The Impact of Managed Care on Mental Health Services for Children and Their Families

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Abstract

For more than a decade, the philosophy of community-based systems of care has guided the delivery of mental health services for children and adolescents served by publicly funded agencies. This philosophy supports system attributes that include a broad array of services; interagency collaboration; treatment in the least-restrictive setting; individualized services; family involvement; and services responsive to the needs of diverse ethnic and racial populations. The notion of systems of care emerged in an era when managed health care also was gaining popularity. However, the effect of managed care on the delivery of mental health and substance-abuse services—also known as behavioral health services—has not been widely studied.

Preliminary results from the nationwide Health Care Reform Tracking Project (HCRTP) inform discussions about the impact of managed behavioral health care on services for children and adolescents enrolled in state Medicaid programs. Most states have used some type of “carve-out design” to finance the delivery of behavioral health services, and there is a trend toward contracting with private-sector, for-profit companies to administer these benefits. In general, managed care has resulted in greater access to basic behavioral health and community-based services for children and adolescents, though access to inpatient hospital care has been reduced. Under managed care, it also has been more difficult for youths with serious emotional disorders, as well as the uninsured, to obtain needed services. With managed care has come a trend toward briefer, more problem-oriented treatment approaches for behavioral health disorders.

A number of problems related to the implementation of managed behavioral health care for children and adolescents were illuminated by the HCRTP. First, there is concern that ongoing efforts to develop systems of care for youths with serious emotional disorders are not being linked with managed care initiatives. The lack of investment in service-capacity development, the lack of coordination with other agencies serving children with behavioral health problems, and cumbersome preauthorization requirements that may restrict access to appropriate service delivery were other concerns raised by
respondents about managed care. As the adoption of managed behavioral health care arrangements for Medicaid beneficiaries expands rapidly, the HCRTP will continue to analyze how this trend has affected children and adolescents with behavioral health problems and their families.

In the United States today, approximately 20% of youths—including both children and adolescents, ages 9 to 17—are estimated to have diagnosable emotional or behavioral disorders. Approximately 9% to 13% of all youths in the 9-to-17 age range are estimated to have serious emotional disturbances that substantially interfere with or limit their functioning in family, school, or community activities; 5% to 9% of all youths are estimated to have extreme functional impairment. With the escalating enrollment in managed care plans that has occurred during the past decade, youths with emotional and behavioral disorders and their families are increasingly being served in mental health care systems that have adopted managed health care approaches directed at controlling service utilization and containing costs. The subgroup of youths with serious emotional disorders poses the greatest challenge for managed care systems, because these youths require a broad range of services at varying levels of intensity for extended periods of time. In addition, managing the care of these children often requires coordination across multiple systems, including mental health, substance abuse, child welfare, juvenile justice, and education.

As a context for understanding the effects of managed care on youths with emotional disorders and their families, it is important to be aware of significant recent developments in the organization, financing, and delivery of mental health services for this population. These developments include the creation of community-based systems of care for delivering mental health services to children and adolescents, as well as the significant role of Medicaid in financing such systems of care. This article briefly describes these trends, outlines the risks and opportunities posed by the introduction of managed care to the delivery of mental health and substance-abuse services for children and adolescents, and presents findings from the first major research project designed to track the effects of managed mental health care on the delivery of these services for youths with emotional disorders and their families.

Development of Systems of Care for Children’s Mental Health Services

In 1969, the Joint Commission on the Mental Health of Children found that children with emotional disorders and their families were typically unserved, or were served inappropriately in excessively restrictive settings such as residential facilities and psychiatric hospitals. Numerous subsequent reports have substantiated these findings. For example, the Children’s Defense Fund’s 1982 publication, Unclaimed Children, documented that of the 3 million children in the United States with serious emotional disorders, two-thirds were not receiving the mental health services they needed, and many more were receiving inappropriate care. All of the reports concurred that to serve these children and their families effectively, coordinated systems providing a wide range of services were needed.

