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Report to the Chairman, Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives

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CHILD WELFARE

Early Experiences Implementing a Managed Care Approach

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The Honorable E. Clay Shaw, Jr.
Chairman
Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

This report, prepared at your request, describes states' efforts to implement managed care in their child welfare systems.

We are sending copies of this report to the Secretary of Health and Human Services, state child welfare directors, and selected county child welfare directors. We will also make copies available to other interested parties upon request.

Please contact me at (202) 512-7125 if you or your staff have any questions about this report. Other GAO contacts and staff acknowledgments are listed in appendix IV.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director
Income Security Issues

Executive Summary

Purpose

Faced with a decade of escalating costs and a poorly integrated patchwork of services, state and local child welfare agencies are looking to new financial and service delivery strategies to meet the needs of the nearly 1 million abused and neglected children in the child welfare system. Managed care in child welfare, like its counterpart in health care, is seen as a strategy to improve access to care while controlling the cost of delivering services. By coordinating the delivery of only those services that are necessary and appropriate, managed care strives to reduce the inefficiencies of the traditional fee-for-service system while providing quality care. However, unlike health care, the child welfare system legally holds the custodial responsibility for the safety and well-being of many of the nation's abused children. Aware of recent criticisms of managed health care's excessive controls over access to services, policymakers, practitioners, and child advocates are concerned about the consequences if the child welfare population is underserved or denied needed services while providers unduly profit.

The Chairman of the Subcommittee on Human Resources, House Committee on Ways and Means, asked GAO to determine the (1) extent to which public agencies are using managed care to provide child welfare services; (2) financial and service delivery arrangements being used under a managed care approach; and (3) challenges child welfare agencies face as they develop and implement managed care, and the results of such efforts to date.

Background

The current child welfare system encompasses a range of programs and services, including child protection, family preservation and support services, and foster care. States and counties administer these programs and services. The services typically provided include a temporary home for abused or neglected children, health care, educational services, and other services to support families, such as parenting education, mental health counseling, and substance abuse treatment. Many of these services are currently provided through a system of separate fee-for-service contracts with private providers. Federal funding is primarily authorized under title IV-E of the Social Security Act, which reimburses states for a portion of out-of-home care costs for those children eligible under the Aid to Families With Dependent Children (AFDC) program.[1] In 1996, federal funding for child welfare services totaled nearly $5 billion.

[1]Although legislation passed in 1996 eliminated the AFDC program, children who meet the 1996 eligibility criteria for AFDC continue to be eligible for title IV-E assistance. The states incur all foster care costs for children not eligible for federal support.

With roots in the health care system, managed care has two primary elements. The first is a prepaid, capitated payment system to control costs and discourage providers from providing unnecessary services. Under capitation, the managed care plan—such as a health maintenance organization—is prospectively paid a preset price for a range of services that are delivered by an established network of affiliated hospitals, physicians, and other providers for a defined population of clients. The managed care plan must then manage its resources to ensure the availability of appropriate services when the need arises. This payment arrangement is a departure from that used by many human service programs, where providers submit bills and are reimbursed on the basis of the number and type of services they provide. Prepaid capitation exposes the managed care plan to some financial risk because the cost of serving clients may exceed the capitated payment. Therefore, setting an appropriate rate that factors in the anticipated costs of all clients' needs—including the needs of high-cost clients—helps build in the financial incentives and protections that are important for both plans and clients. The second element is coordinating service needs through a single entity to improve clients' access to quality care. At this single point of entry, the managed care plan assesses clients' needs, develops the treatment plans, and prescribes the appropriate services needed to achieve desired outcomes. The managed care entity can provide services itself, manage a network of affiliated providers, or authorize out-of-network services to collectively make available the broad array of services that might be needed.

Results in Brief

Nationwide, public child welfare agencies have implemented managed care projects or initiatives in 13 states, with new initiatives being planned or considered in more than 20 other states. Most of the ongoing initiatives involve foster children with the most complex and costly service needs. However, currently, only about 4 percent of the nation's child welfare population is being served under managed care arrangements. In general, public agencies have contracted with experienced nonprofit, community-based providers in their service systems to implement managed care initiatives. For-profit managed care companies have not had a major role in implementing managed care in child welfare; only a few jurisdictions are using for-profit companies to administer and provide child welfare services.

