Pergamon

Children and Youth Services Review, Vol. 22, No. 2, pp. 93–116, 2000
Copyright © 2000 Elsevier Science Ltd
Printed in the USA. All rights reserved
0190-7409/00/$–see front matter

PII: S0190-7409(00)00068-2

Managed Care and Child Welfare: Challenges to Implementation

Richard A. Embry

Paul Buddenhagen

Spencer Bolles
University of California, Berkeley

There is increasing interest in the application of managed care principles to the management of child welfare services. Interest to date has focused on application of these management tools to child welfare populations in the most costly segments of out-of-home care. This article is based on a review of the managed care evaluation literature and information gathered from child welfare administrators in California. The authors argue that there is limited empirical support for the wholesale adoption of managed care principles to child welfare and numerous reasons for concern including a lack of understanding of the essential features of managed care by public sector administrators, limited child welfare risk assessment capabilities, the pervasive role of the courts regarding placement decisions, very limited child welfare management information system capabilities, and the coercive nature of child welfare services. A more incremental approach to evaluating the promise of managed care principles in child welfare settings is urged. Essential policy and administrative issues are identified for further debate.

The convergence of numerous trends at the local, state, and federal levels provide 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, a persistent high need for child protective services without a parallel increase in funding, increasing privatization of essential child welfare services, the apparent success with managed care models in public health and mental health, and what appears to be an unrelenting criticism of current child

The authors thank Michael Austin, Ph.D. and Jill Duerr Berrick, Ph.D. for comments on an earlier draft of this article. Financial support for this research was provided by the Zellerbach Family Fund and Alameda County Social Services Agency.
Request for reprints should be addressed to Richard A. Embry, M.S.W., School of Social Welfare, University of California at Berkeley, Berkeley, CA 94720-7400. E-mail correspondence should be addressed to rembry@uclink4.berkeley.edu.

welfare practices are all promoting interest in the application of managed care principles to the delivery of child welfare services.

This debate over the effectiveness of managed health care has become the backdrop for the consideration of the application of managed care to child welfare. This prolonged debate over the effectiveness of managed health and behavioral health care is being fueled by powerful consumer and economic interests and is being fought with horror stories with limited review of the empirical literature.

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 creation of the Child Welfare League of America's Managed Care Institute and the entry of for-profit companies into the child welfare service continuum have all been elements that have helped sustain the interest in the application of managed care principles in child welfare, but they have also created suspicion amongst some public child welfare administrators. Such predominance of interest by private sector organizations raises the concern by supporters of public child welfare services that managed care child welfare is merely a vehicle for the privatization of public child welfare services.

A recently completed review of the application of managed care principles to child welfare in California included consultation with public child welfare administrators at the state and county levels, surveys of public child welfare administrators in thirteen California counties, focus group discussions with public child welfare administrators, a review of literature on the effectiveness of managed care in the health and behavioral health settings, and a review of numerous experiments in managed care and child welfare currently being conducted around the U.S. (Embry, Buddenhagen, Goldberg, DuBrow, Bolles, & Kramer, 1998). This project provided not only a review of the evidence regarding managed care, but also provided insights into the decision making process used by public child welfare administrators.

This article will describe the brief history and trends in managed care, describe the essential elements of managed care, describe some of the unique challenges the application of managed care to child welfare must address, and identify directions for further policy discussion.

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 that 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

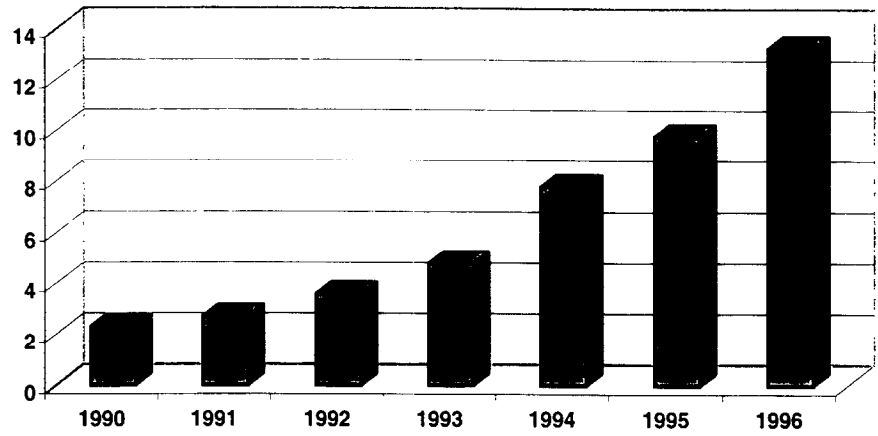
Introducing managed care in the public sector has been accomplished according to §1115(a) and §1915(b) waivers of the Social Security Act granted by the Health Care Financing Administration (HCFA). Under §1115(a) States conduct "research and demonstration" programs and may operate Medicaid programs in 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 1)