Since the publication of Unclaimed Children, the notion of community-based systems of care—also referred to simply as systems of care—has become the prevailing ideology for mental health service systems for children and adolescents and their families. This system-of-care philosophy emphasizes:
A broad array of services, which includes a range of intensive nonresidential and residential options, such as outpatient therapy, home-based services, day treatment, crisis services, respite care, case management, therapeutic foster care, therapeutic group care, and other services;

- Interagency collaboration among the systems that share responsibility for youths with emotional problems, such as education, child welfare, juvenile justice, public health, mental health, and substance abuse;

- Treatment in the least-restrictive appropriate setting;

- Individualized and flexible treatment and services;

- Family involvement in all aspects of the planning and delivery of services; and

- Culturally competent services that are responsive to the needs and characteristics of diverse ethnic and racial populations.8,9

During the past decade, there has been a great deal of progress throughout the country in the implementation and financing of such systems of care, primarily in the public sector, for children with the most serious needs.10–15 State Medicaid programs increasingly have been used to fund these more coherent service-delivery systems.14,15

The early and periodic screening, diagnosis, and treatment (EPSDT) program, a prevention program for Medicaid-eligible children up to age 21, expanded the opportunity to use Medicaid funds to support a broad array of services necessary for the treatment and support of children and adolescents with emotional disorders and their families.16

For children and families whose mental health services are funded by private health plans, the vast majority of mental health services are still provided in a more traditional, nonsystematic, fragmented manner.17 Lourie and colleagues18 identified several obstacles that have impeded the development of a system-of-care approach to mental health service delivery within the private sector. Perhaps most important, private mental health services traditionally have been delivered using a medical model, which focuses narrowly on the pathology of mental health problems and fails to integrate treatment with supportive aspects of care, such as behavioral aides in home and school settings, respite care, and other family support services. In addition, the model adopted by the private mental health delivery system primarily attends to acute care needs, often relegating care for long-term, disabling conditions—such as serious emotional disorders—to public service systems, including special education, child welfare, and juvenile justice, as well as to the public mental health system.

**Managed Care and Children’s Mental Health Services**

During the same decade in which the system-of-care philosophy was embraced, managed health care arrangements were widely adopted. Initially, the use of managed care to finance and deliver mental health and substance-abuse services—also referred to as behavioral health services—occurred primarily within private, employer-sponsored health plans. In recent years, however, managed care arrangements for behavioral health services have been implemented more widely in the public sector, particularly in state Medicaid programs.

Approximately 9% to 13% of all youths are estimated to have serious emotional disturbances that substantially interfere with or limit their functioning in family, school, or community activities.

With the advent of managed care, many questions have been raised about the implications for delivering mental health services to children and adolescents. Of particular concern is whether progress in building systems of care is in jeopardy, whether the system-of-care philosophy will be abandoned, whether the use of Medicaid to support system-of-care components will be curtailed, and whether access to appropriate, comprehensive, high-quality behavioral health services for children and adolescents and their families will be compromised.
Although these questions focus mostly on apprehensions about managed care, both opportunities and risks related to the application of managed care approaches have been identified. In terms of potential positive effects, managed care is clearly intended to result in improvements in the efficiency and cost-effectiveness of services, in part by reducing the use of high-cost services, such as hospital care, when other service options might be equally effective. The shift to managed care also provides an opportunity to redesign the service system and expand the array of services covered by Medicaid, adding a range of intermediate services and supports such as home-based services, day treatment, respite care, behavioral aides, and crisis services. Increased accountability and a greater focus on outcome and quality measurement are seen as opportunities related to managed care.

The Health Care Reform Tracking Project (HCRTP) is the first step toward understanding the effect of managed care on the delivery of mental health and substance-abuse services for children and adolescents.

Concerns about providers have been raised, particularly that smaller programs and nontraditional programs and providers might be eliminated from provider networks and no longer be available. Another serious concern is that families of children and adolescents will have less input in the decisions about services for their own children, and less input in the planning and operation of the systems. Further, it is feared that the needs of culturally diverse children and families will receive less attention under the new managed care systems, with fewer nontraditional providers, less outreach, and fewer services such as transportation and translation, which often enable individuals to use needed health care services.

The Health Care Reform Tracking Project

The potential risks and opportunities identified above may influence the effect that managed care has on the delivery of behavioral health services to children and adolescents. However, the impact managed care has had in this area is largely unknown. The Health Care Reform Tracking Project (HCRTP) described in this section is, perhaps, the first step toward understanding the effect of managed care on the delivery of mental health and substance-abuse services.
for children and adolescents and their families. Currently, this five-year (1995–99) investigation is the only national study on behavioral health managed care focusing on this population of children. The study incorporates a special focus on children with serious disorders, who often depend on multiple public systems—including physical health, mental health, substance-abuse, child welfare, education, and juvenile justice systems—for the receipt of behavioral health care services.