The majority of the ongoing child welfare managed care initiatives have established a capitated payment system. Lacking experience and uncertain

about the feasibility of new fixed payments, however, some initiatives also use mechanisms to limit the financial risk that has been shifted to providers, such as limiting contractors' losses should costs exceed the fixed rate. Managed care initiatives require service providers to organize and coordinate a full array of services to ensure that appropriate and necessary services are available to children and their families. In addition, most of the public agencies responsible for the initiatives have transferred case management functions to private entities—mostly nonprofit service providers. The public sector, however, continues to play an active role at strategic points throughout the service-delivery process, such as determining which clients will be served under managed care. To ensure that providers' cost-controlling strategies do not jeopardize service quality or access to care, public agencies use various quality assurance techniques, such as performance standards to hold service providers accountable for outcomes.

As more public child welfare agencies move toward managed care, the experience of the ongoing managed care initiatives suggests that public officials and their private contractors face several challenges. First, as they develop and implement a capitated payment method, agencies need to find ways to maintain adequate cash flow. Cash flow can be problematic because under capitation the agencies pay providers prospectively but claim federal reimbursement only after services have been delivered. Second, agencies face the difficult task of developing sound management information systems, which are critical to establishing an appropriate capitated payment rate and a performance-based monitoring system. Finally, both public and private agencies face new responsibilities as some traditionally public functions shift to the private sector and new roles emerge. These changes may require these agencies to develop new procedures for case management and program administration and to provide additional training for both public and private employees. Despite these challenges, public officials are encouraged by some positive, though limited, early results from managed care initiatives.

Principal Findings

Managed Care Is a New and Growing Strategy in Child Welfare

The application of managed care in child welfare is a new phenomenon. On average, most initiatives have been operating 2 years or less. Public agencies have implemented one or more initiatives in 13 states, and by the

end of 1998, additional initiatives will be operating in four more states. These numbers are expected to continue increasing, with 18 more states currently in some stage of planning or considering managed care initiatives.

Most managed care initiatives are small in scale, serving targeted populations of children and their families in a limited number of locations. In only one state and one county—Kansas and Sarasota County, Florida—are essentially all children and families in the child welfare system served under new private managed care arrangements. Most initiatives also include the most difficult to serve and high-cost adolescents in need of group or residential care, with many serving this group exclusively. In total, however, only a small portion of the nation's child welfare population is covered by managed care arrangements. In the 13 states where initiatives are in place, about 44,000 children, including both in-home and out-of-home care clients, are served under managed care. This represents about 8 percent of the child welfare population in those states and 4 percent of the nearly 1 million children in the child welfare system nationwide.

Structurally, most of the ongoing child welfare managed care initiatives rely solely on the public and community-based private providers that have traditionally served children and families in the child welfare system. GAO found that the organizational arrangement among public and private entities involved in these initiatives falls into four models:

- The public model, used in 10 initiatives, maintains the system's traditional management and service-delivery structure while the public agency incorporates managed care elements into its own practices and existing contracts with service providers. While payment methods to service providers and performance standards are new, most roles and responsibilities remain unchanged.
- The lead agency model relies on private entities to manage child welfare services and is used in 19 initiatives. The public agency contracts with a private entity, which assumes new responsibility for coordinating and providing all necessary services for a defined population of children and families. In this model, the lead agency provides some or all direct services itself, and may also subcontract with a network of local service providers.
- The administrative services organization (ASO) model privatizes management services, such as billing and reimbursement, development or operation of a data system, training, and technical assistance. The public agency contracts with a private organization for these administrative

services only. In the three initiatives that have implemented this model, the coordination of client services and provision of direct services are the responsibility of a separate private entity as in the lead agency model.

- The managed care organization (MCO) model is most similar to managed care arrangements in health care and can be found in four initiatives. The public agency contracts with a private organization to manage child welfare services, as in the lead agency model. However, in contrast to the lead agency model, the MCO does not provide direct services, but arranges for the delivery of all necessary services by subcontracting with other service providers.

Managed Care Initiatives Use Capitated Payments and Rely on Private Entities to Assume Case Management Responsibilities

In most of the 27 initiatives about which GAO obtained detailed information, public agencies have introduced capitated payments to providers at a rate set either for each referred client or for a defined population of clients residing in a geographic area. Nearly all of these public agencies have limited providers' financial risk by capitating only part of the provider's payment and reimbursing some services through the fee-for-service method, or by specifying contract provisions that limit the extent of providers' financial risk. These provisions include limiting the contractor's losses when costs exceed the capitated payment or setting funds aside to cover unusual catastrophic costs. In addition, while public agencies use various sources and methods to finance their managed care initiatives—including federal, state, and local dollars as well as pooled funds from various human service agencies—contractors are often expected to supplement the contract rate with funds from other sources.