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.

Figure 1
Growth in Medicaid Managed Care Enrollment (in millions)



Source: Health Care Financing Administration. (1996). 1996 Managed Medicaid care enrollment report.

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 re-

garding 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 Information Systems

Adequate management 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 have 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. Risk based contracting attempts to align financial and clinical objectives in such a way that the vendor is at financial risk if "the right treatment to the right person at the right time" is not delivered (McGuirk, Keller, & Croze, 1995).

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.

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).

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 at least the following components: clients, laws, funding, cultural competence, cost shifting, administrative structures, and risk assessment.

Client Populations

Child welfare services are usually provided to the child through the child's family, and family members usually do not have the option of refusing services if they intend to regain custody of their children: services are provided to families under the control of the court system. 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. This

element of choice significantly differentiates people involved in the two systems.

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.

Judicial and 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 the 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. For example, federal funds for family preservation and support services were originally authorized in the Omnibus Budget Reconciliation Act of 1993, PL 103-66, and were continued as part of the Adoption and Safe Families Act of 1997, PL 105-89.

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. 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% believed 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. 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.

Required 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 is 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 Capability

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, whether the child will require placement (and in what setting), and the attendant costs to the child welfare system are central to the application of managed care and fall within an expanded province of risk assessment.

Over time, various methods of risk assessment have been employed in the child welfare system and most have focused on maltreatment recurrence. 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 only one that is 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.

Additionally, most child welfare risk assessment efforts have focused on predicting the level of risk in absence of intervention. Managed care programs will require more advanced risk assessment that can predict the level of service needed—including reasonable prediction of anticipated costs—by the various "types" of clients receiving child welfare services. This degree of risk assessment is absent from current child welfare risk assessment 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.

Policy and Administrative Implications

The administrator of public child welfare services must respond to a tremendously complex and demanding array of responsibilities while being buffeted by program, fiscal and political pressures. Principal 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 encourages re-examination of current practices and experimentation with new models for the management, supervision and funding of child welfare services.

Prior to embarking on quick efforts to manage child welfare systems using managed care principles, policy makers should consider the following:

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 regarding placement duration, the report did not include findings on child and family well-being. Because of the limited nature of the findings and study period (only one year) any conclusions from this one study regarding managed care and child welfare should be considered preliminary. As a result there is no empirical evidence that supports the wholesale conversion of child welfare services to the managed care model of management.

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.

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 grantor's 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.

Based on this review of reforming the management, delivery, and financing of child welfare services we suggest the following areas for further discussion.

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 agency's 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. Concerns regarding large-scale privatization should not preclude 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 child protective services initial investigations. 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. Administrative policies governing placement practices, judicial review of case actions, and availability of placement resources all impact placement decisions (Pecora et al., 1995; Rossi, 1992) as do child and caregiver characteristics (Thieman & Dail, 1997). 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. Due to a combination of design challenges, implementation issues, the need for real-time case level information, delays in data entry and reporting it is unlikely that the Statewide Automated Child Welfare Information Systems (SACWIS) funded under Title IV-E will be suitable for these efforts. The Hamilton County, Ohio/Magellan Public Solutions, Inc. contract made the development of a 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 therapeutic foster care and group care. The crisis-oriented decision making process that is utilized by social workers making emergency placements in response to child maltreatment reports 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 timing 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. Many organized labor groups may view this privatization effort as an effort to eliminate public child welfare case manager and/or social worker positions. The sentiment also exists 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 into every step of the reform effort from investigation, to planning, to implementation, and finally to evaluation.

Summary

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.

