
VI. Special Provisions for Youth with Serious and Complex Behavioral Health Needs

Incorporation of Special Provisions for High Need Populations

An issue emphasized by stakeholders in both of the impact analyses is the need for managed care systems to incorporate special services, arrangements, or provisions for children and adolescents with serious and complex behavioral health needs and their families: children and adolescents with serious emotional disorders, children and adolescents involved with the child welfare system, and children and adolescents involved with the juvenile justice system. Many barriers to serving these high need populations were cited, including:

- Medical necessity and other clinical decision making criteria are rigid or applied too stringently making it difficult for children with serious and complex needs to obtain authorization for services.
- MCOs often do not participate in local interagency service planning processes for children with serious and complex needs.
- Managed care systems may include unintended financial incentives to underserve consumers with the most serious (and potentially most expensive) service needs.
- There has been a tendency within managed care systems to emphasize short-term treatment, which is not appropriate or sufficient for high utilizer populations with serious disorders.
- There has been a lack of understanding of the special legal, logistical, coordination, and treatment needs of children involved in other child-serving systems.

Both previous state surveys explored whether special provisions were incorporated for the population of children and adolescents with serious emotional disorders. Forty-four percent of the reforms in 1995 and 49% of the reforms in 1997–98 reported doing so, indicating a slight increase and perhaps a beginning trend to consider the special needs of this population in managed care system planning and operation. In 1997–98, reforms with carve out designs were twice as likely to have some type of differential coverage or special provisions for children with serious emotional disorders than those with integrated designs.

The 2000 State Survey results show a dramatic increase in the incorporation of special provisions for children and adolescents with serious emotional disorders (**Table 34**), with a shift from less than half of the reforms having any special provisions to the majority of reforms indicating that they now do. Overall, 93% of the reforms reportedly include one or more special provisions for this population— all of the carve outs and 71% of the integrated systems— reflecting a 44% increase from 1997–98. This shift may be the result of recognition of the special needs of this population over time, due to the many problems and challenges encountered in attempting to serve them within the context of managed care systems. The findings continue to reflect the previously established pattern of a greater likelihood of special provisions in managed care systems with carve out designs; however, a substantial proportion of integrated systems also reported having some special provisions for this group.

Table 34 Percent of Reforms with Special Provisions for Children and Adolescents with Serious and Complex Behavioral Health Needs							
	1995 Total	1997-98 Total	2000			Percent of Change	
			Carve Out	Integrated	Total	1995 -2000	1997/98 -2000
Children and adolescents with serious behavioral health disorders	44%	49%	100%	71%	93%	+49%	+44%
Children and adolescents in the child welfare system	Not Asked	Not Asked	91%	71%	87%	Not Asked	Not Asked
Children and adolescents in the juvenile justice system	Not Asked	Not Asked	61%	57%	60%	Not Asked	Not Asked

Though not assessed in previous state surveys, in 2000, 87% of the managed care reforms also reportedly have special provisions of some type for children and adolescents in the child welfare system, and nearly two-thirds (60%) have provisions for children and adolescents in the juvenile justice system.

Types of Special Provisions

Of the special provisions for children and adolescents with serious emotional disorders, as shown on **Table 35**, most take the form of interagency treatment and service planning, intensive case management (each found in 86% of the reforms with special provisions), an expanded service array, or family support services (each found in 79% of the reforms with special provisions). More than half of the reforms (57%) reported using wraparound services as a special provision for children with serious emotional disorders. However, only 29% of the reforms with special provisions include a higher capitation or case rate for these youth, a finding consistent with the 1997-98 data and representing a small (9%) decline in the use of financial incentives for this group. This suggests that although special provisions such as expanded services or intensive case management are included, the resources to provide these additional services to this high need population may not be sufficient.

Special Provisions	1997-98 Total	2000			Percent of Change 1997/98-2000
		Carve Out	Integrated	Total	
Expanded service array	90%	78%	80%	79%	-11%
Intensive case management	86%	87%	80%	86%	0%
Interagency treatment and service planning	57%	91%	60%	86%	+29%
Wraparound services	71%	57%	60%	57%	-14%
Family support services	67%	83%	60%	79%	+12%
Higher capitation or case rates	38%	30%	20%	29%	-9%
Other	0%	26%	0%	21%	+21%

Of particular note is the reported increase in the use of interagency treatment and service planning, reportedly used in 86% of the reforms with special provisions, up from 57% in 1997-98. This 20% increase is accounted for by increased use of interagency treatment planning in carve outs; the use of interagency treatment planning among reforms with integrated designs remains at the 1997-98 level of 60%. Of some concern are declines in the incorporation of an expanded service array and wraparound services for youth with serious emotional disorders — down 11% and 14% respectively of the reforms with special provisions from 1997-98 to 2000.

