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A REVIEW OF MANAGED CARE AS A TOOL FOR CHILD WELFARE REFORM IN ALAMEDA COUNTY

Bay Area Social Services Consortium
Center for Social Services Research
School of Social Welfare
University of California, Berkeley

Prepared for the

Alameda County Social Services Agency

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Center for Social Services Research (CSSR)

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Bay Area Social Services Consortium (BASSC)
Research Response Team

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A REVIEW OF MANAGED CARE AS A TOOL FOR CHILD WELFARE REFORM IN ALAMEDA COUNTY

Executive Summary

The convergence of numerous trends at the local, state and federal level provide county administrators of public child welfare agencies an unparalleled opportunity to initiate systemic reform of the delivery, management and financing of child welfare services. Federal and state initiatives regarding block-granting, utilization of Title IV-E waivers, a persistent high need for child protective services without a parallel increase in funding, increasing privatization of essential child welfare services, and what appears to be an unrelenting criticism of current child welfare practices are all promoting interest in large scale reform initiatives.

There is increasing interest in, and experimentation with, the application of managed care principles to the delivery, management and financing of child welfare services. While managed care methods began in private sector health care, they have now been applied to private sector behavioral health, public sector health care and public sector behavioral health. The perception that managed care practices in public health and public behavioral health have led to cost savings, while assuring satisfactory quality of services and access to care, has added to the interest in managed care in child welfare.

In the Spring of 1996, the Alameda County Social Services Agency (SSA) contracted with the Bay Area Social Services Consortium (BASSC) Research Response Team (RRT) of the Center for Social Services Research at the School of Social Welfare of the University of California, Berkeley (UCB) to investigate approaches for reforming the delivery, management and financing of child welfare services, with a critical look at the applicability of managed care principles and tools. BASSC assisted the county by: (1) compiling this policy briefing paper on

some of the trends, issues and challenges in reforming the child welfare system, (2) conducting a survey of Bay Area child welfare directors on their thoughts and actions regarding reform and managed care approaches and (3) convening a Bay Area forum to initiate an open dialogue in which to frame the issues, strategies and implementation tactics for changing child welfare services.[1]

This briefing paper aims to provide a balanced introduction to managed care and child welfare. This paper examines in depth one proposed innovation--managed care and child welfare--and briefly reviews other options for the reform of child welfare. The paper describes some of the essential features of managed care, examines child welfare out-of-home care trends that are frequently cited to support the application of managed care in child welfare, reviews select managed care experiments in child welfare as well as other options for reforming the child welfare system and details some of the challenges and issues that confront the implementation of managed care and child welfare. The materials from the participant surveys and the proceedings and discussions from the Child Welfare and Managed Care Forum are included herein.

Principal Findings

- The out-of-home care population in the state, Bay Area region and Alameda County continues to grow; this population in Alameda County has grown 34% from 1988 to 1995. The most significant change in the proportion of children in different placement types in Alameda County has been the growth of Foster Family Agency placements and the decline of children placed in Non-Kinship foster homes.
- There has only been one study that has empirically examined the application of managed care principles in child welfare (Wulczyn, Zeidman, & Svirsky,1997). While this study reported positive findings the study period was only for one year.

[1] Additional Support for the Forum was provided by the Zellerbach Family Fund.

- Current child welfare programs that utilize managed care practices vary significantly and few resemble managed care health plans. Most programs do not contain the full complement of managed care techniques such as preauthorization of visits, capitated rates, risk sharing strategies or investment in prevention and early diagnosis.
- Current managed care child welfare programs primarily focus on out-of-home care populations, although an increasing number are applying managed care principles to family preservation and support efforts and for the provision of mental health services to child welfare dependent children living with their parents. We are aware of no program that is applying these principles to emergency response services.
- Current managed care child welfare contracts vary significantly regarding the degree that outcome objectives are specified. Some contracts do a notable job of addressing the complex goals of modern child welfare. The capitated contract provides incentives that encourage movement of children through high-end care while performance based penalties and rewards address a variety of child safety and family functioning issues. This very complexity, however, raises questions regarding the grantors ability to monitor these contracts.
- Managed care and child welfare requires highly sophisticated, integrated and timely management information systems.
- There are numerous factors that are unique to child welfare that complicate the utilization of managed care principles including a very high proportion of involuntary clients, presenting problems that are heavily associated with poverty, poorly developed outcome measures and a lack of actuarial data.

In addition to managed care efforts, this study identified several local and national child welfare reform initiatives that focus on emergency response services, integrated service models, concurrent case planning, increasing family involvement in case planning and foster care and adoption reform.

Policy and Administration Considerations

Based on this objective and comprehensive review of reforming the management, delivery and financing of child welfare services we offer the following policy and administrative considerations.

Policy Issues

Child welfare reform efforts must weigh and balance the needs of children and families versus cost containment. Managed care and child welfare is a contracting strategy that attempts to purchase essential services while simultaneously removing economic incentives for unnecessary long term care and, in some models, placing controls over high cost services. While it is naïve to assert that public child welfare officials do not have a responsibility to provide and purchase cost effective services, the goal of cost containment and managed resource utilization must not overshadow the primary goals of the child welfare system--child and family service. Various managed care child welfare tools (e.g., margin rates) have been developed that attempt to limit the provider agencies financial risk, with the hope that financial concerns do not overshadow client need. However, to date, there has been no empirical examination of the question of whether managed care in child welfare encourages premature discharge from out-of-home care and subsequently puts children at risk for re-abuse or placement failure.

Child welfare reform efforts must contend with the question of whether privatization of social welfare services is a mechanism to promote innovation and efficiency or is a weakening of the commitment to public social welfare programs. While child welfare services in the US originated in the private sector (Leiby, 1978) patterns of privatization of child welfare services vary greatly across the country. Some areas of the country have long histories

of extensive privatization of some segments of the child welfare system (e.g., foster care in New York state and group home services in California) while other areas have less reliance on private sector agencies.

Experimentation with managed care and child welfare does not necessarily increase the public sector commitment to privatization. Deliberations or concerns regarding large-scale privatization should not obscure the examination of managed care and child welfare.

Managed care and child welfare are not isolated reform strategies. The patterns of experimentation with managed care and child welfare services vary tremendously. Some experiments, for example Hamilton County/FCF Management, have goals of cost containment and reduction of unnecessary out-of-home care placements.

Other areas have included managed care in very ambitious reform strategies. The state of Tennessee implemented a managed care child welfare program within a plan that encompassed consolidation of children and youth services at the state level and included revision of the role of the judiciary in children and youth issues. The state of Kansas implemented managed care while privatizing all child welfare services with the exception of emergency response. Managed care should be viewed as one element of child welfare reform efforts.

Many factors influence the duration of out-of-home care stays. The observation by Wulczyn, et al. (1997) that fiscal mechanisms can influence the discharge practices of providers, while worthy of examination, should not obscure the fact that numerous factors have been found to be associated with extended out-of-home care stays. Reform efforts to support effective reunification strategies (Berrick, Brodowski, Frame, & Goldberg, 1997) and efforts to expedite termination of parental rights in some cases have also been advocated.

Administrative Issues

The monitoring of large scale managed care models requires sophisticated MIS and contract monitoring abilities. The most sophisticated managed care initiatives also include elements of performance-based contracting that require clearly thought-out goals, objectives and outcome indicators. The data collection and data management requirements for monitoring these contracts require sophisticated activity and investment in computerization and software by both the grantor and grantee. It is unlikely that the CWS/CMS will be suitable for these efforts. The Hamilton County, Ohio/Magellan Public Solutions, Inc. contract made the development of an MIS a major requirement of Magellan Public Solutions, Inc.

The placement decision-making process in child welfare needs reexamination. Fully developed managed care programs closely monitor systems entry, resource utilization and remove financial incentives for high-end care. Child welfare systems could benefit from studying clinical decision-making models from behavioral health to more closely monitor client entries into group care. The crisis-oriented decision making process that is utilized by emergency response workers appears to be utilized on all other placement related decisions. The child welfare system needs to explore placement decision-making based on thorough multi-disciplinary assessments of child and family needs. Improvements in this essential element of resource management do not require conversion to the managed care model.

The Court system plays a role in the success or failure of a managed care child welfare system. Currently the court system holds a great deal of decision-making power in the child welfare system without bearing any risk or fiscal responsibility. The court system can control the timeline of the decision-making process in any given case in the child welfare system through a process of court delays and continuances. In the current context of over burdened

judicial juvenile dependency calendars, the court system has a great deal of room for reform. As managed care looks to engage the entire system in a more time and cost effective process, the role of the courts becomes an important part of the equation. Involving the courts in the exploration and decision-making process early may be an essential step toward assuring buy-in to a managed care system and other reform efforts.

Organized labor has an important role to play in considering managed care reform efforts. One possible implementation strategy for managed care includes an increase in the privatization of child welfare services. This privatization effort may be viewed by many organized labor groups as an effort to eliminate public child welfare case manager and/or social worker positions. As well, there exists the sentiment that private agencies are not as well equipped either organizationally or staff-wise to work with the most challenging children in the system. Therefore, the push to privatize services through managed care may seem like an effort to compromise both labors' and client needs.

Organized labor should be viewed as an important stakeholder in any reform effort in child welfare. Their opinions and concerns should be heard and considered through the reform process. The best reform efforts, including those involved with managed care, require the presence of all major stakeholders (labor included) into every step of the reform effort from investigation, to planning, to implementation and finally to evaluation.

Recommendations

The empirical support regarding the application of managed care practices to child welfare is minimal; there is no evidence to support the wholesale conversion of child welfare services to this management model. However, the observation by Wulczyn, et al. (1997) that

current out-of-home care payment strategies provide an incentive to the provider to maintain a stable population to cover costs and that this works as a disincentive to discharging children from out-of-home care appears warranted.

We conclude this paper by offering two recommendations which encourage experimentation with out-of-home care placement decision-making processes and fiscal contracting practices.

Recommendation 1: Apply the utilization review strategies that are central to managed care to the placement decision-making process.

Current placement decision-making processes too frequently rely on a combination of ad hoc practice wisdom, quick responses to placement failures, deadlines created by judicial reviews and county administrative pressures to control costs. Efforts to establish a comprehensive standardized process for the evaluation of child and families service needs should begin. Criteria need to be established for entry into various out-of-home care options and a thorough delineation of the service capacities of different out-of-home care resources should be completed. This information should be incorporated into practices of administrative oversight of placement decision-making.

Recommendation 2: Experiment with different models of contracting for out-of-home care services and establish an evaluation design that examines any effect these different contracting strategies may have on outcomes of child and family functioning, child safety, placement re-entry and length of stay.

Counties should implement contract strategies that: (1) utilize performance-based contracts with clearly defined performance incentives and penalties and comparison with (2) contracts that include a combination of capitated rates and performance-based incentives and penalties.

These two recommendations related to entry into out-of-home care placement and experimentation with different contracting strategies provide a reasonable next step for examining the promise of managed care and child welfare. An approach that couples program experimentation with program evaluation provides the best hope for effective reform of the child welfare system.

Section I.
Introduction

The convergence of numerous trends at the local, state and federal level provide county administrators of public child welfare agencies an unparalleled opportunity to initiate systemic reform of the delivery, management and financing of child welfare services.

Federal and state initiatives regarding block-granting, utilization of Title IV-E waivers, a persistent high need for child protective services without a parallel increase in funding, increasing privatization of essential child welfare services, and what appears to be an unrelenting criticism of current child welfare practices are all promoting interest in large scale reform initiatives.

Critics of the current child welfare system argue that the system insufficiently protects children (Finklehor, 1990), inadequately supports families, does a poor job serving communities of color, underrepresented Hispanic children and families (Ortega, Guillean, & Najera, 1996) while overrepresenting African American children and families; and that the social cost of child welfare intervention is too high (Besharov, 1990). It is little surprise that even the most dedicated child welfare professional may feel the current child welfare system is in need of reform.

There have been four major federal reform initiatives that have shaped current child welfare practice. The Adoption and Safe Families Act of 1997 (PL 105-89) included a variety of measures to encourage adoptions of dependent children including provisions of health care for adopted children with special needs, expedition of the consideration to terminate parental rights and financial incentives to states to increase the number of adoptions. The Child Abuse Prevention and Treatment Act of 1974 (PL 93-247) provided funding for model child abuse

prevention and treatment services and required that states establish protocols for the identification, reporting and investigation of suspected child abuse. The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) mandated services and procedures designed to prevent long-term, custodial foster care, promote permanency and provide adoption assistance to children with special needs.

The scope of child welfare services was expanded beyond child protection to include family support services through the Family Preservation and Support Services subpart of the Omnibus Budget Reconciliation Act of 1993 (PL 103-66).

Child welfare reform initiatives that have also received support include efforts to professionalize the Child Protective Services (CPS) worker, promote culturally competent child welfare practices, promote integrated services to children and families (Bruner, 1996) and to promote neighborhood based strategies of child protection and family support (U.S. Advisory Board on Child Abuse and Neglect, 1993).

The highly politicized and frequently conflictive relationships between public child welfare administrators and elected officials, organized labor and private-sector service providers make collaboration regarding child welfare reform very difficult. Distrust of motivations amongst all participants abounds.

This is the environment and these are the stakeholders who must evaluate the promise of the application of managed care and child welfare. Most efforts at child welfare reform have champions and critics but few efforts have elicited such passionate discussion as managed care and child welfare.

The perception that managed care practices in public health and public behavioral health have led to cost savings, while assuring satisfactory quality of services and access to care, has

added to the interest in managed care in child welfare. The creation of the Child Welfare League of America's Managed Care Institute, the continued interest in privatization of all types of governmental services, and the entry of for-profit companies into the child welfare service continuum (Ohio Child Welfare Waiver Increases Flexibility, 1997) have all been elements that have sustained the interest in the application of managed care principles in child welfare. It is estimated that there are 30 states that are experimenting with the application of managed care principles with some aspect of child welfare services (personal communication, Charlotte McCullough, August 5,1997).

Alameda County Social Services Agency - BASSC Research Project

In the Spring of 1996, the Alameda County Social Services Agency (SSA) contracted with the Bay Area Social Services Consortium (BASSC) Research Response Team (RRT) of the Center for Social Services Research at the School of Social Welfare of the University of California, Berkeley (UCB) to investigate approaches for reforming the delivery, management and financing of child welfare services, with a critical look at the applicability of managed care principles and tools. BASSC assisted the county by: (1) compiling this policy briefing paper on some of the trends, issues and challenges in reforming the child welfare system, (2) conducting a survey of Bay Area child welfare directors on their thoughts and actions regarding reform and managed care approaches and (3) convening a Bay Area forum to initiate an open dialogue in which to frame the issues, strategies and implementation tactics for changing child welfare services. [1]

[1] Additional support for the Forum was provided by the Zellerbach Family Fund.

BASSC researchers reviewed the literature on approaches for reforming child welfare services and compiled this policy briefing paper or comprehensive, objective analysis of the issues. As part of this review, we investigated implementation issues in child welfare managed care in other states' public systems. Prior to the forum, researchers surveyed public child welfare directors by telephone about their county's or organization's efforts and plans in reforming child welfare services. The Bay Area Forum on child welfare and managed care served to stimulate advanced thinking about managed care principles and tools and their appropriateness for implementation in child welfare services.

Policy Briefing Paper

This briefing paper aims to provide a balanced presentation of managed care and child welfare. Following this introduction, section two includes an appraisal of possible areas of child welfare services to be targeted for inclusion in managed care plans; a case study of selected child welfare trends in Alameda County/Bay Area Counties and results of a survey of BASSC child welfare directors regarding local reform efforts. Section three provides an introduction to the purposes, principles, tools and techniques of managed care and examines lessons learned from managed care in health and behavioral health and their application to child welfare. The fourth section of the paper outlines a review of select managed care child welfare programs from around the country. Section five details select non-managed care child welfare reforms from around the country. We discuss barriers and issues related to implementation of managed care in child welfare in section six. In Section seven we present on the proceedings and discussions from the Child Welfare and Managed Care Forum. Section eight summarizes the findings of the paper, offers policy and administration considerations and makes recommendations for change.

Contract and descriptive information regarding child welfare reform efforts in Kansas and Hamilton County, Ohio in addition to handouts from the Forum are included as Appendices.