Managed care contracts generally require the contractor to provide, create, or purchase a full package of services. When contractors need to purchase services from other providers, they may develop and subcontract with a network of other service organizations. The managed care entity—whether a public agency, lead agency, or MCO—functions as the single point of entry to the service system and performs case management tasks, such as treatment planning and case monitoring. Although most of the 27 initiatives GAO examined have privatized case management responsibilities, public agencies continue to perform activities surrounding the investigation and substantiation of abuse and neglect—often considered the gateway into the child welfare system. In addition, public agencies continue to play a major role in service-delivery decisions that directly affect the child's safety, such as discharge from care and changes in the level of care.

Public agencies have also implemented quality assurance strategies designed to offset the inherent incentive in managed care to withhold or provide reduced services and balance the desire to control costs with the goal of improving service outcomes. In nearly all of the ongoing initiatives, public agencies have instituted performance standards as a means of holding their contracted service providers accountable for outcomes. Some standards focus on system outcomes, such as returning children to their families more quickly, while other standards are more client-specific, such as completing high school or job training programs. Another quality assurance strategy links financial incentives and disincentives to outcomes, such as offering bonuses to contractors for meeting performance standards and limiting providers' profit levels or requiring unspent revenues to be reinvested in services. Finally, these managed care initiatives will have to be evaluated to determine the efficacy of the new financing and service-delivery arrangements in accomplishing desired objectives and achieving efficiencies.

The Move to Managed Care Is Not Without Challenges

The experiences of the initiatives GAO examined indicate that child welfare agencies face three principal challenges as they seek to implement a managed care approach. First, many public agencies need to find ways to maintain an adequate cash flow as they make prospective payments to service providers while receiving retroactive reimbursement from other sources, such as title IV-E. Moreover, public agency officials expressed concern that federal prohibitions against the use of title IV-E funding for services other than out-of-home care may force states to fund a greater share of capitated contracts. Specifically, if managed care creates incentives for contractors to provide better services and, consequently, return more children home, federal reimbursement for foster care ceases; however, the child and family may continue receiving unreimbursable in-home services.

Second, the child welfare system has historically been plagued with poor service and cost information. Accurate and timely information on services and outcomes is critical. Public agencies are slowly implementing performance standards to hold contractors accountable for desired outcomes; however, ensuring that these standards are the most important ones and are set at reasonable levels becomes especially difficult when baseline and ongoing program data are absent. In addition, establishing and revising an accurate and fair capitated payment rate requires information on an array of services from a variety of providers and their associated unit costs. Public agencies have approached the development

of their information systems in a variety of ways, including contracting specifically for a new system, developing it in-house, or adapting existing systems.

A final challenge both public agency staff and private service providers face is the dramatic changes in their traditional roles and responsibilities. Public agency staff need to adjust to performing less direct client casework and focusing more attention on contract and system management, as private entities assume new responsibilities for managing child welfare services. Where case management and administrative functions have shifted to private entities, some public agencies have had to downsize the public workforce and retrain and move the remaining staff into their new roles as contract managers or quality assurance workers. At the same time, private contractors have found themselves becoming quasi-governmental entities as they assume what were formerly public agency functions, such as direct responsibility for complying with federal and state procedural and paperwork requirements; hiring, training, and retaining qualified staff to perform new case management or administrative functions; and managing and monitoring a network of service providers.

Little quantitative information exists on how managed care has affected the children and families in the child welfare system, as only a limited number of initiatives have collected evaluation data. Preliminary data in these few locations, however, indicate some cost efficiencies when children appropriately avoid residential care. Moreover, public officials are encouraged by other service-delivery improvements, such as increases in the amount and types of services that better match the needs of children and families in the child welfare system.

Agency Comments

GAO obtained comments on a draft of this report from the Department of Health and Human Services (HHS) and state and county public child welfare officials responsible for the managed care initiatives in the four case study sites. HHS and the four public agencies generally agreed with the report's findings and provided additional technical information, which GAO incorporated in the report as appropriate. HHS also said GAO should clarify the report to reflect HHS' efforts to provide public child welfare agencies guidance and supporting information to aid states' consideration and implementation of managed care concepts. GAO clarified the report to reflect this information. (Ch. 5 contains additional information about HHS and the public agencies' comments and GAO's responses.)