The aims of the HCRTP are (1) to document changes in the delivery of behavioral health services to children and adolescents that occur in conjunction with a rapid increase in Medicaid managed care enrollment, and (2) to learn about what works and what does not work from states that have used managed care arrangements to finance and deliver behavioral health services for children and adolescents and their families. These lessons may be useful to other states as they develop and refine their managed care systems to serve this population.

An initial baseline survey of all 50 states and the District of Columbia was conducted in 1995 to identify and describe managed care reforms that had been planned or implemented to change the delivery of mental health and substance-abuse services. The impact analysis phase of this study included an analysis of the effect of managed behavioral health reforms on youths with serious emotional disorders, and on systems of care. During 1996–97, site visits to 10 states were conducted. States selected for site visits were required to be far enough along in the implementation of managed care for behavioral health services for effects to be discerned. The design of managed care systems and geographic diversity were considered in the site selection process. Both components of the HCRTP (a state survey and site visits to a cohort of states) will be repeated during the final two years of the study to update information, track reforms, and further assess the impact of managed care for behavioral health services to children and adolescents and their families.

The findings reported in this article are based on results of the first set of site visits. During each visit, a range of stakeholder groups—including representatives from service systems caring for youths with emotional and behavioral disorders, state Medicaid agencies, MCOs, families, health care providers, child advocates, and others—were interviewed. This process resulted in qualitative, in-depth information about critical issues that have major implications for MCOs, for systems of care, and for children and families.

**Contextual Issues for Managed Medicaid Behavioral Health Services**

Several broad observations from the HCRTP provide a contextual framework for under-
standing the more specific findings about the impact of managed care on the delivery of behavioral health services. First, many systemic problems related to serving children and adolescents existed prior to the advent of managed care. The absence of a broad array of mental health services, a lack of interagency coordination, a lack of family involvement at the system and service-delivery levels, a lack of cultural competence, and poor data systems are among the problems with which states and communities have struggled for many years. The introduction of managed care is not a panacea for these long-standing problems, but may offer an opportunity to address some of them. However, many of these problems persist, largely unaffected by managed care.

A second observation is that the introduction of managed care arrangements into state Medicaid programs forces marriages between two very different cultures: (1) the human-service philosophy that has guided publicly funded behavioral health care on the one hand, and the business philosophy of private-sector managed care on the other; (2) the public-sector movement toward decentralization on the one hand, and the centralized control favored in managed care on the other; and (3) the public sector’s emphasis on collaboration on the one hand, and the business world’s emphasis on competition on the other. These differences create dynamic tensions at all levels of the behavioral health system, and highlight the need to foster a balance between the two opposing cultures.

Another issue complicating the mental health reform process in many states is the speed with which managed care has been implemented. In some states, the result has been damage to relationships with stakeholders, as managed behavioral health reforms have been planned and implemented at breakneck speed, without the benefit of a participatory planning process. Some managed care systems for behavioral health have been designed without input from children’s mental health experts or family members of children with emotional disorders. The fast-paced process has resulted in misinformation and unrealistic expectations about the managed care system. One result has been the need for mechanisms, one to two years into some managed care initiatives, that adjust the system and make it more responsive to the needs and concerns of all stakeholders.

Finally, the Medicaid population has some characteristics that create unique challenges for managed care systems. MCOs, particularly those that have dealt exclusively with the commercial sector, often do not understand the needs of Medicaid enrollees, including the importance of a strong link between treatment and the home and community environment. For example, some families may not have telephones, transportation, baby-sitting, or other supports that are essential to accessing services. Transportation was identified as a top problem in the HCRTP, both in rural and inner-city areas. Also, some families may not have the educational level needed to read and process complicated materials.

Impact of Managed Care on Medicaid Behavioral Health Services

The context outlined above frames the more specific effects of Medicaid managed care on the delivery of behavioral health services to children and youths observed in the HCRTP. The effect of the design of managed care systems will be considered, as well as Medicaid managed care’s effect on financing and costs of behavioral health services, access to services, service delivery, systems of care, behavioral health providers, accountability, families of children with emotional disorders, and cultural competence.