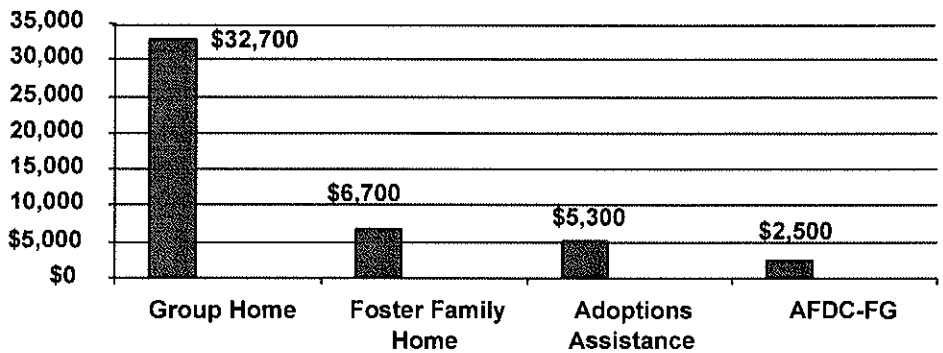
Section II.
Appraisal of the Current Child Welfare System

Possible Areas to Target for Managed Care

The child welfare system is being considered for managed care for several reasons including the reimbursement structure, diminished funding and rising costs. Currently, much of child welfare funding is based on a fee-for-service arrangement. This method of funding tends to create financial incentives to structure service provision in a manner that is inconsistent with some basic child welfare tenets (Wulczyn, Zeidman, & Svirsky, 1997).

There is some evidence that cost containment is possible within the child welfare system. The areas most amenable to saving money involve a shift of foster children out of expensive group homes and into foster family homes. A look at their relative cost makes this point clear. In 1995-96, it was estimated to cost $32,700 annually for a child in a foster care group home and $6,700 for a child placed in a foster family home (CA LAO, 1996) (See Figure 1).

Figure 1: 95-96 California Child Welfare Spending (per child/year)



Despite the great variance in cost of care, there is a dearth of empirical information justifying the placement of children in expensive group homes instead of specialized foster family homes (Chamberlain, 1990). Consequently, this area of the child welfare system is one in

which managed care tools may be useful in realigning the fiscal, clinical and ideological orientation in a way that better serves children and families. In fact, it is in these areas: family foster care, residential care and group care that most of the managed care applications to the child welfare system have been explored (McCullough, 1996). These divisions of the foster care system have received the greatest attention from managed care and are generally considered to be the most amenable to managed care, primarily because they serve high cost populations. Few programs have experimented with managed care within emergency response, family maintenance and preservation, or permanency planning.

Wulczyn, Zeidman, and Svirsky (1997) argue that numerous factors converge to support reforming the delivery, management and financing of child welfare services using managed care principles and techniques. Factors in New York state's foster care population that promoted experimentation included: (1) a 171% increase in the foster care population from 1986-1991, (2) a high rate of reentry of children back into foster care following discharge, (3) foster care caseload dynamics such as increased admissions and decreased discharges and (4) a per diem payment system for foster care where "the fiscal incentive for the provider is to achieve a stable base of care days to support the established cost of operation..." (Wulczyn, Zeidman, & Svirsky, 1997, p 263).

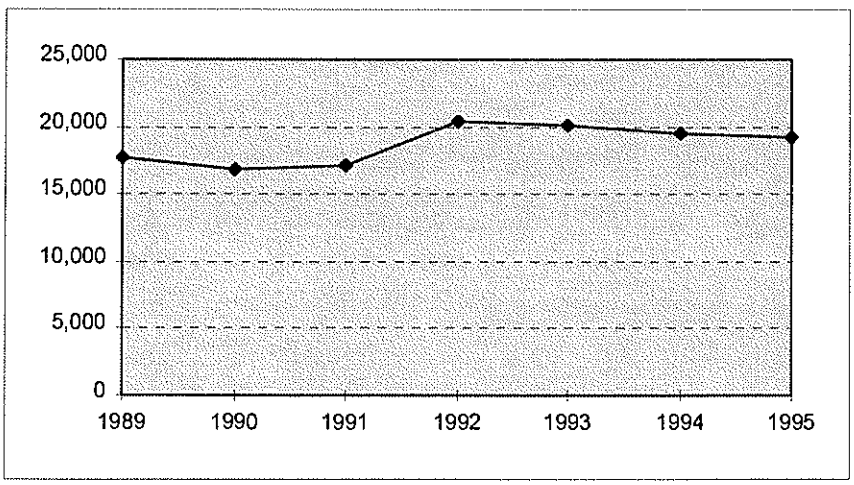
Local Issues --Alameda County

This section of the paper briefly examines child welfare indicators and out-of-home care population dynamics in Alameda County to see if similar trends that prompted the HomeRebuilders experiment in New York are evident in Alameda County. Data utilized in this analysis cover the years 1988-1995 and are drawn from Performance Indicators for Child

Welfare Services in California: 1994 and 1995 (Needell, Webster, Barth, & Armijo, 1996: Needell, Webster, Barth, Monks, & Armijo, 1995).

There has been a three year decline in the number of child abuse reports in Alameda County from 1992 to 1995 (See Figure 2). Reports have dropped from 20,442 in 1992 to 19,176 in 1995 representing a 6.2% decline. This decline follows a period of fluctuation from 1989 to 1992. This decline is similar to trends in the Bay Area Region, but is unlike statewide trends that have seen an annual increase for the past four years.

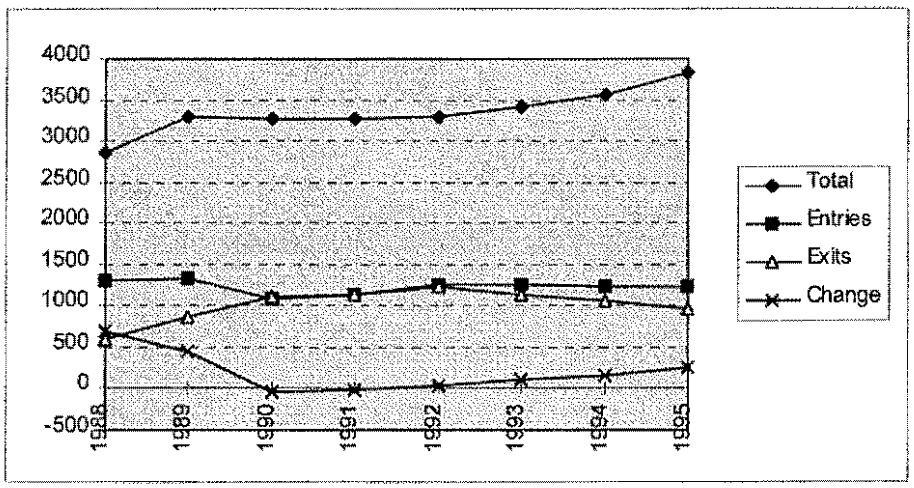
Figure 2: Number of Child Abuse Reports
Alameda County 1989-1995



The number of children under age 18 in the out-of-home care population in Alameda County has grown 34% from 1988 to 1995: the population increased from 2,855 children in 1988 to 3,830 children in 1995 (See Figure 3). Entries into out-of-home care have declined

slightly from 1,308 in 1988 to 1,222 in 1995 while discharges have increased from 605 in 1988 to 957 in 1995. For six of the eight years included in this analysis the net change in foster care activity (i.e., entries minus discharges) has been positive.

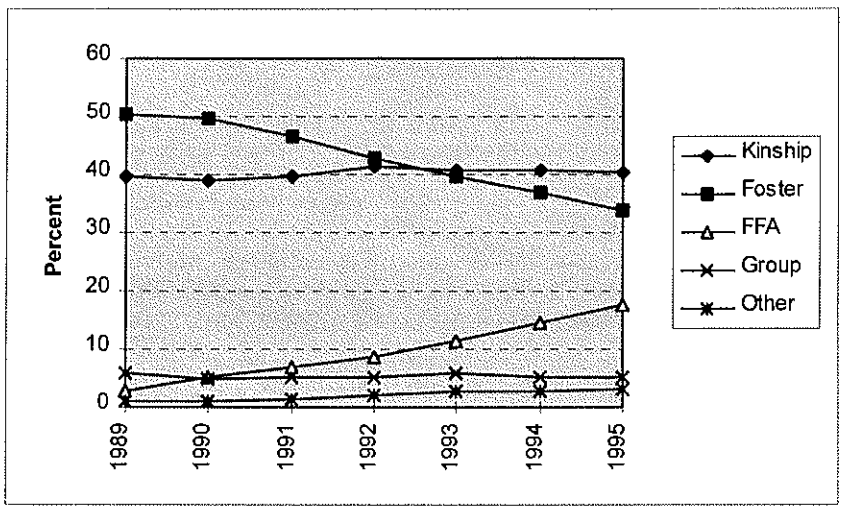
Figure 3: End of Year Out-of-Home Care Population
Alameda County 1988-1995
Entries, Discharges and Net Change



Analysis of the utilization of out-of-home care by placement type shows the proportion of children placed in Kinship Home and Group Home care has remained fairly stable from 1989 to 1995: the proportion of children placed in Kinship Homes has remained approximately 40% while the proportion of children placed in Group Homes had remained approximately 5% (See Figure 4). The proportion of children in Non-Kinship Foster Homes has dropped from 50.4% in 1989 to 33.9% in 1995. The proportion of children placed in FFA Homes has grown 532%; from 2.8% of placements in 1989 to 17.7% of placements in 1995. The proportion of children placed in the Other placement type has grown 300%, from 1% in 1989 to 3% in 1995. Other placement

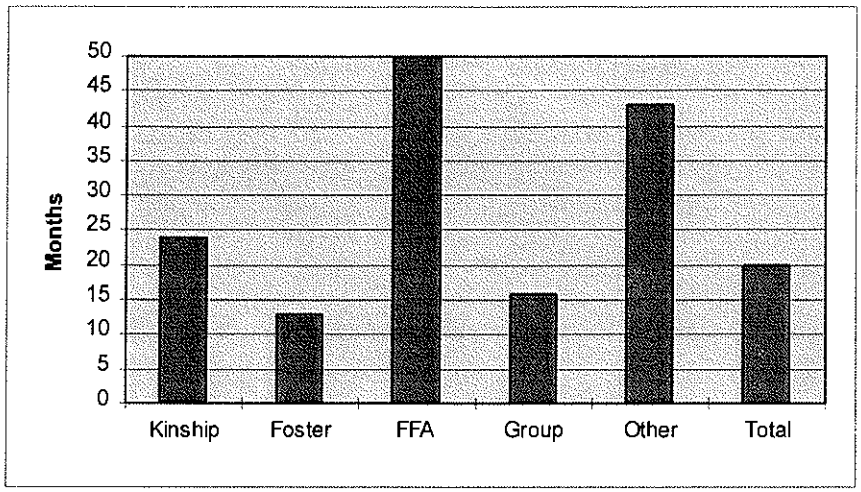
types are defined as "special small family homes, county shelters or receiving homes, medical facilities and other specialized pilot project homes" (Needel et al, 1995, p.1).

Figure 4: Percent of Children <18 by Placement Type
Alameda County, 1989-1995



Analysis of the median length of stay for children in out-of- home care shows considerable variation between placement types. Children placed in FFA Homes had the longest median length of stay at 50 months. Children in other placements (e.g., special small family homes, county shelter or receiving homes, medical facilities and specialized pilot project homes) had a median length of stay of 43 months, children in Kinship placements had a median length of stay of 24 months, children in Group Home placements had a median length of stay of 16 months and children in Foster placements had a median length of stay of 13 months (See Figure 5). The median length of stay for all children in placement in Alameda County was 20 months.

Figure 5: 1989-1995 Entries : First Spell Median Length in Months by Placement Type Alameda County



Alameda County Social Services Agency has seen a 34% growth in the out-of-home care population from 1989-1995. The proportion of children under Alameda County Social Services Agency supervision in out-of-home care has grown from 74% in 1989 to 83% in 1995 (Alameda Social Services Agency, 1995). There have also been significant shifts in which placement types are utilized: the number and proportion of FFA placements have grown considerably during the period of analysis. There has also been a considerable reduction in the number of placements in Non-Kinship Foster placements.

One promise of the managed care approach is that careful controls, through utilization management strategies, performance-based contracting and capitated rates, are placed over the systems most expensive services. The application of managed care principles to the out-of-home care placement process in Alameda County may provide some greater assurance that more expensive out-of-home care is utilized at a rate and duration that is consistent with both the child and family needs and the administrative direction selected by the county.

Regional Issues -- Survey of BASSC Counties

In an effort to assess local child welfare reform initiatives, BASSC researchers surveyed Child Welfare Directors of thirteen Bay Area counties in the summer of 1997. The survey was conducted as a preliminary needs assessment to collect background information on local efforts targeted toward the reform of child welfare services, in preparation for the BASSC Forum on child welfare reform and managed care, to be held in October 1997.

Table 1 provides a brief synopsis of each county's current child welfare reform efforts and is followed by a discussion of common themes from survey results

Table 1: Summary of Interview Results of Child Welfare Reform Efforts, by County

County	Current Reform Efforts in Child Welfare	Perceived Applicability of Managed Care	Needs and Barriers for Reform of Child Welfare System
Alameda	• using a managed care approach with several group home providers • Federal System of Care grant to provide integrated services • creating neighborhood units • changing case review processes	• exploring options cautiously • open to privatizing some direct services, but not emergency response	• need to develop capacity to provide services in a large network • need automated data-base • need to work with labor unions • technical assistance developing contracts and proposals • need non-categorical funding
Contra Costa	• concurrent planning • creating outcome-based service delivery model • piloting kinship care programs	• open to exploring managed care • not interested in privatization of services at this time	• need to have dialogues about which services to privatize • court should be involved in risk-sharing • labor union opposition may be strong • lack sufficient automated data-base
Marin	• AB 1741 • shortening length of time in placement • providing placement at lower levels	• cautious -- will it just create another funding stream?	• technical assistance for developing capitated rates • foundations may withdraw support • courts are potential barrier • waiting for Title IV-E waivers
Monterey	• evaluating internal system for necessary changes • emphasizing outcomes • implementing CWS/CMS	• interested in managed care, particularly for creating specialized rate for foster care	• more funding • more staffing
Napa	• integrated service delivery system • Federal System of Care grant	• interested in managed mental health care and applying concepts to child welfare system	• need better MIS • need model for strength-based family conferencing • CWS/CMS will greatly reduce productivity • courts are potential barrier

San Benito	• waiting for Title IV-E waivers before implementing changes	• not optimistic about the impact on quality of care and access to services	• more foster care homes • more mental health and substance abuse services • labor unions • lack of clear direction and leadership from state level
Santa Clara	• family group conferencing model • wrap-around services • decentralized and integrated services	• funding flexibility could allow for changing and improving expensive out-of-home care placement policies	• shortage of qualified foster homes • lack of flexibility in service provision and financial management • initial difficulties with MIS
Santa Cruz	• Federal System of Care grant • internal systems evaluation • implementing a data-base tracking system	• interested in redirecting funds saved through managed care • having discussions with neighboring counties	• technical assistance with setting rates • risk assessment • examine parallels with health and mental health • discuss community standards/identify "community" • labor unions • lack of information about other counties' and state's perspectives
San Francisco	• reduced caseloads for family maintenance and family preservation • multi-disciplinary review process for cases • improving cultural competency of services	• may provide more structure, accountability • not in favor of privatization	• more funding for prevention, earlier interventions • reduced case loads • more attention to cultural sensitivity
San Mateo	• line workers assigned by city, not function • concurrent planning • proposal to state to explore block-granted services with defined outcomes	• interested in exploring as management and funding strategy • not in favor of privatization	• maintain stable funding base • automated information system • labor unions should be partners in discussion

Solano	• Federal System of Care grant to provide integrated services • concurrent planning	• open to exploring the possibility, with an emphasis on the financial perspective	• internal systems must communicate more effectively • must examine lessons learned from managed care in health and mental health
Sonoma	• preparing to implement CWS/CMS • family maintenance	• wants to be pro-active on the subject • potentially useful for developing outcome measures and coordinated services • public sector can apply managed care principles	• models for implementing managed care in child welfare • technical assistance with capitated rates, developing provider networks, setting outcome measures
Stanislaus	• emergency response and family maintenance programs • family-focused group conferences • integrated, non-categorically funded programs with other departments	• applying a total quality management process to analyze out-of-home care costs • flexibility in funding where dollars can be reinvested	• more substance abuse services • greater flexibility in funding • courts may be barrier • categorical funding barriers • labor unions may oppose managed care • MIS inadequacies

* Note interviews with county representatives conducted during the summer of 1997

Several of the survey respondents reiterated similar ideas or thoughts, particularly when asked about needs and/or barriers in implementing child welfare reform. These common themes are presented below.