Contents

Abbreviations

ACF	Administration for Children and Families
AFDC	Aid to Families With Dependent Children
ASO	administrative services organization
CPS	child protective services
GED	general equivalency diploma
HHS	Department of Health and Human Services
HMO	health maintenance organization
IMPACT	Integrated Managed Partnership for Adolescent Community Treatment
MATCH	Multi-Agency Team for Children
MCO	managed care organization
SACWIS	Statewide Automated Child Welfare Information System
SAMHSA	Substance Abuse and Mental Health Services Administration
SSI	Supplemental Security Income

Introduction

For children who have been abused or neglected by their caregivers, the child welfare system is an expensive and often poor substitute for a permanent home. The children and families in the system often have serious and difficult problems that can require intensive and time-consuming services. Unfortunately, most experts agree that the current system for caring for these children is inadequate. Program officials and policymakers alike are eager to find new and better solutions to meet the growing demands of this vulnerable group. Though not without controversy, managed care has emerged as one strategy to improve the overall care system for families in the child welfare system.

Child Welfare System Is Ripe for Reform

The child welfare system is a complicated network of policies and programs designed to protect and promote the safety and well-being of children. Encompassing a broad range of activities, child welfare services include those designed to protect abused or neglected children, support and preserve families, care for the homeless and neglected, support family development, and provide out-of-home care when children must be removed from their families. The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) established requirements that states undertake reasonable efforts to prevent the need to remove abused and neglected children from their families. If separation is required, however, states must ensure adequate care for the children while providing the necessary services to help reunite the family or locate another permanent home for the child if reunification is inappropriate.

The child welfare system has been under great pressure to meet increased demands. Over the last decade, rising caseloads have dramatically increased federal, state, and local spending for child welfare services. The needs of children and their families in the system are greater and more complex than ever before. Yet, the current system for funding and serving this more difficult population is fragmented and has strained public agencies' ability to adequately meet service needs.

System Seeks to Protect Children

The child welfare system consists of a myriad of agencies and programs that intervene when children are neglected or abused. State or county child welfare agencies carry the responsibility for ensuring the safety of these children through multiple programs funded by local, state, and federal governments. Children generally come to the attention of the child welfare system when someone—a physician, child care provider, or teacher, for example—reports to the state or local child welfare agency an

allegation of abuse or neglect. Child protective services (CPS) workers respond to and investigate these reports, identify services such as parenting classes for the family, and determine whether to remove a child from the family's home.

If removal is warranted, the child is placed in any one of several foster care settings that offer different levels of care depending on the needs of the child. The lowest to highest levels of care—corresponding to the least to most costly foster care settings—include foster family home, therapeutic family foster home,[2] group home, and residential treatment center. A child's stay in foster care is considered temporary, until the family can be reunited, the child is adopted, or some other permanent living arrangement is made. In addition, states provide family preservation and support services to prevent out-of-home placement and help reunite families. These services include family counseling, respite care for parents and caregivers, and services to improve parenting skills and support child development.

Primary responsibility for child welfare services rests with the states, and each has its own legal and administrative structures and programs to address the needs of children. In most states, the state child welfare agency makes major administrative decisions; in 12 states, however, counties administer child welfare programs with considerable autonomy to establish policies and priorities within broad state guidelines.[3] While public workers provide some or all child welfare services in some locations, most state and county child welfare agencies have long relied on private service providers—predominantly nonprofit, community-based agencies—to work directly with children and families. For children entering the child welfare system, public caseworkers are typically responsible for (1) developing a service plan for the child that can identify out-of-home care, educational, and health service needs; (2) directly providing or arranging to purchase from private or other public providers the specified services; and (3) periodically monitoring the child's progress.

Caseloads and Costs Are Rising

During the mid-1980s through the mid-1990s, the child welfare system witnessed dramatic increases in the number of children reported abused

[2]Children with special needs, who would not ordinarily be placed in traditional family foster care, may be placed in a therapeutic family foster home as an alternative to group care or residential treatment.

[3]The 12 states with county-administered child welfare systems are California, Colorado, Georgia, Maryland, Minnesota, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Virginia, and Wisconsin.

or neglected and placed in foster care. An estimated 3 million children were reported possible victims of abuse or neglect in 1996. Upon investigation, CPS workers confirmed maltreatment of almost a third of these reported children. During this same period, the foster care population grew almost 80 percent, from 280,000 children in 1986, to 502,000 in 1996.[4] Child welfare experts attribute the rise in the foster care population to such trends as the increasing use of illegal drugs, especially among young mothers in inner-city areas; rising numbers of homeless families; and the growing number of children whose families live in poverty.