Impact of Design and Administrative Arrangements

To consider whether different types of system designs for managed behavioral health care have different effects, the study sample included states with the three different designs typically used to finance and

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deliver behavioral health services under managed care. These include the carve-out design, integrated design, and divided-benefit design, which are described more fully in Box 1.

The 1995 state survey revealed that the majority of states implementing managed care reforms (72%) were using some type of carve-out arrangement—either full or partial—to administer and finance the delivery of behavioral health services. Findings from the HCRTP indicate that states with carve-out arrangements include a broader array of services, more home- and community-based services, and more nontraditional services for youths with emotional disorders than states with integrated designs. When physical health and behavioral health benefits are integrated, physical health needs often take precedence, and the percentage of available dollars allocated to behavioral health services may be insufficient, resulting in constrained behavioral health services. Although an integrated design expands access to a basic level of mental health services—primarily acute care—there is indication, in the sites studied, that access to extended care and supportive services has become more difficult for those children with more serious and complex disorders. Further, although it is often hypothesized that an integrated design may strengthen the connection between pediatric physical and behavioral health services, this has not proven to be the case. Coordination of these services appears to be challenging regardless of the health system design, and hence requires concerted efforts.

States are using a variety of arrangements to administer managed behavioral health benefits for Medicaid recipients. In some cases, state agencies or regional authorities serve as MCOs and directly operate the managed care systems. Other states contract with community mental health centers, regional boards, other nonprofit organizations, for-profit managed care companies, or some combination of these types of entities to serve as MCOs. The 1995 state survey found that nearly one-third of states contracted directly with for-profit managed health care companies, which in turn sometimes contracted with specialized behavioral health care companies to manage the behavioral health benefit. Another one-third of the states contracted directly with for-profit, specialized managed behavioral health care entities to operate their systems.21 These arrangements indicate an important trend toward the use of private-sector, for-profit companies to manage public-sector behavioral health care services.

Although conclusions about the optimal administrative arrangements for managed behavioral health services cannot be drawn, the HCRTP has elucidated pros and cons of various approaches. The proprietary managed care companies have greater expertise in implementing managed care, as well as the necessary infrastructure in the areas of data systems and financing. These companies also have more capital, and can withstand fluctuations in revenues more easily. However, they are perceived by key respondents as putting their shareholders first, and as being driven primarily by the profit

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**Box 1**

**The Designs of Mental Health Managed Care Systems**

**Carve-Out Design:** Mental health and substance-abuse services are administered and financed separately from physical health services.

**Integrated Design:** The financing and administration of physical and behavioral health care are fully integrated, as in a staff- or group-model health maintenance organization (HMO).

**Divided-Benefit Design:** The financing and administration of selected behavioral health services, usually a basic level of behavioral health services (typically acute care), are integrated with physical health services. Other behavioral health services, typically extended care services, are split out for separate management and financing.
motive, even though profits are capped by states in many systems. In addition, the for-profit entities tend to have the least experience with, and understanding of, Medicaid recipients, potentially compromising the quality of care for this population.

Nonprofit MCOs are seen as having a greater stake in the community, as evidenced by boards made up of community members, and in many instances, a history of service delivery in the public sector. These organizations, however, tend to have less access to capital, and therefore less ability to assume risk. Finally, both nonprofit organizations and public mental health entities—such as regional or local mental health authorities—typically have less experience in implementing managed care, and require a great deal of technical assistance.

**Managed care reforms are resulting in more children receiving mental health and substance abuse services than before.**

Impact on the Financing and Cost of Care

Managed care is intended to streamline service-delivery systems, making them more efficient and less costly. In part, this may be accomplished by reducing the use of high-cost hospital care when lower-cost alternative services may be equally effective, and by reducing administrative costs. It is uncertain, however, whether managed care has helped to contain Medicaid costs for behavioral health services, either by cutting costs or by slowing the rate of growth. In some states, administrative burden and costs have reportedly increased following the implementation of managed behavioral health care. This is particularly true at the provider level, where additional paperwork is now required. Vigilance by states and MCOs is needed in this area, because increasing the bureaucracy and administrative burden has adverse implications for both cost and service delivery.