- Several counties are focusing on family maintenance, family preservation and concurrent planning.
- Many counties have created integrated service delivery systems using federal grants and other collaborative efforts with public health, mental health and probation departments.
- Counties are making concerted efforts to review cases in an effort to reduce the amount of time children spend in high-end care and shift those children to low-end care, when appropriate.
- Automated management information systems (MIS) are not adequate. Although the arrival of CWS/CMS is expected to produce an initial decrease in productivity, it may help managers and administrators obtain more information about child welfare cases. However, it may not be an effective MIS for keeping up with child welfare reform, and particularly with managed care, because it will not provide integrated information from public health, mental health, substance abuse and probation departments, which would be useful in tracking clients' utilization of multiple systems.
- Technical assistance is needed on a variety of topics including: developing capitated rates; examining parallels between managed care in health, mental health and child welfare; working with local providers to develop provider networks and comprehensive wrap-around services; risk assessment; and developing contracts and proposals.
- Courts and child welfare attorneys should ideally meet with family and service providers to come to an appropriate decision about each child. The discretion of the courts varies widely from county to county and in some cases, courts may order children to stay in high-end child welfare services, either out of necessity or because the court may not arrive at a timely review of the child's case. This may lead to an increased cost on the system that the county cannot control and may increase the financial risk to the county.

- Implementing managed care in child welfare does not necessarily require privatization of services. Several county administrators emphasized a belief that the power to remove a child from the home should remain in the public sector. A number of these administrators said that private, community-based providers could effectively deliver direct services, however initial case management should remain in the public domain.
- Child welfare directors shared the opinion that private, for-profit agencies will likely be interested in child welfare only if there is a profit to be made in this field. Unions may interpret the privatization of child welfare services as downsizing the public child welfare work force, which may cause significant conflicts.

Section III.
Overview of Managed Care and Lessons Learned

Brief History and Trends in Managed Care

The first managed care plans were designed to improve access and continuity of care while controlling costs. Staff and group model health maintenance organizations (HMOs) were developed by physician groups and activists attempting to provide high-quality, comprehensive care to communities and patients, emphasizing prevention, early intervention and financial savings (Scallet, Brach, & Steel, 1997). The first HMO model, established by industrialist Henry J. Kaiser and physician Sydney Garfield, flourished during WWII in Oregon and California and eventually became the Kaiser-Permanente HMO (Winegar, 1992). Federal legislation promoted the HMO model with the HMO Act of 1973 which provided start-up grants and mandated large employers to provide HMO coverage for employees. A period of expansion and innovation followed (Scallet, Brach, & Steel, 1997).

HMOs are structured around four common models: The Independent Practice Association (IPA) Model, Staff Models, Group Models and Network Models. IPAs are separate entities representing physicians and other providers that contract with health care organizations for services and pay physicians on a capitated basis. Staff models hire physicians on salary and on a closed panel. Group models contract with multispecialty physicians groups to provide services to members. Network models are made up of several physician groups. A hybrid of these models is the Preferred Provider Organization (PPO) in which payers negotiate discounted rates and incentives are built in for clients to choose selected providers. The trend with PPOs and managed care organizations in general is toward affiliation with large corporate insurance

companies through mergers and acquisitions. Managed care has increasingly shifted from the non-profit sector to a for-profit enterprise (Winegar, 1992).

The use of managed care principles in America's health care system has radically changed the way health care is delivered. Today, managed care plans are ubiquitous in the provision of physical health care and are rapidly entering the spectrum of behavioral health (i.e., mental health and substance abuse). Despite apparent differences between child welfare and health care, closer examination reveals some striking similarities. These similarities are mainly in the areas of fee structuring, level of care and evaluation. Both systems have had expensive services readily reimbursed, incentives to provide services in proportion to the reimbursement rate and outcomes that were not clearly defined (McCullough, 1996). Consequently, it is useful to understand managed care's impact on health care when considering applying these concepts to the child welfare system. Another reason health and behavioral health managed care information is important is that managed care tools and principles have not been widely applied to the field of child welfare, resulting in a dearth of managed child welfare data. This section will explain the basics of managed care, and examine the question of how managed care has affected the access, quality and cost of physical and behavioral health care.

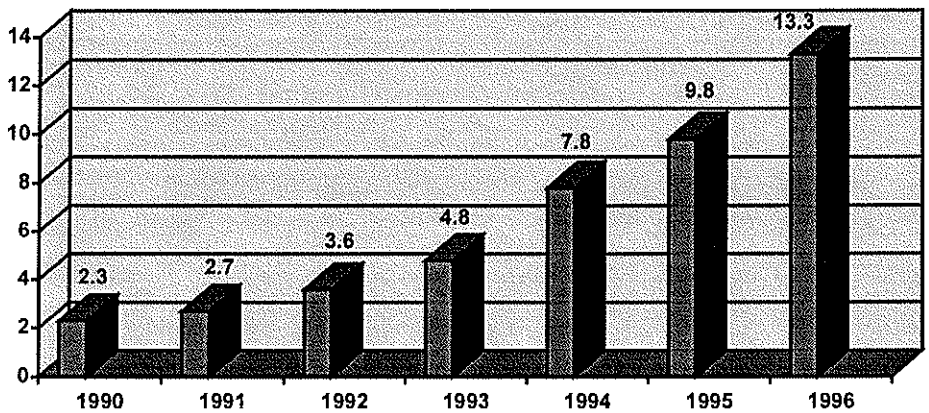
Public Sector Managed Care

Introducing managed care in the public sector has been accomplished according to §1115(a) and §1915(b) waivers of the Social Security Act granted by the Health Care Financing Administration (HCFA). Under §1115(a) States conduct "research and demonstration" programs and may operate Medicaid programs in ways that vary from federal statutory requirements. Waivers give states flexibility to establish guidelines for Medicaid eligibility, enrollment, benefits structure, and provider contracts. Thus far, they have been used primarily to expand

eligibility, share risk with providers, and expand enrollment for managed care plans (Emenheiser, Barker, & DeWoody, 1995).

Current waivers have allowed states to shift vast numbers of Medicaid recipients into managed care plans. Between 1990 and 1996, Medicaid managed care enrollment grew from 2.3 million to more than 13 million people (Rowland, Rosenbaum, Simon, & Chait, 1995; Health Care Financing Administration, 1996) (See Figure 6)

Figure 6: Growth In Medicaid Managed Care Enrollment (in millions)



The potential to institute managed care in the child welfare system will be greatly enhanced by similar waivers. The Federal government is in the process of granting such waivers to selected states so that innovations can be developed within the child welfare system. Some of the states that have received these waivers are in the process of developing and implementing managed child welfare initiatives.

Child welfare reform initiatives that are developed from a managed care perspective should include elements of basic managed care principles and tools. Successfully developing such reforms can be enhanced by an understanding of how they have previously been

implemented within the health and behavioral health care fields and what has happened as a result of their implementation.

Principles of Managed Care

Managed care is expected to help control costs, increase access to services, increase quality of care, integrate and coordinate services among multiple providers and increase the responsiveness of systems. In order to realize some of these benefits, managed care plans have been devised to incorporate several key principles and tools. These are briefly examined below.

Gatekeeping

Consumers enrolled in managed care plans access the plan through a single point of entry. This single point of entry is controlled by a "gatekeeper" who manages client access and eligibility for specialty services and service providers. Gatekeepers must maintain a thorough knowledge of resources and eligibility criteria in order to reduce unnecessary and costly care (Winegar, 1992).

The effect managed care has had on access to services in health and behavioral health is not particularly relevant to child welfare because client participation in the child welfare system is much less voluntary. A basic understanding of managed care and access, however, is helpful. Consequently, a brief outline of some recent findings that document managed care's effects on access to services is included below.

In a meta-analysis of 54 studies of managed care and fee-for-service health plans, Miller and Luft (1994) have identified some general trends regarding access to care. (The studies in their sample did not include Medicaid managed care plans).

- Hospital admission rates are generally lower in HMO's than fee-for-service (FFS) arrangements, although some differences are quite small.

- Hospital lengths of stay are generally shorter in HMO's than in FFS.
- There tends to be a greater use of preventive services in HMO's.

Results of managed care's impact on the access to services of Medicaid populations varies considerably but general findings include:

- A reduction in referrals for specialty services (Hughes, Newacheck, Stoddard, & Halfen, 1995).
- An increase in primary care physician utilization (Mueller & Baker, 1996).
- Little evidence indicating an increase in use of preventive services such as immunizations and prenatal care exists (Rowland, Rosenbaum, Simon & Chait,1995).

Many of the changes that have resulted from the use of managed care plans may result in positive outcomes for clients and the system but current data are insufficient to make such assertions. This significant question of quality will be addressed in the following section.

One final issue of importance is that as of 1995, less than one percent of all disabled Medicaid recipients were enrolled in managed care plans (Rowland, et al., 1995). Reasons for their under-enrollment, relative to the general Medicaid population, may include the difficulty in determining capitation rates for them and the fact that they are an expensive to care for population. Regardless of the reasons, this information raises concerns about the relationship of managed care and vulnerable populations.

Provider Network Development

Managed care is a primary force in sparking service integration and network development among providers. Integration of providers and formation of provider networks may be described as horizontal when similar types of organizations collaborate (e.g., private non-profit community mental health or child welfare agencies) or vertical when disparate types of providers form

partnerships (e.g., inpatient and outpatient services (Murphy, Vedder, Price, Kaufman, & Kammholtz, 1995).

Managed care models emphasize cost containment among providers and the development of systems of care that expand patient volume, expand geographic coverage and absorb actuarial risk. Providers are called upon to resolve inconsistencies between programs, determine the role of local public authorities and discern the level and type of administrative oversight to be conferred on third parties. Integrated service delivery systems have evolved which provide a comprehensive range of services for a capitated rate, allowing for greater control over management of utilization and quality of care (Murphy, et al., 1995).

Utilization Management

Utilization management consists of a critical examination of the appropriateness of levels of care provided to clients; its objective is cost containment. In health care, utilization management is intended to make sure that clients are appropriately cared for in the least expensive manner possible. Approaches to utilization management include preadmission certification and concurrent utilization review. Preadmission certification takes into account necessity for treatment and concurrent review assesses the appropriateness of current client care. The application of utilization management is important to the successful implementation of managed care but must be carefully considered as there is potential to save money at the expense of client services.

Tools and Techniques of Managed Care

Management of Information Systems

Adequate management of information systems (MIS) are indispensable to managed care for demonstrating efficacy of providers and systems. Performance outcome measurement is defined by "the regular collection and reporting of information on the efficiency, quality, and effectiveness" of services (Martin & Kettner, 1997). MIS has been demonstrated to facilitate and improve the delivery of human services (Grasso & Epstein, 1988).

Performance Outcome Measures

Egnew (1997) explains how the move toward capitated models in public sector managed care environments requires the development of outcome measures that ensure quality of services that are accessible, efficiently delivered and cost-effective.

The private sector has developed benchmarks or ranges for service categories that are measured in terms of penetration and utilization, which indicate whether appropriate utilization has occurred for a specific population or group (Christianson, Manning, Lurie, Stoner, Gray, Popkin, & Marriot, 1995). In order to develop successful managed care plans, the public sector should create similar measures of service provision.

Risk Sharing

Risk indicates the potential for financial loss or gain facing providers, payers and consumers. Fee-for-service represents the lowest risk for providers and the highest risk for payers. With capitation, providers assume the highest risk and payers the lowest. The continuum of risk arrangements is displayed in Table 2. Risk based contracting aligns financial

and clinical objectives such that the vendor is at risk for delivery of "the right treatment to the right person at the right time" (McGuirk, Keller, & Croze, 1995).

Table 2: Continuum of Risk

Provider Risk:	Low					High
	☑	☑	☑	☑	☑	☑
Risk Strategy:	Fee-for-Service	Cost Per Unit	Global Fees	Case Rate	Capitation	% of Premium
Payor Risk:	High					Low

Broskowski (1997) contrasts non-financial risks with financial risks under managed care. Non-financial risks include the risk of good or bad outcomes for clients, whereas financial risks are defined as the total cost of providing a defined scope of services to a defined population of potential users over a defined time period. Risk sharing produces incentives including financial rewards and control over resources. Risks can be distinguished by two types: (1) risk for utilization, i.e., how many persons will use services and how much services will they use and (2) risk for cost or price, i.e., uncertainty as to the cost per unit of service, including the method for calculating unit costs (Broskowski, 1997).

Capitation and Rate Setting

Managed care organizations control the cost of services by shifting the risk to service providers and by rate setting. The most prevalent method for containing cost is the capitation contract, where payers prepay providers a set amount for each individual enrolled in the plan, in return for a provider's agreement to provide a range of services (Emenheiser, Barker, & DeWoody, 1995). The goals of capitation are to promote fiscal accountability, integrate funding streams, increase financial flexibility and to produce services that are more efficient and effective. Capitation produces incentives for providers to alter practice patterns by replacing

high cost services with equally effective low-cost services, for example, replacing inpatient services with community based services (Masland, Piccaglia, & Snowden, 1996).

Mechanic and Aiken (1989) define the three crucial elements of capitation: (1) care is prepaid with a predetermined, agreed-upon price; (2) the provider is at financial risk if expenditure exceeds payments and (3) payment is tied to specific capitated patients. Payors may be either a public agency or a fiscal intermediary (i.e., managed care organization).

Capitation rates are either "user based" where the group is made up of current users of services or "population-based," defined by eligibility (e.g., Medicaid eligible) or geographic location. User-based capitation presents a high risk to the provider, since a small group may consume more services than was predicted based on prior utilization. Capitation may be either full or partial. Partial capitation places providers at-risk for only the services included in the capitated rate. Fully capitated programs cover a comprehensive array of services, which requires providers to monitor and coordinate all services received from other providers. Capitation rates may be either flat, such that the same rate is paid to the provider for each enrollee, or risk adjusted, which considers variables associated with higher utilization and assigns enrollees to higher or lower rates based on severity criteria (Masland, Piccaglia, & Snowden, 1996).

Effects of Capitation in Health and Behavioral Health

Rate setting and capitation have impacted health and behavioral health in different ways. These differences may be a result of the wide variety of managed care plans. On one side of the issue, studies suggest that capitated payment systems reduce hospitalization, and thus costs, among seriously mentally ill without "consistent evidence of ill health effects" (Callahan, et al., 1995). Other studies indicate limited savings through capitated plans (Hughes, et al., 1995). Hurley, Freund, and Paul (as cited in Rowland, et al., 1995) have found that Medicaid managed

care savings have been realized about half of the time and generally range from 5% - 15% of pre-managed care expenditures. It is difficult to determine which aspects of the managed care system are responsible for cost savings because of the wide variety of plans, the nature of the clients and the evaluation methods used. Medicaid plans in Oregon, Arizona and several other locales noticed savings after shifting Medicaid to managed care. However, plans in Tennessee, Georgia and Michigan reported an increase in spending after implementing managed care (Rowland, et al., 1995). These results should sound a cautionary note to those who wish to quickly implement managed care plans strictly to save money.

Quality of Care

Measuring the effect managed care has had on the quality of services can be achieved in several manners. Existing studies in this area have measured health quality through assessing timeliness of care, patient satisfaction and observing direct outcomes such as healthy births or readmission rates. Comparisons of managed care and fee-for- service plans in the area of quality of care follow:

- In a survey of more than 1,000 Medicaid managed care recipients and 400 non- managed care enrollees, managed care recipients generally gave higher ratings of satisfaction than non-managed care enrollees (Sisk, et al., 1996).
- Chronically ill elderly patients receiving managed care were twice as likely to decline in physical health as a similar group receiving fee-for-service (Ware, Bayliss, Rogers, & Kosinski, 1996).
- Mental health outcomes were better for elderly managed care patients than a similar group receiving fee-for-service (Ware et al., 1996).
- Outcomes for children in managed mental health were about the same as for kids in fee-for-service (Lambert & Guthrie, 1996).

- Research in Massachusetts demonstrated a 10.1% increase in readmission rates for children in managed mental health services after switching from fee-for-service to managed care (Callahan, Shepard, Beinecke, Larson, & Cavanaugh, 1995).
- Children with psychiatric admissions in Allegheny County dropped out of managed care plans at significantly higher rates than other children (Scholle, Kelleher, Childs, Mendeloff, & Gardner, 1997).

As is clear from the literature, the data gathered thus far are quite mixed. Some studies report an increase in quality, some a decrease, and others have found no significant changes. Generally, though, it appears that the quality of managed medical care versus fee-for-service care for both Medicaid and non-Medicaid populations is similar (Miller & Luft, 1994; Rowland et al., 1995).