With increasing foster care caseloads, expenditures for the basic needs of foster children and program administration have risen dramatically. From 1986 to 1996, federal costs for child welfare services increased nearly fivefold to $4.2 billion. The Congressional Budget Office estimates that this will rise to $5.9 billion by 2002. In addition to facing similar increases in these expenditures, state and local resources have been constrained by competing demands from other activities. States have found it increasingly difficult to maintain sufficient funding levels to ensure that service needs are met.[5] To address these financial pressures, many states have cut child and family services or kept budgets constant.[6] Further, resource constraints force public child welfare workers to prioritize their caseloads, which often means responding to emergency situations, leaving little time to attend to children already in out-of-home care.[7]

Current Funding and Service-Delivery System Is Fragmented

No single federal program fully supports the range of services that typically make up state and local child welfare programs. The major federal programs are found in the Social Security Act:

- Title IV-E Foster Care is an uncapped entitlement that reimburses states for a portion of foster care costs, such as food and shelter, daily supervision, administration, and training for agency staff, for only those

[4]The American Public Human Services Association estimated the foster care numbers on the basis of data voluntarily reported by the states.

[5]Child Welfare: Complex Needs Strain Capacity to Provide Services (GAO/HEHS-95-208, Sept. 26, 1995).

[6]C. Brach and L. Scallet, "Managed Care's Implications for Children and Families: An Overview of Trends and Issues," draft prepared for the Annie E. Casey Foundation, July 1996.

[7]T. Feild, "Managed Care and Child Welfare: Will It Work?" Public Welfare (Summer 1996).

children eligible under the Aid to Families With Dependent Children (AFDC) program.[8]

- Title IV-E Adoption Assistance, also an uncapped entitlement, reimburses states for a portion of adoption costs, including payments to parents who adopt children with special needs as well as administrative and training costs, for only those children eligible under the Supplemental Security Income (SSI) or AFDC programs.
- Title IV-E Independent Living reimburses states for some of the cost of providing independent living services for older foster children.
- Title IV-B Child Welfare Services and Promoting Safe and Stable Families programs provide federal matching grants to states for up to 75 percent of the costs of services such as family preservation and support services, some foster care, and other child welfare services related to preventing out-of-home placements; reuniting families; finding adoptive families; protecting children's safety; and preventing maltreatment.
- Title XX Social Services Block Grant gives states discretion to fund a wide array of social services for children, families, adults, and the elderly.

Federal, state, and local governments share responsibility for funding the child welfare system. In fiscal year 1996, over 65 percent of the $4.7 billion in federal funding for child welfare services under titles IV and XX was for foster care services.[9] Title IV funding of states' child welfare program costs ranged from 50 to 77 percent.[10] In addition, where federal sources are fixed by annual appropriations, as in title IV-B, states fund both the required match and any additional costs above the capped amount. Furthermore, through cost-sharing arrangements with counties, states pay all foster care costs for those children ineligible under the federal program. Nationwide, about half of all foster care placements were funded under title IV-E in fiscal year 1996.

The child welfare service system is also fragmented. The service needs of children and families known to the child welfare system are more complex than in the past. Facing multiple problems of economic hardship, substance abuse, homelessness, and mental or physical illness, these

[8]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) eliminated the AFDC program; however, children who meet the 1996 eligibility criteria for AFDC continue to be eligible for title IV-E assistance.

[9]In addition to the $4.2 billion from titles IV-E and IV-B, the 1996 Social Services Block Grant was about $2.4 billion. However, the most current data available on the amount of title XX funds spent for child welfare-related services were for 1995 and represented about 22 percent of title XX expenditures in that year, or $0.5 billion of the 1996 block grant.

[10]Title IV-E funding for foster care and adoption maintenance costs are tied to the Medicaid matching rate, which ranged from 50 to 77 percent in fiscal year 1997. Federal funding for other child welfare costs under titles IV-E and IV-B is at either 50 or 75 percent of states' costs, depending on the program.

children and their families more often have serious emotional, behavioral, and medical needs. However, rarely does a single state or local agency have control over the full array of services to appropriately address the needs of the child welfare population. Many of the needed services, such as mental health care and drug treatment, are outside the control of the child welfare system. Public child welfare agencies often must tap into a complex set of human service systems, which are usually supported by separate categorical funding sources and have different eligibility criteria. Gaining access to needed services, especially those outside the child welfare system, can be extremely difficult when other systems also have insufficient capacity or do not share child welfare's priorities.[11]

Finally, service providers are rarely held accountable for achieving system objectives to improve the quality of care and service outcomes to ensure children do not languish in foster care. Public agencies traditionally use private service providers who are paid on a fee-for-service basis whereby a provider submits a bill and is reimbursed for the number and type of services delivered. Under this system, the provider has little incentive to, when appropriate, reduce the level of care as children's functioning improves, discharge them from care, or monitor and assess the number of service units provided because these actions may result in lost revenues.