The special provisions incorporated for youth in the child welfare and juvenile justice systems are similar to those for the population of youngsters with serious emotional disorders (**Table 36**). For children involved with the child welfare system, special provisions are most frequently in the form of interagency treatment and service planning (77% of the reforms with special provisions for this group) and an expanded service array (73% of the reforms with special provisions for this group). Similarly, for the juvenile justice population, the special provisions incorporated most frequently are an expanded service array (found in 94% of the reforms with special provisions for this group), interagency treatment and services planning (83%) and intensive case management (78%).

Special Provisions	2000					
	For Children Involved in the Child Welfare System			For Children Involved in the Juvenile Justice System		
	Carve Out	Integrated	Total	Carve Out	Integrated	Total
Expanded service array	67%	100%	73%	93%	100%	94%
Intensive case management	62%	60%	62%	86%	50%	78%
Interagency treatment and service planning	76%	80%	77%	93%	50%	83%
Wraparound services	67%	60%	65%	71%	50%	67%
Family support services	52%	40%	50%	71%	25%	61%
Higher capitation or case rates	14%	20%	15%	14%	25%	17%
Other	10%	0%	8%	14%	0%	11%

A notable difference in the types of special provisions incorporated for these three populations is that intensive case management is a less common strategy for children in child welfare than the other two groups, perhaps because child welfare staff fulfill the case management function. In addition, family support services are much more likely to be included for children and adolescents with serious emotional disorders than for the child welfare or juvenile justice populations. Wraparound services, reportedly provided by about two-thirds of the reforms with special provisions for the child welfare and juvenile justice populations, are slightly less likely to be included as a special provision for youth with serious emotional disorders.

Promising strategies described by respondents to incorporate special provisions for high need populations include the following:

- In **Missouri**, a consortium of state agencies (Interdepartmental Initiative for Children with Severe Needs and their Families) has integrated funding to support comprehensive systems of care for behavioral health services for children and adolescents. Care management organizations are responsible for organizing and delivering locally organized systems of services and supports.
 - **Oklahoma** offers an expanded service array, beyond the basic behavioral health services included in the benefit, to children with special behavioral health needs including home-based services, rehabilitative case management, and therapeutic foster care.
 - The Clinical Services Management Model used in **Delaware** provides a clinical services management team and service coordinator to plan, deliver, monitor, and coordinate services to children with serious behavioral health needs. Additionally, the Care Assurance Model has no predetermined benefit limits.
- (Promising strategies continued on next page)

(Promising strategies continued)

- In **Texas**, a specialty provider network within the larger North Star Program ensures that individuals with serious needs have providers with experience and knowledge about more complex behavioral health problems as well as a history of providing specialized services to these populations.
- In Marion County, **Indiana**, the Dawn Project provides an organized system of care using a managed care approach to serve youth with serious and complex behavioral health needs. Similarly, the Children's Intensive Services Project in **Oregon** creates integrated systems of care for this population.

Two states described promising strategies for incorporating special provisions to meet the needs of the child welfare population.

- In **Maryland**, all children entering the child welfare system are to be screened for mental health problems and appropriate referrals made to the managed care system.
- The child welfare agency in **Oregon** hired regional coordinators to assist case workers in working through access barriers for medical and behavioral health care in the managed care system and to solve problems. The regional coordinators have frequent contact with local MCOs and with the state mental health agency.

Case Management/Care Coordination for Children with Serious and Complex Behavioral Health Needs

The 1997 Impact Analysis found that case management services were expanded to some degree in nearly two-thirds of the states included in the sample. However, very different results were found in the subsequent 1999 Impact Analysis. In the 1999 sample, only one state reported expansion of case management services related to the managed care reform (a state that had added targeted case management services that were not previously covered). Further, two states in the 1999 sample reported that case management services were actually constricted as a result of the managed care reform, due to such factors as the need for authorization, greater emphasis on utilization management as opposed to accessing and coordinating care, and a perception that case management services are neither approved nor reimbursed as readily as under previous fee-for-service systems.

Given these conflicting results, the 2000 State Survey was used to clarify this area and to further assess the effects of managed care reforms on case management/care coordination services. The survey specifically investigated the effects of managed care on case management for children with serious and complex behavioral health needs. As shown on Table 37, in most reforms (71%), case management/care coordination services for this population reportedly have increased as a result of the managed care reform. However, there are notable differences between reforms with carve out and integrated designs with respect to case management. Nearly 80% of the carve outs, but only 42% of the integrated systems reported increased case management attributed to the managed care reform. Additionally, no carve outs reported

decreased case management, compared with 29% of the integrated systems in which case management/care coordination services reportedly have been compromised as a result of the managed care reform.

Table 37 Effects of Managed Care Reforms on Case Management/Care Coordination Services for Children and Adolescents with Serious Behavioral Health Disorders			
	2000 Percent of Reforms		
	Carve Out	Integrated	Total
Increased case management/ care coordination	79%	42%	71%
Decreased case management/ care coordination	0%	29%	6%
No effect	21%	29%	23%

Promising strategies related to case management services for children with serious and complex behavioral health need were cited by several states.