Summary of Lessons Learned

Managed care has significantly changed America's health care system and is beginning to affect other public sectors, including the child welfare system. There are many different ways to devise systems of service delivery. Consequently, studying methods used in health and behavioral health may provide insights for those who wish to further examine managed care ideas.

Results of the use of managed care techniques reveal some general trends but vary depending on the type of managed care arrangements utilized. Generally access to primary care providers increases and cost decreases. How quality of care changes is not well understood. There is information to support nearly all sides of the managed care debate, consequently a careful look at particular design methods, some of which are included in this paper, is helpful in gaining a more comprehensive understanding of the issue.

Section IV.
Review of Select Managed Care Child Welfare Programs

Numerous public child welfare departments around the country are implementing reform initiatives that contain managed care elements. This section will summarize five of these initiatives: programs located in Ohio, Kansas, New York and Tennessee (See Table 3). Two programs in Ohio are county-administered, the Kansas and Tennessee programs are state-wide implementations, while the New York program was a joint effort of the state and city of New York. This program review discusses the type of child welfare services under reform, the target population of the program, unique features of the programs, the managed care elements utilized, selected performance/outcome indicators, performance incentives and penalties, the program evaluation plan and evaluation findings.

Hamilton County, Ohio/FCF Management Program

Hamilton County, Ohio, the home of Cincinnati, has initiated two separate managed care reform initiatives; the Hamilton County/FCF Management Program and the Hamilton County/Magellan Public Solutions, Inc. Program.

The Hamilton County/FCF Management Program is targeted towards youth in the custody of the Department of Human Services who: (1) have either had two or more placements or (2) are under 12 years of age receiving residential treatment services who have been adjudicated as delinquent or (3) whose service needs have not been met through the funding agencies. The program had a first year budget of $12.9 million and is funded through combined revenues of the departments of human services (83%), mental health (6%), developmental disabilities (5%), juvenile court (2%), alcohol and drug (2%) and the managed care contractor

(1.7%). The county agencies serve the gatekeeping function and no utilization review procedures are established at this time.

This consortium of county agencies has contracted with FCF Management, Inc. (FCF) to manage a provider network of four care management agencies. These agencies must accept all children referred by FCF. A care manager assigned by the care management agency is responsible for coordinating all social services for the family. FCF has a contractual obligation to provide 81 different services including individual and family therapy, in-home treatment, live-in worker, emergency shelter, respite, therapeutic foster care, therapeutic group home and long- and short-term residential treatment. FCF is not required to provide physical health care, in-patient hospitalization, psychiatric services or educational services.

A capitated rate of $3,760 per child per month has been set and the program includes a shared risk strategy with a 5% margin rate. Margin rates are common features of child welfare managed care and require that the managed care provider accept responsibility for a predetermined percentage of cost above or below the capitated rate. For example, in a contract with a 5% margin rate and a $100 per child capitated rate, the care provider would be responsible for costs up to $105 per child and could keep savings if costs are as low as $95. The public child welfare agency would be responsible for costs above the margin rate and would be refunded savings beyond the margin rate.

The managed care contract designates six baseline performance indicators including specified time frames for development of care plans and quarterly reviews and completion of risk assessments when children are returned home. Performance penalties for failure to meet performance objectives can be imposed for amounts up to $2,000 per month. FCF will be

awarded a $50,000 bonus if actual costs are no more than 98% of the capitated rate. There is no evaluation plan at this time.

Hamilton County, Ohio/Magellan Public Solutions, Inc.

The Hamilton County/Magellan Public Solutions, Inc. managed care program is particularly unique because it is the first managed care child welfare program in the country with a for-profit company as a partner. The managed care contract is between a collaborative of Hamilton County public agencies--the Hamilton County Alcohol and Drug Addiction Services Board, the Hamilton County Community Mental Health Board and the Hamilton County Department of Human Services, known as the Partnership Team--and Magellan Public Solutions, Inc. The target population is children and families who are part of the child welfare system, primarily live at home and who also utilize mental health services (L. Neltner, personal communication, August 14, 1997). The scope of work encompasses a number of mental health and drug addiction services purchased by the partnership team that were valued at approximately $40 million in 1996.

The Magellan Public Solutions Management Services Organization (MSO) will be responsible for developing a provider network of agencies to provide out-patient mental health services and therapeutic out-of-home services including therapeutic foster care, treatment group homes, treatment independent living and residential treatment. The MSO will also be responsible for the development of a computerized information system that will operate at the individual agency level and at the management oversight level. The RFP for this proposal listed the following services to be provided by the MSO: (1) training to the Partnership Team and the service providers, (2) assessment services provided by credentialed clinicians available on a 24-

hour per day, seven days a week basis with a "no reject/no eject" policy, (3) service authorization and reauthorization, (4) service referrals that meet the needs of children and families and that are consistent with neighborhood-based service delivery goals, (5) care coordination that works cooperatively with CPS caseworkers, (6) utilization review that includes team meetings with CPS staff and mechanisms for appeal of decisions, (7) utilization reporting of individual care plans and aggregate outcome related information, (8) services that are culturally competent, (9) establish a continuous quality management system, (10) develop, operate and manage an information system, (11) conduct financial monitoring and reporting that includes tracking service volume, (12) establishing a complaints and grievances procedure, (13) work with provider agencies to assure that consumer/family rights and responsibilities are protected and (14) promote productive intersystems linkages (RFP for MSO, Hamilton County, Ohio, 1997).

The contract between the Hamilton County Partnership Team and Magellan Public Solutions, Inc. details eight service outcome indicators and 12 MSO performance indicators. Multiple benchmarks have been established for each outcome indicator. Examples of indicator benchmarks for service outcomes include: (1) 95% of assessments are completed within the time frame as a benchmark for children and families will receive timely behavioral health services and (2) outpatient services will be available within 30 minutes of client residence as a benchmark for the indicator that services are available to meet the needs of children and families. Examples of indicator benchmarks for MSO performance outcomes are: (1) 90% of all claims are paid in 30 days of receipt of billing in approved format as a benchmark for the indicator that providers are paid claims on a timely basis and (2) all data will be available via the MIS 10 days after the occurrence as a benchmark for the indicator that the MSO will provide timely, accurate, useful and complete data reports to the Partnership team (Exhibit 2: Established Performance Standards,

7/3/97 See Appendix C). The performance contract includes financial incentives and disincentives that are tied to performance indicators. Magellan Public Solutions, Inc. can earn up to $109,000 in incentives tied to 13 indicators and be penalized up to $96,000 tied to 13 indicators. An evaluation plan for the managed care system was not discussed in the request for proposal.

Kansas

Combining interest in reforming child welfare with responsibilities from a settlement agreement with the American Civil Liberties Union, the Children and Families Services Commission of the Kansas Department of Social and Rehabilitation Services has revised the delivery of services to children and families. In the reformed procedures intake, assessment and eligibility functions are completed by public child protection services; all other services are provided by private providers utilizing several elements of managed care contracting.

The state of Kansas has privatized three major aspects of its child welfare system: family preservation services, foster/group care and adoption services. The services are funded at approximately $68 million per year and were contracted out to eight different agencies. All three program areas employ a capitated rate strategy: the rates were set through a competitive bidding process. The capitated rates are paid on a case rate basis and are: (1) $3,428 per family for family preservation services-the private agency must provide services from 1-12 months from date of referral based on family need; (2) $13,556 per child for adoption services which include payments to foster parents while the child is awaiting adoption, adoptive parent recruitment and training, and 18 months of post-adoption support services; and (3) $13,557 per year for

foster/group services. The program utilizes a shared risk strategy with a 20% margin rate and there are no additional performance incentives or penalties used.

All three program areas, family preservation, foster/group care and adoptions, have numerous outcome indicators. Family preservation outcome indicators include: (a) 90% of families will not have confirmed child abuse or neglect during program participation, (b) 80% of families served will not have confirmed child abuse or neglect within six months of case closure and (c) 80% of participants will report satisfaction with program services. Foster/Group care program outcome indicators include: (a) 95% of children in care will not experience confirmed abuse or neglect while in placement, (b) 80% of children will not experience confirmed abuse or neglect within 12 months after reintegration, and (c) 90% of reintegrated children will not re-enter out-of-home care within one year. Adoption program outcome indicators include: (a) 70% of children will be placed with adoptive families within 180 days of referral and (b) 90% of adoptive placements will remain intact 18 months following finalization of adoption.

Performance indicator monitoring protocol will be developed as a collaborative effort by the state and contract agencies with eventual monitoring of the performance indicators to be done by the state. The state plans to contract out the evaluation of the systems reform implementation.

Preliminary monitoring of performance indicators in the adoptions area shows that for the first eight months of implementation only 34% of the children referred for adoptions had been placed in adoptive homes within 180 days of referral, well short of the goal of 70%. For the first eleven months of implementation the family preservation agencies exceeded seven of the eight performance indicators. Thirty-three percent of the juvenile offenders served by the family preservation were non-recidivist, compared to the contract goal of 65%. No information is available on the performance in the foster/group care area.

New York

Home Rebuilders was a demonstration project initiated by the New York State Department of Social Services with goals: "(1) to demonstrate the effectiveness of service continuity, intensified discharge planning and the provision of aftercare services as a means to achieve earlier permanency for children and (2) to test an alternative to the per diem method of agency reimbursement" (Wulczyn, Zeidman, & Svirsky, 1997, p. 257). The target population for the program was children in foster care. The program was initiated as an attempt to respond to the state of New York's burgeoning foster care population and attempted to remove any economic incentive for long-term foster care.

A capitated rate was established by examining historical data of the participating agencies and calculating the agencies' average length of stay for children in foster family care. The agencies received a fixed reimbursement, based on current per diem reimbursement rates, paid over three years. The agencies received 42% of the payment the first year, 34% in the second year and 24% the final year. The HomeRebuilders program did not use margin rates, additional financial incentives or penalties.

The agencies were also given greater flexibility on how to utilize these revenues; they could invest in foster care services, in-home treatment services or discharge planning services. The general goals of the program were to see if the unique payment structure and greater flexibility given to agencies would result in: (1) reduced length of time for children placed in out-of-home care, (2) reduced reentry rates into care, (3) greater time between spells in placement and (4) an improvement in child and family functioning.

The evaluation of the HomeRebuilders Program utilized an experimental design that included random assignment of children to the experimental program or to regular foster care

services, monitoring of a variety of placement related variables and utilization of standardized instruments to measure changes in child and family functioning. The impact of the program on agency services and organization was also studied.

The preliminary findings of the HomeRebuilders Program after one year of operation show that discharge rates for children served by the program were accelerated when compared to children in the control group. Seventy-nine percent of the children served by the experimental approach remained in care after one year compared to 85 % of children in the control group. It is uncertain whether the different discharge rates were statistically significant.

Tennessee

In 1996 the state of Tennessee began a major restructuring of services for children. Numerous state agencies that focus on issues of mental health, mental retardation, juvenile justice and child welfare were consolidated into a new Department of Children's Services. Drawing on experience gained through implementing a Medicaid waiver program that saw health services expand, the new Department of Children's Services has adopted a managed care model for dependent children residing in intensive treatment settings.

Sixteen residential treatment centers across the state have converted to a Continuum of Care model that may include in-home services, therapeutic foster care services, emergency care, residential treatment foster family care, group home care and adoption services. Agencies are allowed to sub-contract out continuum services, although most do not.

Reimbursement rates are capitated and average $2,201 per month for therapeutic foster care and $2,049-$4,025 per month for residential care (rates depend on the level of residential care). Agencies assume risk by being contractually obligated to accept a predetermined number

of referrals even when earlier referrals do not move through the continuum of care. If a child's reunification fails before nine consecutive months the agencies are required to accept the child back into care. There are no other performance incentives or penalties in the Tennessee model.

The Tennessee model has an overall goal that 80 % of children served will be reunified or in a permanent living situation for nine consecutive months. There are no other performance indicators, nor is there an evaluation plan.

Summary of Select Managed Care Programs

The managed care programs reviewed in this section differ considerably regarding the type of child welfare services that are provided and which managed care tools and techniques are utilized. The programs that are examples of early experiments with managed care--New York's HomeRebuilders Program, Tennessee's plan and Hamilton County Ohio/FCF Management, Inc.--all exclusively serve child welfare target populations in out-of-home care and utilize the capitated rate as the essential managed care contracting element.

The programs that are the most current implementations--programs in Kansas and the Hamilton County/Magellan Public Solutions, Inc. Program--extend the target population to include family preservation services and mental health services for children and parents under family maintenance programs. These more recent programs also utilize a fuller complement of managed care tools and extensively incorporate elements of performance-based contracting. The Hamilton County/Magellan Public Solutions, Inc. Program utilizes preauthorization for visits as part of the program and clearly defined goals; outcomes and outcome indicators are elements of both programs.

The contract goals and performance indicators of the Hamilton County/Magellan Public Solutions, Inc. program include objectives that support community-based and culturally competent services. Hamilton County, Ohio is also a participant in the Family-to-Family initiative supported by the Annie E. Casey Foundation, which promotes neighborhood based foster placements. This is a good example of the integration of management goals into different programs.

With the exception of the HomeRebuilders Program, none of the managed care child welfare programs reviewed for this paper were established to evaluate the effectiveness of the managed care model in child welfare and most have deferred consideration of program evaluation issues for a later date. The HomeRebuilders Program was the only program reviewed that was initiated with an experimental evaluation design. While this investment in evaluation is notable, the evaluation period was only for one year and thus the positive findings from the study must be viewed cautiously.

Table 3: Managed Care Child Welfare Programs

Location	Target Population/Type of Child Welfare Services	Essential Features
Hamilton County, Ohio (FCF Manage-ment)	Serves (1) children under supervision of child welfare system who have had multiple residential placements and currently reside in RTCs, (2) youth under 12 years of age adjudicated as delinquent or (3) whose service needs have not been met through funding agencies.	Program is funded through combined revenues of departments of human services (83%), mental health (6%), developmental disabilities (5%), juvenile court (2%), alcohol/drug (.2%) and managed care contractor (1.7%).
Hamilton County, Ohio (Magellan Public Solutions, Inc.)	Children and families with open CPS cases, who live primarily at home, and utilize mental health and drug treatment services.	A for-profit company, Magellan Public Solutions, Inc. will develop a network of providers to provide out-patient, in-home and out-of-home services.
Kansas	Family Preservation Reintegration/Permanency: Foster/Group Care Adoption	State of Kansas privatizes, under managed care principles, all child welfare services except emergency response.
New York	Foster Care Reunification services	Model program designed to evaluate effectiveness of (1) service continuity, intensified discharge planning, and aftercare services on achieving earlier permanency and (2) removing economic incentive for long term foster care.
Tennessee	Residential Treatment Services	Sixteen residential treatment centers across the state convert to a Continuum of Care model. Providers receive a monthly maximum liability total. If children do not successfully move through the continuum the provider will be required to serve more children/families at the same amount of money due to conditions of contract that require provider to accept predetermined number of referrals per month.

Section V.
Review of Select Non-Managed Care Child Welfare Reform Efforts

Numerous efforts to reform the child welfare system are underway: this section will review five such programs. Programs were selected for review that aim to reform dimensions of child welfare services typically not addressed through managed care programs or because they attempt to reform services through non-managed care methods. Two of the programs reviewed are state level while three are county-level pilot projects with possible state-wide implementation.

This review will describe the focus of the reform effort, the evaluation plans of the reform initiative and the evaluation findings when available. The information is displayed in Table 4, with people to contact for additional information, included in Appendix B.

Table 4: Summary of Non-Managed Care Child Welfare Reform Efforts Reviewed

Program	Location	Reform Focus	County or State
California Child Welfare Structured Decision Making Project	California	Emergency Response	Pilot at County-level for State-wide implementation
Family Assessment & Response Demonstration (SB 595)	Missouri	Emergency Response	Pilot at County-level for State-wide implementation
Families for Kids	Arizona, Colorado, Indiana, Kansas, Louisiana, Maine, Michigan, Mississippi, Montana, New York, North Carolina, Ohio, South Carolina, Washington, Washington, DC	Adoption	County & State
Family to Family	Alabama, Maryland, New Mexico, Ohio, Pennsylvania & Georgia	Foster Care	County & State
New England Region Joint Effort on Quality Assurance	Connecticut, Maine, Massachusetts, New Hampshire	System-wide	Pilot at County-level for State-wide implementation

California Child Welfare Structured Decision Making Project

A project of the California Department of Social Services, the California Child Welfare Structured Decision Making (SDM) Project is a pilot study that focuses on the use of research based risk assessment and decision making aids. The overall goal of the project is to professionalize and standardize the initial child safety assessment procedure, standardize family assessment and case planning processes, and to develop research-based tools for assessing the potential for future maltreatment. The SDM pilot project will also include components that: (1) develop methods for prioritizing investigative responses to reports of child maltreatment, (2) integrate the SDM process with a workload analysis to assist management with resource allocation issues and (3) create an information system to integrate case assessment, case planning, case outcome and workload data for purposes of program monitoring, planning and evaluation.

