further, very few managed care systems use other risk adjustment mechanisms of any type. This raises a question as to the adequacy of safeguards to protect against underservice to children with serious disorders and their families.

Table 9
Percent of Systems with Risk Adjusted Rates for High-Need Populations

	2003 State Survey		
	Carve Out	Integrated	Total
Use of risk adjusted rates for children and adolescents with serious behavioral health disorders	18%	6%	13%
Use of risk adjusted rates for children and adolescents in the child welfare system	5%	18%	10%
Use of risk adjusted rates for children and adolescents in the juvenile justice system	5%	12%	8%
Use of stop loss	5%	24%	13%
Use of risk corridors	18%	6%	13%
Use of reinsurance	5%	18%	10%
Use of risk pools	5%	0%	3%

Understanding of the Special Needs of Children with Serious and Complex Needs

Lack of understanding of the special legal, logistical, coordination, and treatment needs of children with serious and complex behavioral health needs reportedly has compromised the provision of appropriate services and supports to this group, according to stakeholders. This is particularly the case for youngsters involved in other child-serving systems, such as child welfare or juvenile justice, since these systems may have custody of youth needing treatment and complicated legal, logistical, and clinical issues are the norm. To increase understanding of these populations and their needs, states may provide training, education, and technical assistance to MCOs and providers. Such training is most commonly related to children with serious disorders and children in the child welfare system. Still, many managed care systems do not provide training in these areas, raising questions as to the preparedness of MCOs and their provider networks to adequately address the needs and service delivery challenges presented by these high-need, complex youth.

Table 10
Percent of Managed Care Systems Providing Training and Education to MCOs

	2003 State Survey		
	Carve Out	Integrated	Total
Training on children and adolescents with serious behavioral health disorders	86%	46%	71%
Training on children and adolescents in the child welfare system	73%	31%	57%
Training on children and adolescents in the juvenile justice system	64%	31%	51%

Responding to the Needs

Incorporation of Special Provisions

Over time, many managed care systems recognized the need to incorporate special provisions or arrangements for children with serious and complex needs to address the issues outlined above, perhaps due to the many problems and challenges they experienced in attempting to serve these youngsters. Through the 1997-98 survey, fewer than half of the managed care systems reported including any differential benefits or special provisions for this population, but by 2000 a dramatic increase was noted with 93% of the managed care systems incorporating at least one special provision. The 2000 and 2003 results continued to reflect the previously established pattern of a greater likelihood of special provisions in managed care systems with carve outs, however a substantial proportion of the integrated systems also reported having some special provisions for children with serious disorders. While a decline in reports of special provisions was found in 2003, over time, the inclusion of such provisions has increased dramatically since the first state survey in 1995 (up 37%).

Table 11
Percent of Managed Care Systems with Special Provisions for Youth with Serious Disorders

1995 State Survey	1997/98 State Survey	2000 State Survey	2003 State Survey	Percent of Change 1995 – 2003
44%	49%	93%	81%	+37%

Based on the results of the 2003 survey, special provisions are most likely to take the form of intensive case management, use of the wraparound process for service planning and delivery, interagency treatment and service planning, and an expanded service array or benefit. However, fewer than one-third of the systems with special provisions reported including a higher capitation or case rate, representing a small decline from 1997–98. This

suggests that although special provisions such as intensive case management, expanded benefits, or the wraparound process are incorporated, the resources to provide these additional services may not be sufficient.

Table 12
Types of Special Provisions Included by Managed Care Systems with Special Provisions

	1997/98 State Survey	2000 State Survey	2003 State Survey
Expanded benefit/service array	90%	79%	85%
Intensive case management	86%	86%	100%
Interagency treatment and service planning	57%	86%	88%
Wraparound process	71%	57%	92%
Family support	67%	79%	77%
Higher capitation or case rate	38%	29%	31%

Incorporation of System of Care Philosophy and Approach

Many of the special provisions included in managed care systems for children with serious disorders are rooted in the system of care philosophy and approach, designed originally to address the multiple needs of youth with serious emotional disturbances and their families. A significant focus of the Tracking Project has been to assess whether states are linking their managed care systems for behavioral health to previous and ongoing efforts to develop systems of care for youth with serious disorders and their families. Early Tracking Project activities found reports that most managed care systems were "building on" previous system development efforts, and the 2000 and 2003 surveys found that in about three-quarters of the cases, managed care systems reportedly are generally supporting and facilitating systems of care. Striking differences between systems with carve out and integrated designs have consistently been found in this regard, with behavioral health carve out systems far more likely to be consistent with and supportive of the system of care philosophy and approach. The basis for these responses typically was that managed care systems have allowed for coverage of and payment for services linked to the system of care philosophy, and have created opportunities and incentives for the development and use of these services. Systems with integrated designs were described as more "traditional," and stakeholders tended to believe that their design and features were discrepant with the system of care philosophy and approach.

Table 13
Effect of Managed Care Systems on Systems of Care

	2003 State Survey		
	Carve out	Integrated	Total
Managed care systems that generally support and facilitate systems of care	90%	44%	70%

A more specific look at the system of care principles incorporated into managed care systems through RFPs, contracts, service delivery protocols, and other key system documents found that many managed care systems reported including these principles, although systems with carve out designs consistently have had higher rates of inclusion of each principle.

Table 14
Incorporation of System of Care Principles into Managed Care Systems

	1997/98 State Survey	2000 State Survey	2003 State Survey
Broad array of services	72%	85%	89%
Family involvement	79%	88%	69%
Individualized care	79%	79%	77%
Interagency treatment planning	77%	85%	69%
Case management	86%	79%	77%
Cultural competence	81%	79%	80%

Despite the general support of systems of care, and reportedly high rates of inclusion of system of care principles, most states have not used managed care reforms as strategic opportunities to advance the goal of system of care development for children and adolescents with serious behavioral health disorders and their families. Only a few states reported that these reforms were used deliberately and planfully to advance the goal of developing systems of care and better meeting the needs of youth with serious disorders.