What Is Managed Care?

The origins of managed care lie in the health sector. Prepaid health care plans were first developed to improve access to and continuity of health care while controlling costs. Early health maintenance organizations (HMO) served primarily an employed population. Contracting with prepaid, fixed-fee managed care plans to deliver health care services to Medicaid beneficiaries first became an option for states in the 1960s. As federal and state Medicaid expenditures soared, states increasingly turned to managed care programs to help bring costs under control and expand access to health care for low-income families. By 1997, states had extended prepaid managed care to more than 48 percent of the Medicaid population.[12]

Prepaid managed care plans have two fundamental elements—a prospective capitated payment system and coordinated services. In general terms, states pay contracted plans, such as an HMO, a monthly or capitated fee per enrollee to provide a range of medical services that are

[11]Child Welfare: Opportunities to Further Enhance Family Preservation and Support Activities (GAO/HEHS-95-112, June 15, 1995) and GAO/HEHS-95-208, Sept. 26, 1995.

[12]Medicaid is a joint federal-state health financing program for the poor and provided health care to an estimated 36 million people in 1997.

coordinated through primary care physicians and typically delivered by an established network of affiliated hospitals, physicians, and other providers. With its fixed prospective payment, this model attempts to create an incentive for plans to provide preventive and primary care and to ensure that only necessary medical services are provided. The second managed care element brings together an array of different services to ensure that an enrollee has access to needed care by linking individual beneficiaries with a single provider responsible for coordinating their health care needs.[13]

Prospective Financing Transfers Risk

A capitated payment is a prospective rate paid for a range of services for a specified population. The methods for developing the capitated payment generally involve bundling rates by aggregating costs for a related set of services and paying a single average rate on a fixed-fee basis. Separate rates may be established for specific populations, such as individuals with chronic illnesses or disabilities. The fact that the price is fixed exposes the managed care plan to some financial risk. Plans have an incentive to control expenses to avoid losses but always face a risk that the needs of certain patients may result in unexpectedly high costs.

Two types of fixed payment arrangements, in particular, illustrate how risk is shifted to providers. The first type, a case rate payment, transfers to the managed care plan the risk that patients' service level, duration, and cost will exceed projections. Under this arrangement, the health plan's payment rate is fixed to cover all expected costs incurred for a specified patient. Although each client generates a new payment, providers have an incentive to reduce the duration of treatment and avoid serving patients whose treatment will be costly or lengthy. The second type, a capitated rate, similarly shifts financial risk when service use is higher than anticipated but also includes a factor of uncertainty because the number of clients that will actually require services is unknown. A capitated rate is a single, previously negotiated, monthly or periodic fee paid for all members of a pool of potential service users, whether or not an enrollee uses any services. The plan is expected to respond to whatever level of service is needed by the enrollees, as long as the service falls within contractual terms.

Services Are Coordinated to Meet Clients' Needs

In a managed health care plan, the primary care provider is responsible for delivering or arranging for the delivery of all health services required by

[13]Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996) and Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort (GAO/HEHS-97-86, May 16, 1997).

the covered person under the conditions of the provider contract. A primary care physician is typically responsible for approving and monitoring the provision of all services covered by a health plan to the patient and family. As the case manager, this primary care physician acts as the gatekeeper or single point of entry for patient access to health care services. To simplify access to a continuum of services and ensure coordination of care, the plan may incorporate a broad range of general and specialty services within a network or organization of affiliated providers. In addition, the plan may provide services itself or authorize out-of-network services. To discourage and reduce unnecessary procedures or inappropriate service use, a patient may be required to obtain prior approval, or preauthorization for payment, before admission to inpatient facilities, emergency rooms, or other high-cost or high-risk services. Furthermore, requiring approval for appropriate and necessary care as a condition of payment authorization reduces excessively prolonged or unnecessarily expensive treatment levels. Costs can also be reduced when patients are diverted from unnecessary or overly expensive levels of care into suitable, less costly alternatives.