The Project will work with the Children's Research Center of the National Council on Crime and Delinquency to develop research-based risk assessment tools, develop other elements of the structured decision making process and to conduct the evaluation study. Research-based risk assessment and structured decision making protocol will be tested in seven participating counties. Child protective service departments in Alameda, Humboldt, Orange, Sacramento, San Bernardino and Santa Clara counties are participating in the pilot study. The project is expected to last 36 months with piloting of the protocols targeted to begin no later than December 31, 1998.

Family Assessment and Response Demonstration (SB 595)

The Family Assessment and Response Demonstration (SB 595), enacted into law during the 1994-1995 legislative session in the state of Missouri, established a demonstration project designed to implement and evaluate a different method for responding to allegations of child abuse and neglect. The goals of the reform effort were to:

- "Protect children from abuse or neglect in the *least disruptive and intrusive way that recognizes the value of the family;* and
- Provide this protection in the most *efficient and effective manner possible within the framework of state, community, and family resources* " (Investigation/family assessment and services protocol, 1995, p. 4) [italics added].

SB 595 established five demonstration sites in Missouri that bifurcated the emergency response to allegations of abuse and neglect into either an *investigation response* or a *family intervention determination.* The *investigation response* is utilized when the "acts of the alleged perpetrator, if confirmed are criminal violations and/or where the action/inaction of the alleged perpetrator may not be criminal, but which if continued, would lead to the removal of the child or the alleged perpetrator from the home" (Investigation/family assessment and services protocol, 1995, p. 9). The *investigation response* is utilized when acts of serious physical abuse, medical or emotional abuse or serious neglect are suspected, in all reports of sexual abuse and all reports referred regarding out-of-home care investigations. During the investigation response the CPS worker must see the child within 24 hours, or immediately in emergencies.

The CPS worker responding to cases under the *family intervention determination* must initiate contact with the reporter or other persons knowledgeable regarding the family situation within 24 hours of the report. This contact, however, can be by telephone if it is determined the

child is safe during the interim. The CPS worker responding to *family intervention determination* cases is expected to work closely with community service providers and to link families to necessary support services. Conclusions from the *family intervention determination* can result in a case being opened or not opened. Cases receiving an *investigation response* can be transferred for a *family intervention determination* and vice verse.

The evaluation of the Family Assessment and Response Demonstration is being completed by a private research and evaluation firm. A quasi-experimentally designed evaluation plan is being utilized and includes comparison of pre-demonstration period data with demonstration period data and comparison between demonstration area data with matched non-demonstration area data on outcome indicators related to child safety and CPS system improvements. Data sources include state-level administrative data, case record review, surveys and interviews with family members, CPS workers and community organizations.

Preliminary evaluation findings after 17 months of program implementation produced findings that largely support the reform initiative. Findings include: (1) 43% of families in the study had prior open CPS cases; (2) 73% of new families were screened for the assessment response rather than for investigation; (3) use of the new method reduced the number of families with new cases by 30%; (4) the length of time cases remained open increased by 14%; (5) no change in the number of families entering the system for sexual abuse reasons was detected; (6) no difference in out-of-home placement rates have been found that are attributable to the project; (7) 70% of the cases where removal was more immediate were screened for investigation while 30% were screened for assessment; (8) there was an increased referral to and utilization of community resources during the demonstration period and (9) families served by the assessment

service reported better relations with CPS workers and greater overall satisfaction (Siegel & Loman, 1997).

Families for Kids

The Families for Kid's Program, supported through grants from the W.K. Kellogg Foundation, focuses on reform of adoptions. The program, which began in 1990, addresses the following goals: (1) the reduction of any backlog of children waiting longer than one year for permanent homes; (2) to increase the number of children entering permanent homes within one year; (3) support for the special needs of children of color awaiting adoptions; (4) an emphasis on promoting local community planning regarding adoption reform; (5) promoting changes in system funding, orientation and administrative structure and (6) judicial, legislative and policy reform (Families for Kids, no date).

The Families for Kids initiative began with year-long community planning processes involving 14,000 people in 15 states (Families for Kids, 1997). Stakeholders in participating communities identify local issues, assets and barriers to effective adoption services. Program design and implementation follows from this planning phase. Specific reform strategies that have been adopted by participating communities include: (1) upgrading of administrative MIS to ensure adequate tracking of children in the child welfare system; (2) funding of market research and creation of adoption marketing programs; (3) engagement of churches in recruitment and support efforts; (4) establishment of permanency centers for families of color; (5) establishment of vouchers for children and adoptive families to promote adoption; (6) expanded use of employer-paid adoption benefits; (7) creation of new casework teams that work with children

from intake to permanency and (8) promoting simultaneous case planning that promotes both reunification and adoption (Families for Kids, no date).

The evaluation of the Families for Kids Initiative is being conducted by Walter A. MacDonald and Associates, a private for-profit evaluation firm. Information regarding the evaluation design and findings was not available at this time.

Family to Family Program

The Family to Family Program is focused on reform of the foster care component of the child welfare system. Supported by the Annie E. Casey Foundation and operating in the states of Alabama, Maryland, New Mexico, Ohio, Pennsylvania and five counties in Georgia, the initiative promotes: (1) neighborhood-based, culturally sensitive foster placement, (2) a cooperative model between biological and foster families, (3) an increase in the number and quality of foster homes and (4) a reduced reliance on institutional and congregate care for out-of-home placements (A.E.C. Focus, 1995).

Foundation publications (Annie E. Casey Foundation 1995 Annual Report) report that in 1993, 70% of the children placed in out-of-home care in Cleveland, Ohio lived within eight zip codes, but fewer than 30% of the available foster homes were in the same zip codes. Recruitment efforts in the first program year resulted in a gain of 148 foster families in the targeted areas and a 33% reduction in the number of children in residential institutions. Program efforts also focus on providing family support services to families at-risk for placement of children: efforts in Augusta, Georgia include placement of entire families with mentoring foster families.

The evaluation of the Family to Family Program is being conducted by the Research Triangle Institute and the School of Social Work at the University of North Carolina, Chapel Hill (Family to Family Evaluation Team, 1996). The evaluation plan uses a quasi-experimental design and includes a non-randomized two group comparison design. The evaluators have provided extensive consultation to all states involved in the initiative to develop databases that allow the evaluators to study a group of children who enter care and all subsequent placements, exits from care and re-entries into care. Early evaluation efforts have focused on establishing pre-intervention baseline rates for: (1) volume and patterns of initial placements, (2) disruptions of care, (3) lengths of stay and patterns of exit from care and (4) permanent placements and re-entry to care.

New England Region Joint Effort on Quality Assurance

The New England Region Joint Effort on Quality Assurance was launched as a cooperative effort of the Boston Regional Office of the US Department of Health and Human Services Administration for Children and Families (US/DHHS/ACF), the National Child Welfare Resource Center for Organizational Improvement and the departments of child protective services of the states of Connecticut, Maine, New Hampshire, Massachusetts, Rhode Island and Vermont. The effort promoted a collaborative multi-state effort to establish Quality Assurance procedures that were uniquely designed for each state but met federal child welfare system goals of *safety, permanency* and *child and family well-being.*

The reform effort replaced previous federal reviews of state child welfare programs which focused on procedural requirements while the new approach measured outcomes of services delivered to children and families.

The Quality Assurance review process that was developed included: (1) a self-assessment by the state, (2) collection and analysis of data and (3) an on-site review. The on-site review is completed by a joint federal/state team which: (1) reviews a randomly selected sample of case records, (2) conducts interviews with key informants including children, biological, foster and adoptive parents, CPS workers and court personnel. A report is compiled and presented to state officials following the review.

Participating states have chosen their own systems to guide the focus of the quality assurance review. For example, the state of Maine focused their initial efforts on review of dependent children under five who have been in out-of-home care longer than two years while other states evaluate the outcomes of all aspects of their child welfare services.

There is no evaluation plan associated with the joint effort. The current focus of the effort is on improving state data collection systems and on selection of instruments to use during the quality assurance review.

Summary of Select Non-Managed Care Programs

The non-managed care child welfare reform efforts reviewed for this paper focus on reform of emergency response, foster care, adoption services and system-wide quality assurance efforts. Two of the reform efforts are funded through state government resources, one through combined federal and state resources and two through the resources of foundations.

All of the programs reviewed focused on reform of child welfare services and management and many of these reform efforts have clear economic implications. None of these efforts, however, focused on reform of the funding of child welfare services, nor attempted to restructure the economic or contractual practices of private sector child welfare services.

Section VI.
Issues and Challenges to Managed Care and Child Welfare

An examination of current applications of managed care within the health and behavioral health fields suggests that its successful transfer to child welfare will require a substantial modification of the medical model. Child welfare services target families in a more holistic and broader manner than that used in the medical world and will need to be approached accordingly (McCullough, 1996). Issues and challenges to managed child welfare abound and include the following components: clients, laws, funding, cultural competence, cost shifting, administrative structures, and risk assessment. These important child welfare issues are addressed in this section.

Client Populations

Child welfare services are usually provided to the child through the child's family, and family members often do not have the option of refusing services if they want custody of their children. Even if they do not believe that the services offered to them are helpful, they still must comply with the provisions of the child welfare system as handed down by the court. Conversely, people seeking medical services do so of their own volition. Thus, it may be more difficult to determine in advance what will constitute an appropriate level of service provision to child welfare recipients than Medicaid recipients. This element of choice significantly differentiates people involved in the two systems.

Also, federal law mandates the use of quality control devices that may be difficult to apply to the child welfare system. These quality control measures are essentially comprised of two elements. The first requires that Medicaid recipients have the right to disenroll on demand from the managed care plan in which they are enrolled. This provision is intended to promote

competition among providers based on quality of services instead of cost. The second specifies that managed care plans serving Medicaid recipients must have a privately insured enrollment of at least 25 % (Winterfeld, 1995). Quality control is an important part of managed care and will have to be thoughtfully considered as measures used in health are not always compatible with the child welfare system.

Legal Issues

A thorough understanding of the legal and financial underpinnings of the child welfare system is important to achieve prior to implementing managed care. The laws and funding streams that guide the child welfare system are compatible with managed care arrangements but are complex and must be incorporated into any successful managed care plan.

The judiciary has considerable influence on lives of children who come into contact with the child welfare system. Understanding how the power of the court may impact managed child welfare can be achieved through a comparison of the health and child welfare fields. As discussed earlier, controlling access and utilization are two fundamental components of managed care. Within health and mental health systems, these issues are partially managed through the use of a single point of entry, usually primary care physicians, who approve or deny the provision of services. Managed care organizations give these primary care physicians detailed information to guide their decision making process. In this way, managed care organizations control access, utilization and cost. In the child welfare system, however, the power of the court supersedes the decision making ability of child welfare staff or any managed care organization. As such, convincing these organizations to accept financial risk while not allowing them to control access and service provision may be difficult (Feild, 1996).

Another legal consideration relates to who is responsible for children in the foster care system. Private providers deliver a substantial proportion of child welfare related services in many states. Under Federal law, however, even if states contract out their foster care services, they are still legally responsible for the actions of the contracting agency. This may have a significant impact on the way in which managed care contracts arrange for risk sharing (McHugh, 1996).

Categorical Funding

There are many different funding streams that are used to pay for child welfare services. Public Law 96-272 amended two of these, Titles IV- A and IV-B and created another, Title IV-E. These acts were developed with the intention of financially rewarding states for creating systems based on "best practice" standards (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 1992). The implementation of these new acts has served to further fragment child welfare funding and has driven the development of programs and services. Funding for Title IV-E, directed to foster care and adoptions, has been considerably higher than funding for preventive, family strengthening services. This may be a barrier to implementing managed care if it restricts the allocation of money in ways inconsistent with the managed care plan. Recently, however, several Title IV-E waivers have been granted to states seeking innovative ways to restructure their child welfare systems.

Cultural Competency, Capacity-Building and Community-Based Services

For several years child welfare scholars have discussed the positive relationship between child maltreatment and poverty (Pelton, 1978; Sedlak & Broadhurst, 1996). Advocates have also asserted that neighborhoods with high rates of families living in poverty may be

disproportionately impacted by problems of unemployment, crime and drug abuse and do not have the corresponding proportion of community assets that provide formal and informal child and family support.

These observations have provided support for child abuse prevention and treatment services that are community-based, culturally competent and asset-forming in neighborhoods heavily impacted by child abuse and neglect. This capacity-building approach to child welfare services can take many forms including: (1) the provision of technical support to grass-roots organizations, (2) the encouragement of collaborative efforts between well-established and emerging organizations and/or (3) the requirement that traditional child welfare agencies improve service capacity to high need communities through aggressive recruitment and retention of culturally diverse staff and through location of services in community settings.

Is there reason to think that implementation of managed care in child welfare will support or hurt these initiatives? Do the financial and technical resources that are required to assume risk sharing responsibilities work against emerging grass roots child welfare service providers? Would the entry of managed care into child welfare lead to consolidation of independent child welfare agencies and promote a degree of organizational homogeneity which is in conflict with efforts to promote culturally competent neighborhood based services?

An empirical study of child welfare contracting in Illinois gives support to the hypothesis that private agencies with service and contract expertise, as well as the ability to use political leverage, tend to receive higher levels of funding (Grønberg, Chen & Stagner, 1995). Would this trend be accelerated under the managed care environment?

Others have expressed concern that the consolidation that has occurred in the health and behavioral health industries through managed care would also happen in child welfare and would

favor well established child welfare agencies that are disproportionately anchored in the Euro American communities and traditions and have high proportions of Euro American staff and traditions. Abe-Kim and Takeuchi (1996) have argued that the application of managed care to mental health has evolved without systematic consideration of the needs of ethnic minorities. Additionally, a survey of African American physicians found that 92% felt African American doctors have contracts terminated by managed care organizations more often than European-American doctors (Lavizzo-Mourey, Clayton, Byrd, Johnson, & Richardson, 1996).

To address these concerns the Hamilton County, Ohio/Magellan Public Solutions project has included geographic accessibility of services and service delivery by culturally diverse staff as outcome indicators in their contract (Exhibit 2: Established Performance Standards, 7/3/97). In a review of the impact of behavioral health managed care on children and families, McCarthy (1997) concluded that managed care neither advanced nor hindered initiatives promoting culturally competent services. The primary factor influencing efforts to promote culturally competent services was the organizational commitment to those principles, not managed care administration of contracts.

Cost Shifting

In a capitated system, agencies receive a fixed amount of money to provide services. Thus, they have a fiscal incentive to limit services so that they do not spend more money than they are allocated. Because of this pressure the potential for shifting clients from one department to another in a way that relieves the agency of their financial burden must be acknowledged. The application of managed care tools to single funding streams may have this type of effect and

must be guarded against. Cost shifting has occurred to varying degrees in health and mental health and its potential to do harm to children in the child welfare system exists.

Additional cost shifting problems may arise from the nature of the managed care contract. If agencies are awarded short term contracts they may not concern themselves with the long term implications of their actions. For example, they may not develop adequate prevention and early intervention strategies and in failing to do so, pass on the long term costs to whatever entity is responsible for providing care at a later time. The trend in managed health care to look for financial savings through early identification of problems and preventive methods seems to be shifting to the use of gatekeeping and utilization management. This type of shift in focus may negatively impact the provision of services especially for populations lacking in self-advocacy experience.

Administrative Structures

Networks of community providers have developed numerous alternative managed care models. Provider networks may either compete or contract with managed care organizations. Specialized managed care organizations act as administrative service organizations (ASOs) contracting for such functions as provider selection or utilization review. Joint administration, partnerships and risk sharing arrangements may be formed between provider networks and managed care organizations (Scallet, Brach, & Steel, 1997).

Managed care as applied in child welfare systems necessitates a fundamental restructuring of child welfare services and administration. Functions that are presently performed by the public child welfare agency may be reassigned to other organizational domains. Reassignment of responsibilities are determined according to the elements of design ensuing

from the planning process for implementation of managed care principles and tools. Change will be effected in organizational structure, personnel, information systems and service delivery. As alluded to above, the application of managed care in child welfare may subscribe to any of the following three basic administrative structures:

- Public child welfare agencies contract with Administrative Service Organizations for administration of contracts with private provider networks
- Public child welfare agencies contract with Managed Care Organizations who contract with a provider network according to shared administrative responsibilities
- Public child welfare agencies retain administrative responsibilities and contract directly with service provider networks.