It was apparent from this project that many child welfare analysts have a limited understanding of the essential ingredients of managed care such as financial risk-sharing and capitated rates. Additionally, the debate regarding managed care and child welfare frequently becomes confused with the debate over increased privatization of child welfare services.

We offer two recommendations that 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 administrative pressures to

control costs. Efforts to establish a comprehensive standardized process for the evaluation of child and family 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.

The degree of attention given to the application of managed care principles to child welfare services may have obscured the examination of alternate contracting mechanisms that also could promote improved practices within a fiscally responsible approach. Other public social service sectors like health and behavioral health systems have more fully developed utilization review and quality assurance programs that have not been applied to child welfare services.

We encourage experimentation with and evaluation of a variety of contracting mechanisms in the child welfare setting. For example, public child welfare agencies could evaluate contract strategies that: (1) utilize performance-based contracts with clearly defined performance incentives and penalties and compare them 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 provides 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.

References

Abe-Kim, J. & Takeuchi, D.T. (1996). Cultural competency and quality of care: issues for mental health service delivery in managed care. *Clinical Psychology: Science & Practice, 3*, 273-295.

Berrick, J., Brodowski, M., Frame, L., & Goldberg, S. (1997). Factors associated with family reunification outcomes: understanding reentry to care for infants. Univer-

sity of California at Berkeley: School of Social Welfare (Bay Area Social Services Consortium).

Berrick, J., Courtney, M., & Barth, R. (1993). Specialized foster care and group home care: similarities and differences in the characteristics of children in care. *Children and Youth Services Review, 15*, 453-473.

Broskowski, A. (1997). *The role of risk-sharing arrangements. Managed Care: Challenges for Children and Family Services*, Anne E. Casey Foundation.

California Department of Finance (1997). A performance review: California's child welfare system. Sacramento, CA: Performance Review Unit.

Available: http://www.dof.ca.gov/spec_rev/cws2.pdf.

Christianson, J., Manning, W., Lurie, N., Stoner, T., Gray, D., Popkin, M., & Marriot, S. (1995). Utah's prepaid mental health plan: The first year, *Health Affairs*. 14(3): 160-172.

Doueck, H. J., English, D. J., DePanfilis, D., & Moote, G. T. (1993). Decision-making in child protective services: A comparison of selected risk-assessment systems. *Child Welfare*, 72 (5).

Egnew, R.C. (1997) Developing relevant public sector outcome measures, *Administration in Social Work, 21*, 77-80.

Embry, R., Buddenhagen, P., Goldberg, S., DuBrow, A., Bolles, S., & Kramer, K. (1998). A review of managed care as a tool for child welfare reform in Alameda county. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Center for Social Services Research, Bay Area Social Services Consortium.

Emenheiser, Barker, & DeWoody (1995). *Managed care: An agency guide to surviving and thriving*. Washington, DC: Child Welfare League of America.

Feild, T. (1996). *Managed care and child welfare: Are they compatible*? Bethesda, MD: Institute for Human Services Management.

Grasso A. & Epstein, I. (1989). The Boysville experience: integrating practice decision-making, program evaluation, and management information. *Computers in Human Services, 4*, 85-94.

Grønberg, K., Chen, T. & Stagner, M. (1995). Child welfare contracting: market forces and leverage. *Social Services Review, 69*, 583-613.

Health Care Financing Administration. (1996). 1996 managed Medicaid care enrollment report. [On-line].

Available: http://www.hcfa.gov/medicaid/trends.htm.

Hughes, D.C., Newacheck, P.W., Stoddard, J. J., & Halfon, N. (1995). Medicaid managed care: Can it work for children? *Pediatrics, 95*(4).

Johnson, W. (1996). Risk assessment research: Progress and future directions. *Protecting Children, 12*(2).

Lavizzo-Mourey, R., Clayton, L., Byrd, W.M., Johnson, G., & Richardson, D. (1996). The perceptions of African-American physicians concerning their treatment by managed care organizations. *Journal of the National Medical Association, 88*, 210-214.

Leiby, J. (1978). A *history of social welfare and social work in the United States.* New York: Columbia University Press.

Lindsey, D. (1992). Reliability of the foster care placement decision: a review. *Research on Social Work Practice, 2,* 65-80.