Managed Care Is Viewed as a Solution to Child Welfare Problems

Public agencies are beginning to adopt these managed care elements in their child welfare systems. According to child welfare experts, policymakers and child welfare administrators are attracted by the twin promises of managed care—cost containment and improved service access and quality—and hope that managed care can improve shortcomings in the current child welfare system. Currently, for example, a public child welfare caseworker may have difficulty accessing different services, such as group or individual counseling and parent training, from a number of separate providers. This fragmentation can lead to delays in receiving needed services and prolonged stays in foster care, and offers little assurance that children and families are getting services that best match their needs. In addition, provider payments are typically made on a fee-for-service basis with little incentive for the provider to reduce the child's type and amount of services or recommend discharge from care when appropriate. Under managed care, a single entity is responsible for arranging and coordinating the child's care among a network of providers and is reimbursed on a capitated basis rather than for the total amount of services provided.

Similar to the pressures the Medicaid program faced, rapidly increasing child welfare expenditures and eligible populations have strained state and local budgets, while providers and policymakers have experienced

difficulties in meeting their fiscal or program goals amid calls for system reform. As we have previously reported, the current federal system for financing child welfare services makes it easier for states to place children in foster care rather than provide services to avert the need for foster care because federal funding under the open-ended entitlement program of title IV-E is available only when a child is in out-of-home care.[14] Federal funding under titles IV-B and XX is capped for in-home services, such as those to prevent the need to reenter foster care, and has not kept pace with growing demands.

The implementation of Medicaid managed care—which serves many of the same vulnerable populations that child welfare agencies serve—has also created interest in managed care in child welfare. Child welfare clients may already be required to access health care or behavioral health[15] services through a managed care system. As of fiscal year 1997, more than 48 percent of Medicaid-eligible clients, including some in the child welfare system, were enrolled in managed health care or behavioral health programs.

Child welfare experts point to several other factors that have coalesced to heighten interest in managed care. First, child welfare providers are responding to and adapting their practices to new managed care environments in other human service systems. Private child welfare service providers often serve children, youth, and families from various service systems, including child welfare, mental health, and juvenile justice. In an attempt to diversify their funding streams, some of these providers have pursued the commercial business of behavioral health managed care organizations and marketed themselves as a less expensive alternative to inpatient care. These efforts enable the providers to capture new private clients, learn managed care skills, and advocate privatizing the child welfare service-delivery system. Second, states are seeking the opportunity to allocate money more efficiently by using more appropriate and effective services. As many states have addressed financial pressures by cutting children and family services or keeping budgets constant in the face of increasing demand, managed care is seen as well suited to downsizing and cost containment. Finally, behavioral health managed care

[14]Foster Care: Services to Prevent Out-of-Home Placements Are Limited by Funding Barriers (GAO/HRD-93-76, June 29, 1993) and GAO/HEHS-95-208, Sept. 26, 1995.

[15]The term behavioral health is used to specify mental health and substance abuse treatment and includes inpatient, outpatient, and residential care.

organizations are seeking new markets in the child welfare system.[16] In chapters 2 and 3, we describe state and local efforts to implement managed care in the child welfare system.

Fundamental Differences Exist Between the Child Welfare and Health Care Systems

In contrast with health care, the child welfare system is uniquely affected by several factors, including the characteristics of the clientele, the role of the judiciary, legal and policy goals and responsibilities, and service delivery complexities.[17] One significant difference between child welfare and health care is that most child welfare services are delivered on an involuntary basis. Child welfare services are most often imposed on unwilling clients at the direction of the courts, police, or a CPS worker, after concerns are raised about their parenting abilities. In the health care system, the patient wants the protection of a health insurance plan and seeks out services when the need arises. In child welfare, families are often resistant or hostile to system intervention. In these situations, according to child welfare experts, it may not be appropriate to assume that a limited number of visits or treatments will resolve long-standing family issues that have led to child abuse or neglect.

A second difference between the child welfare and health care systems is that courts play a key role in child welfare decision-making, and this could limit providers' control over costs. In health care, the payer is also the arbiter of what services are delivered and paid for, guided by contractual and regulatory guidelines. In child welfare, however, many cases—including all out-of-home care—are under the jurisdiction of the state's family or juvenile court. State law determines the full extent of the court's authority. In some states, neither the public child welfare worker nor a service provider ultimately controls a child's treatment plan because the court has the authority to order specific services and placement at individual facilities, or the court may order different services from those recommended by child welfare professionals. Moreover, courts may be backlogged or disagree with recommendations about children's movement within foster care or discharge from care; in either case, children may remain in or at a level of care longer than clinically necessary.