Implementation of redesigned administrative structures requires thoughtful consideration of the agency's ability to manage new responsibilities. When considering the agency as a vehicle for contracting out services one must analyze the potential associated costs and benefits. These include:

- An accurate prediction of the real costs of providing services. This can be difficult to obtain, as there are many hidden costs and potential future changes in the population.
- Will new management arrangements and funding structures be expected to save money?
- Where do current revenues come from and how are they likely to change?
- Is the current administrative structure capable of supporting changes in financing procedures?
- Are the proposed financial restructurings congruent with the agency's goals?

All of these factors and more must be assessed, in effect, to determine if the agency is in a position to be able to write financially and programmatically sound contracts with service providers. The agency must also be ready to restructure its administration in a manner that is consistent with the newly created organizational demands.

Implementation of redesigned administrative structures may be met with institutional resistance which must be carefully considered and strategies for including stakeholders and mediating resistance must be developed as core components in the planning and implementation phases of redesign.

Risk Assessment

Another element of the child welfare system that makes it uniquely different from health and mental health relates to risk assessment. Risk assessment is a process used to determine the chances that in the future, a child will be the victim of abuse or neglect (Wald & Woolverton, 1990). Accurately predicting whether or not a child will be abused or neglected, the severity of the abuse and the attendant costs to the child welfare system are central to the application of managed care and fall within the province of risk assessment.

Over time, various methods of risk assessment have been employed in the child welfare system. Earlier assessments relied mainly on the clinical judgment of individual workers; more recently there has been a shift to consensus-based and actuarial models (Doueck, English, DePanfilis, & Moote, 1993). Consensus-based models are the most commonly used method of risk assessment in the United States and are developed by committees of practitioners, administrators and other experts. Actuarial systems of risk assessment are comprised of a list of case characteristics found, through scientific testing, to be predictive of the future occurrence of maltreatment. Questions regarding support for the principal caretaker and the stress level of parents are often included in actuarial models (McDonald & Marks, 1991). Of the three methods, the actuarial is the most empirically based. Though actuarial models hold promise for the improved diagnostic ability of workers in the child welfare field, substantiating research is

necessary before such tools can be deemed more accurate and consistent than currently used models of risk assessment (Johnson, 1996). Consequently, researchers (McDonald & Marks, 1991; Wald & Woolverton, 1990) caution that actuarial models should not be implemented before they have been critically analyzed for predictive ability.

Without risk assessment methods that have been tested for reliability and validity, determining in advance the levels and frequency of service children will need is done by individual clinical assessments and may vary tremendously. Successful managed care programs require a methodical system of risk assessment that results in consistent decision making. When consistent, accurate diagnoses of problems are made, anticipating levels of care and setting rates accordingly is possible. Thus, assessing risk is fundamental to determining capitation rates and is crucial to the successful provision of services. The field of risk assessment is rapidly developing and has many applications for managed child welfare. Consequently, people considering managed care should pay close attention to new developments in risk assessment.

Summary of Issues and Barriers

Implementing managed care tools within the child welfare system will require addressing a number of issues and barriers. An understanding of medical managed care arrangements can be helpful but is not adequate as there are significant systematic differences. These differences, which include some of the main issues and challenges to managed child welfare, are in the areas of client populations, legal considerations, funding structures, cultural competence, cost shifting, administrative structures and risk assessment. A thorough understanding of these complex issues and challenges will serve to greatly aid the developer of managed child welfare services.

Section VII.
Proceedings from the Bay Area Forum on Child Welfare and Managed Care

The Bay Area Forum on Child Welfare and Managed Care served to stimulate advanced thinking about managed care principles and tools and their appropriateness for implementation in child welfare services in the foreseeable future.[1] The intention of the forum was to aid Bay Area counties and others to be better able to: (1) take the pulse for reform efforts in child welfare services, (2) share information and resources and (3) create an environment where reform strategies could be examined. The purpose of the forum was not to promote managed care as the sole option of reform, but to provide an opportunity for child welfare professionals to come together to explore its strengths and barriers.

The day-long forum was held on October 30, 1997 at the Alameda County Conference Center in Oakland, California. Sixty people attended the forum representing eleven Northern California Departments of Social Services, the State Department of Social Services, Federal agencies, foundations, schools of social work and other interested parties. All registrants received a copy of the briefing paper before the forum to assist with developing a shared base of understanding of the issues.

A keynote speaker introduced the topic and set the stage for the discussion to follow. Two panels were held to debate the benefits and challenges of a managed care approach to child welfare services and address current field experiences and lessons learned with implementing managed care. Small group discussions followed allowing attendees to share their thoughts about child welfare managed care and privatization, organized labor, the role of the courts, system readiness and service integration efforts.

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[1] Additional support for the Forum was provided by the Zellerbach Family Fund.

In this section of the paper, we overview the varied components of the Forum and summarize major themes.

Overview of Child Welfare and Managed Care

Tracey Feild , Senior Associate, Institute for Human Services Management, the keynote speaker, spoke about why there is a move toward managed care. Some of the reasons for the shift toward this type of model are: (1) a transition by Medicaid into managed care, (2) loss of open-ended Title IV-A entitlement funds, (3) fear of the impact of TANF, (4) overall cost increases, (5) increases in cost per child in out-of-home care and (6) pressure from the outside to do something different.

Feild said that most managed care models incorporate similar characteristics including:

- a single intake and assessment process
- common decision-making protocols
- a process to monitor consistency in decision making and continued need for service
- coordinating services through a single point
- defining and measuring outcomes
- a quality assurance process
- provider profiling, payment based on client type and not service type
- flexible payments to encourage low-cost services.

Yet, models differ from program to program. These differences result from varying motivation levels within the system and/or external political pressures, service structures (i.e., behavioral health vs. child welfare), geographic area of service coverage, types of populations, types of services offered, administrative structures, roles and responsibilities of different providers (public vs. private) and types of payment mechanisms.

Feild presented current managed care models from four different service areas: State of Massachusetts, State of Tennessee and District 8 and 13 in Florida. A brief summary of each model follows:

- *Massachusetts:* Six major regions within the department control intake and case management. Each region has a lead agency with administrative services under a separate contract. Services are provided through a network of agencies while payment differs for out-of-home and aftercare services. Agencies receive a bonus for achieving the key outcome of permanence for six months after case closing.
- *Tennessee:* This state is in the process of moving toward a public managed care system. They are currently developing a regional service system to include a full range of services with common assessment, decision-making and planning tools among all regions. During this early stage they are using "continuum of care" contracts with individual providers. Success in this program is defined as a continuation in permanent placement for six months after case closure.
- *District 13 (Florida):* This district is comprised of a single provider in a rural district who provides services to all children entering shelter care for the first time . A case rate of $20,000 has been set for each child entering the system regardless of length of stay. This rate was set based on a review of utilization and cost. All case management is done by the single provider. Outcomes of the program include child safety, child and family functioning and permanency.
- *District 8 (Florida):* This district is comprised of a coalition of providers in an urban county. There is a great deal of community and private support for this coalition. The caseload for the coalition is comprised of all cases opened by CPS. The coalition receives a quarterly allocation and bills Medicaid separately. The public agency oversees the following components of case management: approval of case plan, approval of reductions in care and quality assurance. Outcomes include child safety, child and family functioning and permanency.

Feild raised some major issues to be examined by the public child welfare system in relation to managed care including: (1) categorical constraints of Title IV-E funding, (2) the "tidal wave" movement of managed care, (3) specific child welfare client issues (i.e., involuntary involvement, custodial relationships and protection issues), (4) behavioral health's efforts to absorb the child welfare system, (5) the role of for-profit companies in child welfare and (6) the appropriate role of the public agency. She concluded that it is too soon to assess the impact of managed care approaches on children and families.

The Benefits and Challenges of Managed Care and Child Welfare

Fred Wulczyn, Director of the Managed Care Forum, Chapin Hall Center for Children, spoke to the benefits of managed care and child welfare services. Wulczyn stated that managed care incorporates many of the same reform ideas as other theories except it takes a closer look at "how we pay for services and what we buy." He believes that the central problem to child welfare reform is the proportion of foster care reimbursement paid for by federal funds. In attempting to make change, it is essential to examine the federal reimbursement system and its impact on entry rates and length of stay. Yet, as counties look to provide better and more cost effective services, they risk a reduced level of federal funding.

Wulczyn reviewed information on theory of reimbursement. In the spectrum of fiscal management of child welfare service, fee-for-service is at one end and fixed level of funding for a certain "package" of services is at the other. Managed care looks to combine reimbursement and utilization of case management services. Federal block grants do not generally include utilization review as a standard for setting grant amounts. Wulcyzn believes that this is a

weakness in this system. The current fiscal system is based on the number of kids in the system at the beginning of the year. Very little money is currently invested in preventive services.

Wulczyn argued that there needs to be a reevaluation of risk sharing strategies, to include volume (i.e., entrances into the system), duration of stay in the system and unit cost per day. Volume risks are the greatest because entrances into the system are tied to larger systemic forces beyond the influence of the child welfare system. Duration risks are more stable in that they can be controlled to a greater extent by the child welfare system. Finally, unit cost is the easiest risk to control and changes the least. Wulczyn encouraged counties to begin thinking about manipulating these risk factors to best meet their needs.

In summary, Wulczyn offered the following recommendations for reforming the child welfare system: (1) reduce the amount of increase in foster care Title IV-E expenditures and channel these funds into Title IV-B (i.e., a revenue neutral funding shift which increases the focus on preventive programs), (2) gain a better understanding of risk sharing and why case loads fluctuate between increases and decreases, (3) think about risk in terms of volume, duration and unit cost and (4) get a better understanding of who is in the foster care system and greater clarity about desired outcomes.

Mark Courtney, Assistant Professor at the School of Social Welfare, University of Wisconsin-Madison talked about the challenges of reforming child welfare services using a managed care model. Courtney argued that looking for solutions through managed care reform efforts is dangerous because managed care is not about incremental change. He cautioned that managed care "is a train that is desperately trying to get to the final station." It is important to "get off at the first station" and figure out the motivation behind this push.

Courtney discussed four main obstacles to managed care in child welfare. First is the *political nature of this reform effort.* The principal motivation for implementing managed care is politically charged and crisis driven. Oftentimes it is a response to court-ordered reform. The second obstacle involves the *buyers/consumers of child welfare services.* Clients in the child welfare system are involuntary recipients of services. Children, and more specifically poor foster care children cannot advocate for themselves, and have a limited capacity to engage in the managed care debate. The third obstacle is the *lack of information and contract development skills of public agencies.* Public agencies lack risk assessment information based on empirical information, diagnostic value and level of care assessment. They may need the assistance of private providers to write their contracts and to set up solid monitoring systems. The fourth obstacle is the *inadequate funding* for child welfare services. There are no baseline data on what effective child welfare services look like and what they cost.

In summary, Courtney asserted that the lack of knowledge regarding child welfare outcomes is significant enough to warrant a more incremental and thoughtful approach to reforming the system. Forging ahead with a managed care set of initiatives is not incremental and may well impede thoughtful reform efforts.

Field Experiences with Managed Care

Ken Berrick, Chief Executive Officer of the Seneca Center, presented a description of Project Destiny, a pilot program which introduced managed care to child welfare in Alameda County. With the passage of AB 1741, the waiver system freed up monies for prevention-based and capitated services. This project provides "high end" intensive services to 24 children with the greatest needs currently in the county child welfare system. The goal is to provide comprehensive intense in-home services to transition these youth back into the community.

Project Destiny works in collaboration with two other agencies in the community (Fred Finch Youth Center and Lincoln Center) with Seneca Center serving as fiscal agent. A sub-capitated rate of $20,000 per agency/client was established, based on AFDC/FC rates paid over a two year period (April 1994 through March 1996). Funding sources include mental health, education and social services. Most of the children were MediCal eligible and therefore Title XIX eligible though few were Title IV-E eligible. Outcome measurements to be tracked include: recurrence of physical abuse, sexual abuse and neglect, levels of placement restrictiveness and rates of academic success.

Berrick mentioned a number of stumbling blocks for the project such as: a difference in the perception of available resources by the public agency and private providers, a reticence to share resources (i.e., agencies have different funding levels), divergence in agency cultures/treatment philosophies and an inability to realign federal dollars.

Pat Jordan, Former Assistant Director of the Department of Mental Health, San Mateo County, spoke of the implementation of managed care in mental health services. The California mental health system provides mental health care for MediCal eligible persons, medically indigent persons, those in foster care, in addition to a small Fee-for-Service (FFS) system with limited services for more episodic and incidental users. San Mateo County currently is under a MediCal Managed Care Plan and within the next six months will move into a full consolidation of mental health services.

The impression in the county agency was to "get on the train early, because if we did not do something, something would be done to us." Jordan reviewed the reasons the county had for moving towards a publicly managed care model in mental health services: (1) they knew the target population best, (2) they wanted to be able to "reinvest" cost savings in services, (3) they

had worked more closely with consumers and family members than any of the commercial managed care organizations, (4) they believed it was possible to implement based on county size, politics and bureaucracy and (5) the county was there to bear the risk.

Jordan said that mental health managed care has increased access to the system through its collaborative approach to service delivery. Individuals can access services through child welfare, shelter care, intensive in-home care, child abuse and sexual abuse treatment programs and therapeutic foster care.

The county has developed outcome measures in three domains: (1) administrative (e.g., access, utilization, client satisfaction and provider satisfaction), (2) clinical and (3) fiscal (e.g., cost effectiveness). First year outcome highlights include: increased access by number of people served, decreased inpatient length of stay, 85% positive client satisfaction, 87% positive provider satisfaction and decreased MediCal inpatient costs with a reinvestment of more money into outpatient programs.

In summary, Jordan reported some of the overall impacts of managed care: (a) lessons from private managed care providers in terms of "businesslike management," (b) improved access, (c) increased accountability through fair hearings procedures and consumer advocacy, (d) more flexibility in how funds are spent and savings reinvested (block grants) and (e) an overall shift to the concept of managing risk with a stronger move toward prevention.

John O'Keefe; Senior Vice President of Magellan Public Solutions, Inc., represented the for-profit sector involved in the management of child welfare services. Magellan Public Solutions is a managed care firm providing behavioral health and child welfare services management, fiscal analysis and oversight, computer software and hardware support.

O'Keefe explained Magellan's current working relationship with Hamilton County, Ohio as an example of a "True Care" partnership of the public and private sectors. In Hamilton County, the Department of Human Services (DHS) decides at the front end who receives services including out-of-home placements, behavioral health services and substance abuse services. Magellan's technical assistance to Hamilton County has included: comprehensive and integrated MIS (incorporating DHS, Alcohol and Drug Services and the Mental Health Board), outcomes measures, customer satisfaction tools, clinical protocols and staff training. They have developed a two level approach in establishing the MIS: vertical integration (same data base for provider, manager and payer) and horizontal integration (a single automated clinical record for each child in the managed care program). Components of Magellen's staff training include a series of topics related to MIS/Operations (hands-on computer systems, authorization procedures, use of utilization reports and financial management of at-risk services) and clinical issues (clinical protocols, continued quality improvement, customer service and utilization management techniques). Magellan incorporates extensive consultation from social service experts into every component of its work.

Small Group Discussion Reports

Privatization of Child Welfare Services and the Role of Organized Labor in Reform Efforts

The discussion groups that focused on privatization of child welfare services and the role of organized labor in the reform of child welfare services were consolidated.

Most county representatives reported that they perceive little political will in their respective counties for any increase in privatization of child welfare services. The political strength of organized labor was mentioned as influencing local elected officials on this issue.

Directors of public child welfare services also mentioned other factors that inhibit any increase in privatization. These factors include a concern that the private sector would accrue cost savings by hiring less qualified staff leading to a deprofessionalization of child welfare services. County representatives said that they hire MSWs for staff positions and one county reported an average length of service among child welfare staff of 17 years. Managers of child welfare services have some concern about the longevity of their own positions if privatization was increased which may inhibit exploration of this option.

There is a perception amongst some public child welfare administrators that public agencies have, and always will, hold ultimate responsibility for dependent children. This fact has led to some resentment by public child welfare officials that private agencies too often appear organizationally unstable or unwilling to work with the most challenging children. This has led to a fundamental suspicion of both the quality of private child welfare services and their ability to be stable partners for essential child welfare services.

The group discussed legal barriers to privatization of some child welfare services. It was reported that in California, it is currently illegal to contract out case management services. Legislative action would be required to change this or programs could creatively examine definitions of case management services.