A few states report cost savings simply because the behavioral health budget was cut before implementing managed care. Respondents in 8 of the 10 states studied reported cost savings associated with reductions in inpatient hospital use. However, in one state, increased access to services and greater utilization of outpatient and community-based services have offset any savings that might have been associated with reductions in inpatient care.

The effect of managed care on behavioral health costs in other systems, such as juvenile justice, special education, and child welfare, must be determined as well. For example, interviewees from the juvenile justice and child welfare systems in eight states in the study sample suggested that their costs were going up as a result of managed behavioral health care reforms. Most states, however, are not systematically tracking the cost shifting that may be occurring across the systems caring for these children, and these remain anecdotal and impressionistic reports.

A concern for children is that the capitation and case rates paid to MCOs are based on data of poor quality. Respondents in 4 of the 10 states studied report that the lack of good historical data on the utilization of behavioral health services for children led to establishing unrealistically low rates. Low capitation or case rates create incentives for MCOs and providers to limit services to enrollees, making it likely that those with behavioral health treatment needs will be underserved. The risk of underservice is greatest for children and adolescents with serious and complex disorders, since these youths are the most expensive to serve. The challenge of rate setting is compounded for children because in many instances, the broader service array envisioned for the managed care system has not yet been fully developed. Also, behavioral health services are spread across multiple children’s systems. At least 3 of the 10 states studied have compensated by building in “floating” capitation rates, which are expected to change at specified intervals based upon new utilization or encounter data that is more reflective of the reformed system.

A related issue with which states are struggling is how to structure risk to ensure that providers are protected and that incentives to underserve recipients are minimized, particularly for persons with serious disorders. There are no proven methodolo-
gies or formulas available for behavioral health risk structuring to guide states in this area, particularly with respect to children and adolescents with serious emotional disorders. States are experimenting with different approaches, including stop-loss provisions, risk pools created by states to protect MCOs against losses, capitalization requirements for MCOs, and others. (The problems associated with pediatric risk-adjusted rates, and the issues of reinsurance and other shared-risk arrangements, are discussed more fully by Fox and McManus in this journal issue.)

Impact on Access and Service Delivery

It appears that managed care reforms are resulting in greater access to mental health and behavioral health services in several respects:

- Penetration rates have increased—more children are receiving mental health and substance abuse services than before.

- It appears to be easier to obtain a basic level of mental health and substance abuse care.

- Waiting lists and delays for services have been minimized because of system standards that prohibit them.

Despite these improvements in access, HCRTP findings suggest that it is more difficult for youths with serious emotional disorders to obtain necessary services under managed care. These youths tend to be high service utilizers, and are often involved with multiple agencies; they pose a particular challenge to managed care systems because they tend to require services at varying levels of intensity for extended periods of time. Managed care systems that limit behavioral health benefits must determine how extended care needs for these youths will be met. There are indications that this group fares better in carve-out situations, in which there are better prospects for a planning process focused on their needs. Several states, realizing that their managed care systems are not meeting the needs of this group, are engaged in planning processes to design managed care strategies that will address the needs of this vulnerable population more effectively.

A pressing issue brought up in four states was the dwindling resources available to serve youths with emotional and behavioral disorders who are not eligible for Medicaid. For these children and adolescents—the near-poor or those who have exhausted their insurance benefits—services have been harder to obtain since the implementation of managed behavioral health care. As increasing portions of state mental health budgets are used to fund Medicaid services, as well as those services not included in managed care contracts for Medicaid recipients, the behavioral health needs of this non-Medicaid group may be increasingly
neglected. The recently enacted State Children’s Health Insurance Program (Title XXI of the Social Security Act) may help states redress this problem.

Across the states studied, findings indicate that managed behavioral health care has made it easier in 7 states to obtain home- and community-based services, but more difficult in all 10 states to gain access to inpatient hospital care. Managed care reforms have made it easier, in states that have used behavioral health carve-out designs, to provide flexible, individualized services. However, the use of managed care to finance the delivery of publicly funded behavioral health care for youths has not solved preexisting problems with service capacity, nor has it diminished the need for states to invest in service-capacity development. Interviewees reported that MCOs expected providers to develop services on their own initiative, but that providers were not willing to take such risks without knowing which services would ultimately be purchased by MCOs. To promote the availability of behavioral health services, three of the states studied are structuring their managed care systems to require or encourage the investment of any profits beyond a specified level in creating new services. The development of service capacity is particularly important for children and adolescents, for whom, historically, there have been enormous gaps in the range and availability of mental health and behavioral health services.