- **Delaware's** Clinical Services Management Model provides a clinical services management team and a service coordinator to youth with serious and complex needs.
- In **Texas**, children with complex needs are assigned to specialty network providers who have expertise in the provision of case management and wraparound services.
- In **Missouri**, MCOs are contractually required to provide case management services for all special needs children.
- MCOs in **Arizona** provide intensive case management to youth during out-of-home placements and transition care coordination to the outpatient provider network when the child returns to the home or community.

Support and Facilitation of Systems of Care

An important focus of the Tracking Project has been to assess the link between efforts to develop community-based systems of care for children and adolescents with serious behavioral health disorders and their families and managed care initiatives in states.

The 1997–98 State Survey explored whether managed care reforms “built on” previous efforts to develop community-based systems of care. The survey found that 85% of reforms were characterized by respondents as having been built on previous or ongoing efforts to develop systems of care, with striking differences between carve outs and integrated systems in response to this item. All carve outs reportedly were building on previous system of care initiatives, compared with only about half (54%) of the integrated reforms.

The 2000 State Survey took a slightly different perspective and examined whether managed care reforms, in general, have facilitated and supported the further development of local systems of care for children and adolescents with serious behavioral health disorders. In response to this question, 75% of the reforms were thought to facilitate and support local systems of care (**Table 38**).

Table 38			
Percent of Reforms that Facilitate and Support the Development of Local Systems of Care for Children and Adolescents with Serious Behavioral Health Disorders			
	2000		
	Carve Out	Integrated	Total
Reforms facilitate and support local system of care development	88%	29%	75%
Reforms do not facilitate and support local system of care development	12%	71%	25%

Similar to the earlier survey results, the difference between carve outs and integrated reforms was substantial. Managed care reforms are reportedly supportive of systems of care in the majority of the carve outs (88%) but in only 29% of the integrated reforms.

The impact analyses support these findings. In the 1999 Impact Analysis, for example, stakeholders in all but one reform with carve out designs felt that managed care reforms have generally supported and facilitated the development of local systems of care in communities, primarily by allowing for coverage and payment for services that are linked to the system of care philosophy and by creating incentives for the development and use of these services. However, this was not the case for integrated systems. In both impact analyses, stakeholders in most states with integrated physical health-behavioral health designs felt that managed care reforms impeded system of care development, based on their assessment that the design and features of the managed care system were discrepant with the system of care philosophy and approach. This is seen in the 2000 State Survey results, as only 12% of the carve outs, but 71% of the integrated reforms reportedly do not support the development of local systems of care, according to respondents.

Despite the consistent finding across Tracking Project activities that managed care reforms generally support systems of care (at least in carve outs), the impact analyses found that most states did not use managed care reforms as a *strategic opportunity* to advance system of care development. In both impact analyses, stakeholders in only about a third of the states in each sample reported that managed care reforms were used deliberately and planfully to advance the goal of developing community-based systems of care in communities across the state.

The all-state surveys also have examined the extent to which system of care values and principles have been incorporated into the reform's RFPs, contracts, service delivery protocols, and other key system documents — principles including a broad array of services, family involvement, individualized/flexible care, interagency treatment and service planning, case management/care coordination, and cultural competence.

The 1997–98 State Survey found striking differences between behavioral health carve outs and integrated systems in the extent to which system of care values and principles are included in their system documents, and thus incorporated into managed care systems. The 2000 State Survey found the same differences. **Table 39** shows that behavioral health carve outs have a much higher rate of inclusion of all of these principles. Nearly all (92%) include a broad array of services, family involvement, and interagency service planning; the other principles are included by more than 80% of the carve outs. None of the values and principles reach these high levels of inclusion in the integrated reforms. Most principles reportedly are included in about half (57%) of the reforms with integrated designs, with reports of greater inclusion of the values of family involvement and individualized care.

	1997–98	2000			Percent of Change 1997/98–2000
	Total	Carve Out	Integrated	Total	
Broad array of community-based services	72%	92%	57%	85%	+13%
Family involvement	79%	92%	71%	88%	+9%
Individualized, flexible care	79%	81%	71%	79%	0%
Interagency treatment and service planning	77%	92%	57%	85%	+8%
Case management	86%	85%	57%	79%	-7%
Cultural competence	81%	85%	57%	79%	-2%

The impact analyses also found that carve outs were more likely to include system of care principles, but some inclusion of system of care principles was observed in integrated systems as well. Of note is the observation that the incorporation of three of the principles as requirements reportedly has increased since 1997–98 — a broad array of community-based services, family involvement, and interagency treatment and service planning. These increases appear largely due to increased incorporation of these principles in integrated systems. □