There was mention that the high cost of public child welfare services is a factor that is promoting interest in increased privatization. Because of uncontrolled indirect costs, approximately $105,000 is needed to fund all personnel and administrative costs associated with one child welfare worker in California.

There is also frustration with governments' slow process at promoting change and innovation. Examples of slow and only partially successful attempts at innovation and

modernization mentioned included the long time-frame spent to develop wrap-around services in California and the limitations of the CWS/CMS.

Working with the Courts: A Wild Card in Service Reform

Group members felt the courts can be a major roadblock in any efforts to reform the child welfare system. Currently the courts hold a great deal of power with little accountability of shared risks or funding with the county. Though this group believed that the power to remove a child from a home or terminate parental custody should be that of the courts, they felt the courts are playing too large of a role in the ongoing case management of clients. One such example is the issue of placement approval and/or change. Counties must return to the courts whenever they propose that the child move. With the current overload of the court system, these service decisions have become very time consuming and hinder the county's efforts to effectively move the case along within federal and state timeline mandates.

The group raised the issue of accountability. There was strong agreement that the courts need to "manage their component of care" with more accountability for issues such as timely hearings and definitions of safety. Courts continually delay cases without any consideration for the cost for services or length of permanency determination mandates.

The group recommended a redefinition or examination of key terms involved in working with the courts, such as reasonable efforts (as they pertain to court decisions), issues of influence (individually determined control versus State or Federal mandate) and definitions of risk (as viewed by the county or the court). Finally, there was some discussion about trust, most agreeing that currently there is little trust between the courts and the county.

The group thought that the courts will play a large role in the success or failure of a managed care system. Judges may take on the role of gatekeepers and monitors of a managed care system. The group discussed numerous next steps including:

- Educating the courts about managed care (e.g., the "Beyond the Bench" joint conference). This education should include a discussion of roles and responsibilities along with a determinant of levels of discretion. Educational forums could also be presented through the judiciary using retired judges as facilitators.
- Looking at ways for the legal system to share risk and costs associated with child welfare services. This may encourage the county and courts to have more of a vested interest in determining and monitoring outcomes.
- Legislating limitations on the courts to have powers solely on legal issues. This will move courts away from case management and service delivery decisions.
- Developing positive fiscal incentives for the courts to move cases along with the fewest delays and continuances.
- Studying parent involvement as it relates to delays of cases and other empirical data.
- Organizing public relations and advocacy campaigns surrounding the role of the courts in child welfare services.

Impact of Managed Care and Child Welfare on Service Integration Efforts

In framing the issues, the group discussed the need to define "service integration," the adequacy of resources and information for successfully integrating services and funding strategies (e.g., opportunities for blended funding, developing capitated rates across systems). There was consensus that looking at outcomes across systems is extremely difficult. Managed care may provide some tools for this yet trouble spots remain. The group saw collaborations as a way to manage service integration. This strategy depends on the history of inter-organizational relationships within a county.

Some of the critical questions raised by group members necessitating further exploration include: (1) is privatization counter to developing neighborhood-based services and (2) is service integration cost shifting?

There was discussion about whether a "system of care" county is a form of managed care. Additionally group members looked at the issues of where to target change (e.g., deep-end vs. prevention) and the impact of kin-care on managed care.

There were several next steps offered by the group including: (1) focusing on collaborations at the State and local levels, (2) sorting out State and Federal categorical restrictions and rate structures, (3) exploring Bay-Area wide Title IV-E waivers and (4) compiling integrated, common outcomes and ways to look at data across systems.

Child Welfare Systems Readiness and Managed Care

Much of the group discussion centered around lessons learned from the two-year old pilot Project Destiny, a managed care program serving adolescents in group care in Alameda County. All parties to this agreement are reconsidering the rate setting structure for the third year of operation. (One method to explore is used in New York, where the system reverts to per diem payment when the capitation rate is spent).

Rate setting and MIS were key technical issues raised by the group. One could capitate rates according to the age of kids, duration of contract, number of care days, levels of care and availability of services. The group raised the issue that refinement of rate setting methodology may lead to a change in incentive structure. In addition, the group discussed the issues of who to reimburse and subcontracting to provide network care. The pros and cons of capitated versus per diem rates for agencies were seen as affecting decisions regarding levels of care and placement.

Regarding MIS, group participants agreed that the systems' capacity to manage and use information for decision-making has remained static. Information is difficult to manage and use for decision-making. It might be best to use few data elements well. Group members spoke about the failure to meet performance goals against benchmarks (e.g., management and service barriers to effective organization). Other problems raised were the efficiency of retrieving information and the timeliness and expense of reporting information that is relevant to care and service delivery. Additional domains to consider include communication (e.g., single point of information at multiple sites), and the time commitment in developing relationships between parties (e.g., public sector, private sector). An example of the proactive use of information was raised in that Los Angeles County links data systems for the Social Services Department, Police Department and Courts to match kids in trouble.

Major Themes

The Bay Area Forum on Child Welfare and Managed Care included presentations and discussions about many of the major components and issues surrounding managed care as a reform tool for public child welfare programs. Following are a number of the important themes raised throughout the day:

- Managed care is not a "set package." It has many components which can be tailored and/or eliminated to meet the needs of the county or state sponsor.
- It is important to fully understand all of the components of managed care and how they relate to child welfare before taking action. This is especially true because there exist no baseline data on the cost of effective child welfare services, and there is a lack of empirical data on risk and the assessment of proper levels of care.

- No matter what reform tool is selected for child welfare, counties still carry the weight of overall accountability as relating to risk and fiscal management.
- Managed care is not about limiting resources for the consumer, it is about how to pay for services and what to buy.
- In order for managed care to work effectively in a public child welfare setting, there needs to be more federal fiscal reform including an increase in Title IV-E waivers, with a shift in resources to Title IV-B (Preventive Services). Furthermore, there needs to be more collaborations on the State and local levels in terms of financial and accountability structures.
- In addition to looking at cost, we need to develop better child welfare outcomes by starting with simple outcomes measurements and incorporating ongoing modification. This is particularly difficult since there are conflicting/competing outcomes inherent in child welfare services (e.g. child protection, family preservation and permanence).
- Many issues surround the privatization of child welfare services. The best route for change is a well thought out selective, incremental approach. This issue becomes politicized when considering organized labor's view that privatization leads to a deprofessionalization and reduction in county case worker positions.
- The courts play an important role in the success of child welfare reform, specifically managed care and child welfare. Currently, the courts hold limited accountability in terms of risk or fiscal management and therefore have little motivation to reform the system. Efforts need to be made to educate the courts about managed care and bring them into the reform process early.

Section VIII.
Summary and Recommendations

The county administrator of child welfare services must respond to a tremendously complex and demanding array of responsibilities while being buffeted by program, fiscal and political pressures. Principle responsibilities include the provision of effective child abuse identification, treatment and prevention services to a growing client group at the same time that revenues and resources continue to shrink. This mandate to seek effective services with limited public dollars in a rapidly changing social welfare system are factors that encourage re-examination of current practices and experimentation with new models for the management, supervision and funding of child welfare services.

This briefing paper has examined in depth one proposed innovation--managed care and child welfare--and briefly reviewed other options for the reform of child welfare. The paper has described some of the essential features of managed care, examined child welfare out-of-home care trends that are frequently cited to support the application of managed care in child welfare, reviewed select managed care experiments in child welfare as well as other options for reforming the child welfare system and detailed some of the challenges and issues that confront the implementation of managed care and child welfare.

Principle Findings

- The out-of-home care population in the state, Bay Area region and Alameda County continues to grow; this population in Alameda County has grown 34% from 1988 to 1995. The most significant change in the proportion of children in different placement types in Alameda County has been the growth of Foster Family Agency placements and the decline of children placed in Non-Kinship foster homes.

- There has only been one study that has empirically examined the application of managed care principles in child welfare (Wulczyn, Zeidman, & Svirsky,. 1997). While this study reported positive findings the study period was only for one year.
- Current child welfare programs that utilize managed care practices vary significantly and few resemble managed care health plans. Most programs do not contain the full complement of managed care techniques such as preauthorization of visits, capitated rates, risk sharing strategies or investment in prevention and early diagnosis.
- Current managed care child welfare programs primarily focus on out-of-home care populations, although an increasing number are applying managed care principles to family preservation and support efforts and for the provision of mental health services to child welfare dependent children living with their parents. We are aware of no program that is applying these principles to emergency response services.
- Current managed care child welfare contracts vary significantly regarding the degree that outcome objectives are specified. Some contracts do a notable job of addressing the complex goals of modern child welfare. The capitated contract provides incentives that encourage movement of children through high-end care while performance based penalties and rewards address a variety of child safety and family functioning issues. This very complexity, however, raises questions regarding the grantors ability to monitor these contracts.
- Managed care and child welfare requires highly sophisticated, integrated and timely management information systems.
- There are numerous factors that are unique to child welfare that complicate the utilization of managed care principles including a very high proportion of involuntary clients, presenting problems that are heavily associated with poverty, poorly developed outcome measures and a lack of actuarial data.
- In addition to managed care efforts, this study identified several local and national child welfare reform initiatives that focus on emergency response services, integrated service models, concurrent case planning, increasing family involvement in case planning and foster care and adoption reform.

Policy and Administration Considerations

Based on this objective and comprehensive review of reforming the management, delivery, and financing of child welfare services we offer the following considerations for policy and administration.

Policy Issues

Child welfare reform efforts must weigh and balance the needs of children and families versus cost containment. Managed care and child welfare is a contracting strategy that attempts to purchase essential services while simultaneously removing economic incentives for unnecessary long term care and, in some models, placing controls over high cost services. While it is naïve to assert that public child welfare officials do not have a responsibility to provide and purchase cost effective services, the goal of cost containment and managed resource utilization must not overshadow the primary goals of the child welfare system--child and family service. Various managed care child welfare tools (e.g., margin rates) have been developed that attempt to limit the provider agencies financial risk, with the hope that financial concerns do not overshadow client need. However, to date, there has been no empirical examination of the question of whether managed care in child welfare encourages premature discharge from out-of-home care and subsequently puts children at risk for re-abuse or placement failure.

Child welfare reform efforts must contend with the question of whether privatization of social welfare services is a mechanism to promote innovation and efficiency or is a weakening of the commitment to public social welfare programs.

While child welfare services in the US originated in the private sector (Leiby, 1978) patterns of privatization of child welfare services vary greatly across the country. Some areas of the country have long histories of extensive privatization of some segments of the child welfare

system (e.g., foster care in New York state and group home services in California) while other areas have less reliance on private sector agencies.

Experimentation with managed care and child welfare does not necessarily increase the public sector commitment to privatization. Deliberations or concerns regarding large-scale privatization should not obscure the examination of managed care and child welfare.

Managed care and child welfare are not isolated reform strategies. The patterns of experimentation with managed care and child welfare services vary tremendously. Some experiments, for example Hamilton County/FCF Management, have goals of cost containment and reduction of unnecessary out-of-home care placements.

Other areas have included managed care in very ambitious reform strategies. The state of Tennessee implemented a managed care child welfare program within a plan that encompassed consolidation of children and youth services at the state level and included revision of the role of the judiciary in children and youth issues. The state of Kansas implemented managed care while privatizing all child welfare services with the exception of emergency response. Managed care should be viewed as one element of child welfare reform efforts.

Many factors influence the duration of out-of-home care stays. The observation by Wulczyn, et al. (1997) that fiscal mechanisms can influence the discharge practices of providers, while worthy of examination, should not obscure the fact that numerous factors have been found to be associated with extended out-of-home care stays. Reform efforts to support effective reunification strategies (Berrick, Brodowski, Frame, & Goldberg, 1997) and efforts to expedite termination of parental rights in some cases have also been advocated.

Administrative Issues

The monitoring of large scale managed care models requires sophisticated MIS and contract monitoring abilities. The most sophisticated managed care initiatives also include elements of performance-based contracting that require clearly thought-out goals, objectives and outcome indicators. The data collection and data management requirements for monitoring these contracts require sophisticated activity and investment in computerization and software by both the grantor and grantee. It is unlikely that the CWS/CMS will be suitable for these efforts. The Hamilton County, Ohio/Magellan Public Solutions, Inc. contract made the development of an MIS a major requirement of Magellan Public Solutions, Inc.

The placement decision-making process in child welfare need reexamination. Fully developed managed care programs closely monitor systems entry, resource utilization and remove financial incentives for high-end care. Child welfare systems could benefit from studying clinical decision-making models from behavioral health to more closely monitor client entries into group care. The crisis-oriented decision making process that is utilized by emergency response workers appears to be utilized on all other placement related decisions. The child welfare system needs to explore placement decision-making based on thorough multi-disciplinary assessments of child and family needs. Improvements in this essential element of resource management do not require conversion to the managed care model.

The Court system plays a role in the success or failure of a managed care child welfare system. Currently the court system holds a great deal of decision-making power in the child welfare system without bearing any risk or fiscal responsibility. The court system can control the timeline of the decision-making process in any given case in the child welfare system through a process of court delays and continuances. In the current context of over burdened

judicial juvenile dependency calendars, the court system has a great deal of room for reform. As managed care looks to engage the entire system in a more time and cost effective process, the role of the courts becomes an important part of the equation. Involving the courts in the exploration and decision-making process early may be an essential step toward assuring by-in to a managed care system and other reform efforts.

Organized labor has an important role to play in considering managed care reform efforts. One possible implementation strategy for managed care includes an increase in the privatization of child welfare services. This privatization effort may be viewed by many organized labor groups as an effort to eliminate public child welfare case manager and/or social worker positions. As well, there exists the sentiment that private agencies are not as well equipped either organizationally or staff-wise to work with the most challenging children in the system. Therefore, the push to privatize services through managed care may seem like an effort to compromise both labors' and client needs.

Organized labor should be viewed as an important stakeholder in any reform effort in child welfare. Their opinions and concerns should be heard and considered through the reform process. The best reform efforts, including those involved with managed care, require the presence of all major stakeholders (labor included) into every step of the reform effort from investigation, to planning, to implementation and finally to evaluation.

Recommendations

The empirical support regarding the application of managed care practices to child welfare is minimal; there is no evidence that would support the wholesale conversion of child welfare services to this management model. However, the observation by Wulczyn, et al. (1997)

that current out-of-home care payment strategies provide an incentive to the provider to maintain a stable population to cover costs and that this works as a disincentive to discharging children from out-of-home care appears warranted.

We conclude this paper by offering two recommendations which encourage experimentation with out-of-home care placement decision-making processes and fiscal contracting practices.

Recommendation 1: Apply the utilization review strategies that are central to managed care to the placement decision-making process.

Current placement decision-making processes too frequently rely on a combination of ad hoc practice wisdom, quick responses to placement failures, deadlines created by judicial reviews and county administrative pressures to control costs. Efforts to establish a comprehensive standardized process for the evaluation of child and families service needs should begin. Criteria need to be established for entry into various out-of-home care options and a thorough delineation of the service capacities of different out-of-home care resources should be completed. This information should be incorporated into practices of administrative oversight of placement decision making.

Recommendation 2: Experiment with different models of contracting for out-of-home care services and establish an evaluation design that examines any effect of these different contracting strategies may have on outcomes of child and family functioning, child safety, placement re-entry and length of stay.

Counties should implement contract strategies that: (1) utilize performance based contracts with clearly defined performance incentives and penalties and comparison with (2) contracts that include a combination of capitated rates and performance based incentives and penalties.

These two recommendations related to entry into out-of-home care placement and experimentation with different contracting strategies provide a reasonable next step for examining the promise of managed care and child welfare. An approach that couples program experimentation with program evaluation provides the best hope for effective reform of the child welfare system.

Section IX.
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Appendix A
Survey

A Survey of Bay Area Child Welfare Directors Regarding Reform Efforts

Researchers made an initial telephone call to the child welfare director, or in some cases, the director or deputy director of the local Department of Social Services to set up an agreed upon time and date to conduct a phone interview. Prior to the interview appointment, researchers faxed the survey of the interview questions to each of the directors. Directors were asked to discuss issues of child welfare reform relating to the management, delivery and financing of local child welfare services. Particular emphasis was given to the directors' thoughts about and experiences with managed care and the child welfare system.

Bay Area Counties Surveyed

Alameda County. Alameda County is engaged in several projects which involve reforming the child welfare system through an emphasis on collaboration, integration, and prevention: (1) Project Destiny applies a *managed care approach* with several group home providers and uses flexible funding to provide high-level group home services; (2) under a federal System of Care grant, the child welfare system has teamed up with children's mental health and probation departments to provide *integrated services* to children who need multiple services; (3) the county continues to develop *neighborhood units* staffed by social workers. Alameda County is also undergoing administrative reform by changing its current review process for cases, with a particular emphasis on children ages six to twelve.