One of the major effects of managed care on direct service delivery is a discernible trend (noted in all 10 states) toward briefer, more problem-focused treatment approaches for behavioral health problems. Many respondents welcomed this shift, because in the past, children often were kept in treatment for unnecessarily long periods of time. However, respondents also complained about time-limited treatment being inappropriately applied when children and their families needed more long-term services for serious or complex problems.

In six states, the implementation of managed care for Medicaid-covered behavioral health services has improved the availability of case management services appropriate for youths with emotional disorders. To improve the effectiveness of case management services, Arizona implemented two levels of case management: one level focuses on service coordination, and the second level involves intensive case management interventions and coordination for children with serious emotional disorders. The HCRTP also explored interagency treatment and service planning whereby representatives of all involved child-serving agencies come together, in partnership with the family, to jointly develop and implement a coordinated, individualized service plan for the child and family. In five of the states studied, requirements for interagency service planning were included in managed care systems, but stakeholders in only three states indicated that this is actually occurring to any great degree.

Impact on Family Involvement and Cultural Competence

Families of children and adolescents with emotional disorders typically were not involved in planning, designing, or implementing managed care systems. Findings from the HCRTP show that this was the case even in states with strong family-advocacy organizations, indicating that the system-of-care philosophy of involving families at all levels of the system was not initially adopted by managed care systems. In some states, efforts to create avenues for family input and involvement are occurring, but not until after the initial design and implementation of managed care. States are beginning to create family advisory groups, include family members of youths with emotional disorders on established planning and advisory bodies, hold focus groups, consult with family organizations regularly, and hire family advocates to fulfill various roles within managed care systems.

In 7 of the 10 states visited, stakeholders indicated that managed care reforms have
not affected the overall level of cultural competence in the system and that little attention was given to cultural issues in the initial planning and implementation of the reforms. In most states, managed care has not resulted in significant changes in the availability of culturally diverse providers or in culturally appropriate service delivery for children and families of color. Some states are making efforts to incorporate cultural competence goals into managed care. Six states have some requirements related to cultural competence, for example, that culturally and linguistically diverse providers be included in provider networks. Other states, including Washington and Arizona, have ensured that services such as interpreters and indigenous providers—for instance, Native American healers—are incorporated into managed care networks. Despite these efforts, the need to improve the cultural competence of service-delivery systems is a longstanding problem that remains a challenge regardless of managed care reforms.

Impact on Systems of Care and Interagency Relationships

A major concern emanating from the study is that, in half of the states, ongoing initiatives to develop community-based systems of care for youths with serious emotional disorders and their families are proceeding separately from, and without much connection to, the managed care initiatives. In these states, little thought was given to how the system-of-care philosophy could shape and guide managed care arrangements for behavioral health, especially for children and adolescents with serious emotional disorders. In the other five states, the introduction of managed care was reported to be supportive, to some degree, of the development and ongoing functioning of systems of care, with substantial local variation in interpretation of various aspects of managed care, depending upon local “buy-in” to the system of care concept. These five states incorporated at least some system of care principles as requirements in their managed care systems.

The HCRTP found that when the system-of-care philosophy was not incorporated into managed behavioral health contracts, along with compliance monitoring, it was not likely to be implemented by MCOs. Requirements for a broad array of community-based services, family involvement, interagency coordination, and cultural competence were unlikely to be implemented without strong mandates that they be a part of the Medicaid managed care system for behavioral health.

The lack of interagency coordination among agencies caring for children with emotional and behavioral disorders continues to be a problem under managed care. The HCRTP found that other systems—including child welfare, education, and juvenile justice—usually were not consulted or involved in planning for managed behavioral health care. The lack of interagency involvement has created new problems, or has exacerbated preexisting problems, in some states. To address this issue, Arizona has convened a “process improvement team” of mental health and child welfare representatives to develop strategies addressing intersystem problems that have arisen. Similarly, Iowa is using “roundtables” to obtain input from other agencies. Respondents in eight states indicated that managed care reforms may actually improve interagency collaboration by default, forcing systems to come together to resolve problems and issues created by the initial implementation of managed care systems. In seven states, however, managed care reforms have reportedly aggravated the problems of determining which system is responsible for delivering and paying for services to individual children and families. Cost shifting from the managed care system to other systems (especially child welfare and juvenile justice) was alleged by stakeholders in eight states, although states are not systematically tracking this.