McCarthy, J. (1997). Presentation notes: impact of behavioral health care on children and their families: Teleconference call, May 16, 1997, W.K. Kellogg Foundation's Families for Kids Initiative, Project Directors. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

McCullough, C. (1996). Managed care and child welfare: An overview of 1996 trends, issues, and challenges. Child Welfare League of America, Washington, D.C.

McDonald, T. & Marks, J. (1991). A review of risk factors assessed in child protective services. *Social Service Review, 65*(1).

McGuirk F.A., Keller, A.B., & Croze C. (1995). Blueprints for managed care: Mental health care concepts and structure. Washington, DC: USDHHS (Publication #3B81).

McHugh, D.W. (1996). Implementation of managed care in child welfare: the legal perspective. *Behavioral Healthcare Tomorrow, 5*(6), 3-7.

Martin, L.L, & Kettner (1997) Performance measurement: The new accountability. *Administration in Social Work, 21*(1), 17-30

Masland, M., Piccaglia, G., & Snowden, L. (1996). Planning and implementation of capitated mental health programs in the public sector, *Education and Program Planning, 19*(3): 253-262.

Mechanic D. & Aiken L.H. Eds. (1989). *Paying for services: Promises and pitfalls of capitation.* San Francisco: Jossey-Bass.

Miller, R. H., & Luft, H. S. (1994). Managed care plan performance since 1980: a literature analysis. *Journal of the American Medical Association, 271*(19).

Mueller, A., & Baker, J. A. (1996). Evaluation of the Arkansas Medicaid primary care physician management program. *Health Care Financing Review, 17*(4).

Murphy, K., Vedder, B., Price, R., Kaufman, K., & Kammholtz, S. (1995). *Formation of networks, corporate affiliations and joint ventures among mental health and substance abuse treatment organizations.* Washington, DC: USDHHS.

Needell, B., Webster, D., Barth, R.P., Armijo, M., & Fox, A. (1997). Performance Indictors for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center.

Ohio child welfare waiver increases flexibility. (1997, May). *The Children's Vanguard* 1(3), 1-3.

Pecora, P. J., Whittaker, J. K., Maluccio, A. N., Barth, R. P., & Plotnick, R. D. *The child welfare challenge.* (1992). New York: Walter de Gruyter, Inc.

Precora, P., Fraser, M., Nelson, K., McCroskey, J. & Meezan, W. (1995). *Evaluating family-based services.* New York: Aldine de Gruyter.

Pelton, L. (1978). Child abuse and neglect: the myth of classlessness. *American Journal of Orthopsychiatry, 48,* 608-617.

Rossi, P. (1992). Assessing family preservation programs. *Children and Youth Services Review, 14*, 77-97.

Rowland, D., Rosenbaum, S., Simon, L., & Chait, E. (1995). *Medicaid and managed care: Lessons from the literature*. Washington, D.C.: Henry J. Kaiser Family Foundation.

Scallet, L., Brach C., & Steel, E. (1997). Managed care: challenges for children and family services. Policy Resource Center. Baltimore, MD.

Sedlak, A. & Broadhurst, D. (1996). *Third National Incidence Study of Child Abuse and Neglect: Final Report*. Washington:DC: U.S. Department of Health and Human Services.

Thieman, A. & Dail, P. (1997). Predictors of out-of-home placement in a family preservation program: are welfare recipients particularly vulnerable? *Policy Studies Journal, 25*, 124-139.

Wald, S. M., & Woolverton, M. (1990). Risk assessment: The emperor's new clothes? *Child Welfare*, 69.

Wells, K. (1991). Placement of emotionally disturbed children in residential treatment: a review of placement criteria. *American Journal of Orthopsychiatry, 6*, 339-347.

Winegar, N. (1992). *The clinician's guide to managed mental health care*. Binghamton, NY: The Haworth Press.

Winterfeld, A. S., (1995). Managed care, privatization, and their impact on the child welfare system. *Protecting Children, 11*(4).

Wulczyn, F., Zeidman, D., & Svirsky, A. (1997). HomeRebuilders; A family reunification demonstration project. In Barth, R., Berrick, J., & Gilbert, N. (Eds.) *Child Welfare Research Review*; New York: Columbia University Press.