Alameda County is interested in exploring the applicability of *managed care principles* to the child welfare system, including possible options to privatize certain child welfare services. The Director of Child and Family Services expresses caution that Emergency Response Services

remain within the public domain, but believes that some preventative services as well as services for children in long-term placement could be handled by the private sector. Managed care could change the role of the county from delivering all of the direct services associated with the child welfare system to contracting out and monitoring more services. Alameda County is concerned about the possibility of losing control over the quality of services provided by the child welfare system, but would like to explore alternative possibilities with its colleagues. The Director believes that while there is room for improvement in the child welfare system, any changes should not be hastily adopted but, instead, need to be carefully and cautiously considered.

Contra Costa County. For the past two years, one of Contra Costa County's main efforts at child welfare reform has been to implement *concurrent planning* in which child welfare workers simultaneously plan for family reunification and long-range adoption from the child's initial entry into the child welfare system. Contra Costa County is also in the process of implementing an *outcome-based service delivery model* and is developing outcomes for each program within the child welfare system. The child welfare system is piloting *kinship care programs* in North Richmond and Pittsburg, two of the County's lowest income and highest risk communities.

The Child Welfare Director is interested in exploring managed care as a potential vehicle for child welfare reform, recognizing that it may be a useful tool for achieving fiscal accountability. However, she wants to be certain that managed care concepts are explored in the context of prioritizing children's safety. She does not believe that the power to remove a child from the home should be taken away from the public sector and given to the private sector, nor does she support privatizing case management services. In addition, the director noted that if public child welfare workers are assigned larger case loads due to the privatization of case

management services, this may serve to deprofessionalize the child welfare field because intensive social work interventions will not be needed to track cases on a county level. Finally, in adopting a managed care approach to child welfare, the Child Welfare Director would like to involve the courts in sharing the financial risk so that they become more accountable for timely reviews of child welfare cases and do not order children to have longer stays in the child welfare system without attention to cost.

Marin County. Marin County's child welfare reform efforts center around providing *integrated services* to more effectively deliver services to children and their families through the implementation of Assembly Bill 1741, the Youth Pilot Project. Additional reform goals of Marin County's child welfare system have been: (1) to *shorten the length of time* children are in placement; and (2) to *provide placement at lower levels* by placing children in more foster care homes, rather than group homes or residential treatment. Child welfare administrators in Marin County are currently waiting for Title IV-E waivers, before further reforming the child welfare system.

The Director of Social Services at the Department of Health and Human Services is cautious regarding the application of managed care principles to the child welfare system, asking if managed care will succeed in doing more for child welfare than merely creating another funding stream with different amounts of funding allotted to children and families, depending on their needs. The director expressed the opinion that creating block-granted funds at the local level already poses challenges for ensuring that funds are spent in the broadest way possible, and was extremely concerned that a switch to managed care in the child welfare system would specifically allocate funds on the family unit level and make the best delivery of services even more difficult to accomplish.

Another concern of management staff is the changing financing of child welfare services. Marin County is in a unique position because it receives strong financial support from the Marin Community Foundation. County administrators and managers are concerned that as funding waivers are passed, the Foundation may withdraw some support and expect the County to use more of its funds to purchase services from community-based agencies, thereby decreasing the County's financial resources.

Monterey County. Through a grant from the Packard Foundation, Monterey County is in the process of evaluating its child welfare system to determine areas for *systemic change*, with an emphasis on outcomes. The County has also been adjusting to the recent implementation of the computerized Child Welfare Services/Case Management System (CWS/CMS), which has caused a loss of productivity in its initial phase and cultural change as line staff become accustomed to a new technological process. Once the transition to CWS/CMS is completed, Monterey County is looking to place an increased focus on *kinship care, concurrent planning, and the adoptions initiative*. A proposal has been prepared to begin applying managed care principles to create a more specialized rate system for children in foster care. In addition the director would like to expand the county's *collaborative efforts with the Department of Mental Health* to provide a wide network of services within the child welfare system. In order to continue implementing changes within its system, however, Monterey County could benefit from additional funding and staffing, as well as support to continually evaluate the child welfare system and determine the most effective outcomes.

Napa County. Because Napa County has an integrated health and human services agency, it has approached child welfare reform by using an *integrated model* and weaving the delivery of child welfare services into the delivery of health and mental health services whenever

possible. Napa County Health and Human Services management personnel are currently focusing on the development and implementation of managed care in the areas of health and mental health, before turning their attention to significant efforts to reform child welfare. In the field of mental health, managers are currently working on establishing the county's rate structure and developing a utilization review process. If the child welfare system in Napa eventually adopts more managed care principles, administrators say they would like to create principles similar to those used in federal System of Care grants, that emphasize strength-based, family-led care not only the desire to control cost.

San Benito County. San Benito County is not currently implementing or considering any child welfare reforms because managers are waiting for Title IV-E waivers before making significant changes or starting any pilot projects. The director of San Benito County Human Services Agency believes very strongly, based on his experiences with managed health care, that introducing managed care concepts into the child welfare system would produce negative results, creating an incentive to limit services to children. Instead, he believes that the child welfare system in San Benito County needs more foster care homes, and additional mental health and substance abuse services for children and families. At this time, San Benito County administrators are focusing their reform efforts on *obtaining more services*, including specific efforts to procure funds for *additional mental health services* for children and families in the child welfare system.

San Francisco County. San Francisco County is engaged in several child welfare reform efforts. Internally, the system has been undergoing significant changes because one-third of the staff has left due to early retirement or attrition. These changes have led to a cultural shift within the agency. In addition, the agency has begun new demonstration projects, including the creation

of two voluntary service units aimed at *family maintenance* and *family preservation*, in which line workers' caseloads have been reduced from 30 cases to ten. With *smaller caseloads*, line staff work more intensively with families and are encouraged to contribute four hours per week of volunteer work either in a community resource center or school setting. This is an effort on the part of the Family and Children's Services Division to contribute to neighborhood communities and help staff avoid feeling "burnt out." These voluntary service units participate in a *multi-disciplinary review process* in which each case is reviewed at three months and six months. Currently the evaluation process has indicated a high success rate of 96% of families staying intact when their case was closed, however, a quality assurance program is being designed to follow up on each case three months after the interventions are completed.

The Family and Child's Services Division is also making efforts to improve its *cultural competency*. As part of a Title IV-E training partnership with San Francisco State University, the Division has developed a training curriculum for working with African American families, who make up a disproportionately large number of clients in the system. The Division is also exploring new *collaborative possibilities with the Department of Mental Health*, and it is looking to expand its shelter program and child protection center. In addition, the Division is involved in a *neighborhood planning process* in Bayview Hunter's Point, where it is forming a community advisory group to give input on the development of a neighborhood resource center aimed at family preservation.

With regard to managed care, the Deputy Director does not favor privatization of the child welfare system; however he believes that managed care principles may provide more structure and accountability to the system. He can envision establishing a rate structure that is based, in part, on the specific tasks of care providers, but is cautious about creating a system that

is based on cost effectiveness at the expense of children and families. To implement further changes in the child welfare system, he would like more funding for: prevention efforts; earlier interventions; further reduced case loads; and continued efforts to develop cultural sensitivity to clients.

San Mateo County. San Mateo County has been reforming its child welfare system to create a continuum of *integrated services* by delivering services through "community-based units," in which line workers are assigned by city rather than by functions of emergency response or family maintenance workers. In addition, San Mateo has been implementing *concurrent planning* for more than ten years. In an effort to develop creative funding strategies, San Mateo County recently issued a proposal to the State Department of Social Services to explore the delivery of *block-granted services* and define a set of *outcomes* for these services. The child welfare director is interested in exploring managed care as a management and funding strategy, but does not believe that privatization of child welfare, with the exception of some direct services, will occur in San Mateo County.

Santa Clara County. Santa Clara County is involved in several innovative reforms of its child welfare system. These include: (1) *the family group conferencing model*, (2) *wrap-around services* for severely emotionally disturbed children, and (3) *restructuring services* among several geographic areas. The family group conferencing model is used to increase self determination of families that are in the process of working with the county in determining a plan for the care and supervision of children removed from the home. Wrap-around services with severely emotionally disturbed children in Santa Clara County have been used to provide more comprehensive services to families in an effort to enable children in expensive out of home care to return home sooner than otherwise would be possible. Another reform Santa Clara

County is in the process of developing is the decentralization of its service provision. By January of 1998 the county plans to begin implementing community-based neighborhood teams to provide services in a more community involved manner. Crucial to this process is forming a climate within both the community and the agency of strategic partnership.

Santa Clara County is involved in some limited application of *care management* ideas. There have been some moves towards instituting principles of managed care. The director of the county's child welfare agency believes that the system could better serve its clients if there was greater financial flexibility. One of the initiatives the county is working with is transitioning children out of expensive out-of-home care placements sooner while still providing high quality services.

Some of the barriers to child welfare reform are the (1)lack of qualified foster homes, (2) lack of financial flexibility, and (3) newness of the management information system, CWS/CMS. This last barrier is believed to be temporary as it contains foundations for capturing good outcomes information

Two final issues identified by the county director are cultural competency and sustainable living wage jobs. The county is still struggling with the high number of children of color who are involved with the child welfare system. Reasons for this situation and the ability to provide culturally competent services must be constantly examined and acted upon accordingly. Finally, the director believes that there is not enough emphasis in case plans on the issue of economic self sufficiency for clients.

Santa Cruz County. Santa Cruz County has a federal System of Care grant, through which it offers *integrated health, mental health, social services, and probation.* Like Napa County, Santa Cruz County operates its child welfare services in a collaborative way, using

blended funding from Early Periodic Screening and Disability Testing (EPSDT) and working with CPS, mental health, and social services to reduce a child's length of stay in foster care. Selected foster care cases are reviewed periodically to ensure that children receive the least restrictive care possible and that family reunification or permanency planning is adequately pursued.

As a result of the increasing costs of foster care and the County Board of Supervisors' recent decision to decrease foster care expenditures, Santa Cruz County has begun internal evaluations of its child welfare system. While Santa Cruz County spent $6.6 million dollars on child welfare services last year, funds will be reduced by 20% this fiscal year. In preparation for reform in the child welfare system, Santa Cruz County has recently implemented an integrated data-base tracking system, modeled after its mental health data base system. This tracking system is intended to help county managers better identify specific costs incurred by placing children in the foster care system. The Director of Social Services for Santa Cruz County Human Resources Agency emphasized the county's priority and commitment to providing a safety net for children, regardless of cost. Santa Cruz County child welfare managers are also engaging in frequent dialogues with child welfare management staff from San Mateo, Monterey, and Santa Clara Counties in an effort to learn about other counties' child welfare reform efforts.

Solano County. Solano County's child welfare system is constantly changing to adapt to the needs of the children and families it serves. Solano County had a significant role in authoring Assembly Bill 327, which authorized kinship foster care parents to receive a foster care rate of pay. The child welfare system in Solano County also is making efforts to *assess children's immediate needs* while planning for their long-term needs. Solano County also uses its federal System of Care grant for *integrated mental health services* to broaden the scope of

child welfare services, using a *blended-funding approach* to provide a broad spectrum of services (e.g., case management, parent education, and a diversion program through the juvenile detention system) as part of child welfare services.

In observing Solano County's transition to Medicaid managed care in the health and mental health fields, the Child Welfare Program Manager is particularly concerned that internal administrative systems establish excellent communication channels so that future steps can be taken to adopt managed care principles in the child welfare system.

Sonoma County. Currently Sonoma County's child welfare system is in the process of an internal reorganization to prepare for the implementation of CWS/CMS. Internal changes include augmenting the emergency response unit and providing training for staff to learn to use the new system. Sonoma County focuses its child welfare efforts on *family maintenance* services, taking as few children into custody as possible. Instead, Sonoma County has created a large service component which focuses on *brokering services* to help troubled families stay together.

The Director of the Family, Youth, and Children's Division of the Human Services Department believes that Sonoma County should be pro-active about considering managed care principles for the management of child welfare. In particular, *outcome measures and coordinated services* should be developed. The director said that adopting managed care does not automatically imply that fewer services will be available or that services will need to be privatized, although these are common assumptions about the implications of managed care. She also believes that counties should have input in developing outcome measures, but that guiding principles should be set at the state level. The Sonoma County child welfare department participates in several interagency councils to identify gaps in services and maintain

collaborative efforts with other departments who serve clients using multiple services. She also believes that these kinds of collaboratives will be useful for the eventual development of provider networks and service delivery outcomes for a managed care system.

Stanislaus County. Stanislaus County is focusing its child welfare reform efforts on *emergency response* and *family maintenance programs*, having recently submitted a proposal to the County Board of Supervisors to double the number of staff in its family maintenance unit. In addition, the county uses a strength-based approach in working with families by creating *family group conferences*, in which members of the extended family are invited to a case conference to help give input into the plan for the child. Also, as part of a *collaborative effort* which is benefiting the child welfare system, the departments of mental health, public health, probation, and social services have contributed county general funds towards creating a "Families in Partnership" program which is an integrated team approach to provide non-categorically funded programs.

Stanislaus County has implemented a *total quality management process* to analyze out-of-home care costs and evaluate the placements of children from a financial and service perspective with the goal of *reducing costs and reinvesting funds in front-end services*. The Deputy Director for Family Services and the program manager of the Child Welfare Department are confident that an effective managed care system would need to include flexibility in funding in which any dollars that are saved could be reinvested in other programs within the system.

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Bay Area Social Services Consortium (BASSC)
University of California, Berkeley
School of Social Welfare
Survey Questionnaire for Child Welfare Directors

Bay Area counties are responding to federal and state policies to reform child welfare and child protective services through block-granting, Title IV-E waivers, and other forms of new legislation. We would like your answers to this survey to include issues of management, delivery, and financing of child welfare services as they apply to the county in which you work.

1. What, if any, child welfare reforms is your county implementing and/or considering?

   If any changes have been implemented, what have been the affects? (Please be specific about programs.)

2. What are your thoughts about applying managed care principles to the child welfare system?

   What are some of the implications of implementing managed care principles to the child welfare system?

   Has your county taken any steps towards exploring and/or implementing managed care If yes, please describe them.

3. What are your county's needs and/or barriers in planning for and implementing child welfare reform, including managed care?

4. What else would you like us to know about your county with regard to this topic?

Appendix B

Additional Tables on Select Managed Care Child Welfare Programs

Location	Managed Care Model	Risk Sharing Strategy	Utilization Review	Capitated Rate
Hamilton County, Ohio (FCF Manage-ment)	Administrative agency, FCF Management Inc., provides contract, referral and coordination services to area providers.	Shared Risk 5% Margin Rate	No	$3,760 per child per month
Hamilton County, Ohio (Magellan Public Solutions, Inc.)	Administrative agency, Magellan Public Solutions, Inc.., provides contract, referral and coordination services to area providers.		Yes	
Kansas	Continuum of care provided largely by sole providers.	Shared Risk 20% Margin Rate	No	Family Preservation: $3,428 per family Adoption: $13,556 per child Foster/Group Care: $13,557 per family
New York	Continuum of care provided largely by sole providers.	None	No	Unknown
Tennessee	Continuum of care provided largely by sole providers.	Full Risk	No	Therapeutic Foster Care: $2,201 per month. Residential Care (Level II): $2,049 per month. Residential Care (Level III): $4,025 per month.

Location	Selected Outcome Indicators	Additional Performance Incentives	Additional Performance Penalties
Hamilton County, Ohio (FCF Manage-ment)	• 90% plan of care submitted within 45 days of enrollment • 90% of quarterly reviews provided within 30 days of review date • 90% of risk assessments implemented when child returns home • 100% of IV-E reporting requirements met within 30 days of report period	$50,000 to network coordinator if actual costs are 98% of $3,760 times actual child months for 1997: distribution to network members at discretion of network.	Amount available for sanction for each one of the six performance indicators: $2,000 per month X each county agencies allocation percentage.
Hamilton County, Ohio (Magellan Public Solutions, Inc.)	Service Outcomes • 95% of care managers are assigned within 24 hours of completion of assessment • 60% of placement services will be provided in Hamilton County • 90% of staff in MSO & provider network are trained in cultural competency MSO Performance • 95% of consumers are satisfied with services • 95% of providers have been trained & are competent in Managed care technologies revenue maximization benchmarks include generating $112,405 in revenue the first year	Incentives up to $109,000 are tied to 13 service outcomes and MSO performance indicators	Penalties up to $96,000 are tied to 13 service outcomes and MSO performance indicators