Children involved with the child welfare system because of a history of abuse or neglect comprise a population that is especially challenging to managed care systems. A range of problems is associated with providing behavioral health services to this group, including a lack of coverage for

Minimal integration between child welfare and Medicaid managed care exists in most states.
sexual abuse treatment; MCOs discharging children from hospitals without regard to the availability of safe placements; disagreement between courts and MCOs regarding treatment needs; children relocating and requiring shifts in MCOs or providers; and children moving in and out of the Medicaid managed care system based upon changing involvement with child welfare, which determines their eligibility. Although states are working through these problems, minimal integration between child welfare and Medicaid managed care exists in most states.

Impact on Mental Health Providers
Managed behavioral health care may influence several aspects of provider practice, including clinical decision making and practice patterns; credentialing and licensing requirements; and the inclusion of small or nontraditional agencies in provider networks.

Identifying the flow of clinical decision making is critical for managed care systems. This identification encompasses a determination of how, by whom, and on what basis decisions will be made about the type, amount, and duration of services for each child or family. The medical necessity criteria that guide these decisions are open to interpretation, and many respondents reported that such criteria are inconsistently applied across different MCOs, geographic areas, and individual cases. Some complained that the medical necessity criteria are too narrow, particularly for behavioral health services targeting children and adolescents. Iowa has responded by developing “psychosocial necessity criteria” appropriate for this population. Further complicating the decision-making process is the lack of well-developed practice guidelines for the delivery of mental health services for children and adolescents. Although this problem extends well beyond the boundaries of managed care systems, the lack of well-developed guidelines for clinical decision making for children and adolescents forces each state and/or MCO to develop its own practice guidelines.

Of all of the managed care techniques used to influence practice patterns and control service delivery, the one that has generated the most concern in the area of mental health services is prior authorization, which requires that recipients receive authorization from their MCOs for behavioral health services. MCOs often are perceived as micromanaging care by requiring authorization for every service provided. From the perspective of MCOs, however, this requirement is a tool to prevent the overutilization or unnecessary utilization of services. Concerns about this requirement seem to be alleviated in situations in which providers have the flexibility to provide a specified number of outpatient visits without obtaining prior authorization, or in which only more intensive services—such as day treatment, residential care, or inpatient services—require prior authorization. Complaints about prior authorization are largely eliminated when providers are involved in subcapitation payment arrangements with MCOs (through which they are at financial risk), offering them more flexibility and control in making clinical decisions.

The HCRTP also found that credentialing and licensing requirements for providers have changed in five states with the implementation of managed behavioral health care. In some instances, managed care has made the requirements for staff working with children and adolescents more rigorous, and has excluded certain providers, such as paraprofessionals, substance-abuse counselors, and bachelor’s- or even master’s-level staff. To ensure that the availability of mental health providers is not reduced, a few states have adopted provisions to allow these providers to offer services as long as they are under the supervision of credentialed staff within an agency. Respondents in five states, however, reported that managed care reforms have resulted in an expanded array of providers in the system.

Results from the HCRTP show that smaller agencies and nontraditional agencies and providers often have a more difficult time surviving under managed care.
They may not meet credentialing standards or have the requisite administrative and financial capacity needed to participate in managed care networks unless they affiliate or merge with larger agencies. It is important to note that the agencies that have served culturally diverse populations tend to be smaller and less traditional, and thus are likely to experience some of these problems.

**Impact on Accountability**
Greater accountability for the delivery of behavioral health services, and an increased focus on outcome and quality indicators, are potential benefits associated with managed care. However, early results from the HCRTP suggest that the development of quality measurements and the use of outcome data for evaluating behavioral health services for children and adolescents are rare. The 1995 state survey revealed that states were monitoring managed care plans with respect to cost, access to services, and utilization patterns; less attention was given to the measurement of clinical and functional outcomes. However, clinical and functional outcomes were more likely to be tracked in states with carve-out designs for behavioral health services than in states that used integrated systems for the delivery of physical and behavioral health services. Only a few states (Utah and North Carolina, for example) had defined measurable outcomes for youths with behavioral health disorders, and were monitoring the managed care system for these. During the impact analysis, stakeholders in seven states reported some efforts to assess the quality of services, with the major focus on the process of service delivery. The measurement of clinical and functional outcomes is at an early stage of development, especially for children and adolescents; six states reported that the development of outcome measurement systems is in process.

With respect to utilization patterns, respondents reported that hospital admissions and/or lengths of stay for psychiatric disorders had been reduced in 8 of the 10 states visited as a result of managed behavioral health care reforms. Three states reported increased recidivism rates. Five states reported increases in the use of residential treatment, often outside the managed care system—a change attributed by many respondents to the tighter controls on inpatient use. The use of home- and community-based services was reported to have increased in 7 of the 10 states.

**Conclusion and Recommendations**
The adoption of managed care arrangements to finance and deliver Medicaid behavioral health services is occurring rapidly. The HCRTP will continue to describe and analyze how this shift to managed care affects children and adolescents with behavioral health problems and their families. Current findings from this project provide some important lessons to direct future policy and planning efforts. The following recommendations, which emanate from stakeholder interviews, are relevant for system planners and administrators as well as for providers, families, and advocates as they continually strive to refine both the design and the operation of their managed care systems.

**System Planning**
- Use the system-of-care philosophy to shape the design and implementation of managed behavioral health care systems.
- Include requirements in requests for proposals (RFPs) and managed care contracts for such features as a broad array of behavioral health services for children and adolescents, interagency service planning, flexible and individualized care, family involvement, and cultural competence.

**Stakeholder Involvement**
- Include families of children with behavioral health problems in the planning, implementation, and refinement of managed care systems.
- Create opportunities for agencies that serve children and adolescents to offer...
input, participate in designing managed care systems, and participate in ongoing problem solving and system refinement to ensure that systems are more responsive to the needs of youths and their families.

**Access and Service Delivery**
- Ensure that states and managed care organizations invest resources in building needed service capacity for behavioral health services for children and adolescents and their families.
- Ensure that a dedicated process is adopted to plan and manage service delivery for children and adolescents with serious emotional disorders.
- Develop strategies to provide services to children and adolescents who are not Medicaid eligible, but who are dependent upon the public sector for behavioral health services.

**Data and Evaluation**
- Improve data and methodologies for establishing appropriate capitation and case rates, as well as adequate risk-adjustment strategies to minimize incentives for underserving children and adolescents and to protect providers from undue financial risk.
- Conduct or support research and evaluation on the effects of managed care on youths with behavioral health problems and their families.

**Advocacy and Oversight**
- Ensure strong leadership, advocacy, and oversight at the national, state, and local levels so that the needs of youths with emotional disorders and their families will be met within managed care.

Because the HCRTP is still under way, these recommendations are broad and primarily focus on the development and refinement of managed behavioral health systems for children and their families. After this study is complete, additional recommendations will address more specific features of the delivery system that may improve behavioral health outcomes for the vulnerable population of children and adolescents with behavioral health disorders and their families who depend on public systems.

6. Children with serious emotional disorders are defined as those from birth to 18 years of age who currently, or at any time during the past year, had diagnosable mental, behavioral, or emotional disorders of sufficient duration to meet criteria in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM III-R), resulting in functional impairment that substantially interfered with or limited their role functioning in family, school, or community settings. See Friedman, R., Kutash, K., and Duchnowski, A.J. The population of concern: Defining the issues. In Children’s mental health: Creating systems of care in a changing society. B. Stroul, ed. Baltimore, MD: Paul H. Brookes Publishing Company, 1996.


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23. The 10 states selected for site visits included Arizona, Connecticut, Delaware, Iowa, Massachusetts, North Carolina, Oregon, Rhode Island, Utah, and Washington.


25. Capitation funding is a method of at-risk contracting that provides preset, prospective funding based on the total number of persons covered by the benefit plan. Case-rate funding is a method of at-risk contracting that provides preset, prospective funding assigned on the basis of the number and type of enrolled persons who present for services, as opposed to the number of persons covered by the plan.