A third factor unique to the child welfare system is the scope of care provided by public agencies. Public agencies do not look merely at a

[16]Brach and Scallet, "Managed Care's Implications;" and T. Feild, Managed Care and Child Welfare: Are They Compatible? Institute for Human Services Management (Bethesda, Md. 1996).

[17]Feild, Managed Care and Child Welfare: Are They Compatible?; and A. Winterfeld, "Managed Care, Privatization and Their Impact on the Child Welfare System," Protecting Children, 11(4) (1995).

child's clinical needs but also at the child's other needs, such as safety, protection, and social supports. In addition, the overall well-being of the child's family is a concern of public agencies. In many cases, the child's primary need may be the services provided to the parents, such as substance abuse treatment or parenting classes. Recalcitrant, hostile, or uncooperative parents may prolong the intervention required for a seemingly simple problem. In addition, if a child cannot be reunited with the family, then the child welfare agency assumes the difficult task of finding an alternative permanent home for that child that will offer appropriate supervision and guidance until the child reaches adulthood.

Last, the links between diagnoses, interventions, and outcomes are less clear for clients in the child welfare system. In health care, one can generally predict with reasonable confidence the incidence of particular ailments for a given population, costs of care, and probable outcomes. This predictability allows a managed care provider to anticipate service demand and, therefore, costs. In the child welfare system, however, predicting needs and outcomes is much less certain and depends more on social factors, which are less predictable than physical ones. Moreover, social services are much less standardized than health services and are often delivered very differently from community to community and from family to family, according to factors unrelated to the family's situation.

Federal Role in Child Welfare Managed Care Is Limited

Federal involvement in managed care in child welfare has thus far been limited. While the federal role in states' managed health care efforts has expanded recently, no comparable role has emerged for managed care in child welfare. The Administration for Children and Families (ACF) within the Department of Health and Human Services (HHS) administers the federal child welfare programs; this involves monitoring states' compliance with federal statutes and regulations, providing technical assistance to states, funding various resource centers across the country, and supporting research and evaluation efforts. To date, ACF has included managed care topics in some of its conferences and responded to specific inquiries about managed care financing in child welfare but has so far not provided any formal guidance or technical assistance. In addition, HHS was given the authority in 1994 to establish no more than 10 child welfare demonstrations that waive certain restrictions in title IV-E and allow broader use of federal foster care funds. Although a waiver could facilitate managed care, the purpose for granting waivers is to test a variety of innovations including but not limited to managed care. The Adoption and Safe Families Act of 1997 (P.L. 105-89) expanded HHS' authority to approve

up to 10 states' waiver demonstrations in each of the 5 fiscal years 1998 through 2002.

Objectives, Scope, and Methodology

The Chairman of the Subcommittee on Human Resources of the House Committee on Ways and Means asked us to review states' efforts to implement managed care arrangements into their child welfare systems. This report describes (1) the extent to which public agencies are using managed care to provide child welfare services, (2) the financial and service delivery arrangements under managed care that are being applied to the child welfare system, and (3) challenges child welfare agencies face as they develop and implement managed care, and the results of such efforts to date.

To determine the number of managed care initiatives in the child welfare system and how they are being implemented, we surveyed all 50 states, the District of Columbia, and selected localities. To obtain more detailed information about managed care arrangements as well as implementation challenges and results, we studied ongoing managed care efforts at four locations—Kansas, Massachusetts, Boulder County in Colorado, and Sarasota County in Florida—where different managed care models of varying scope are being implemented. We also interviewed public agency officials in states and localities that are implementing managed care initiatives and reviewed available documentation about individual initiatives. In addition, we reviewed relevant literature, and interviewed experts about managed care in both health care and child welfare as well as representatives from national and state child advocacy organizations. To learn about the federal government's involvement in state efforts to implement managed care, we spoke with officials at the Substance Abuse and Mental Health Services Administration (SAMHSA) and ACF.

GAO Survey

The purpose of the survey was twofold. First, we wanted to determine the total number of states and localities operating or considering managed care projects or initiatives nationwide and, for those projects in operation, obtain a description of the types of managed care arrangements being used. Second, because some locations have more than one ongoing managed care initiative, we wanted to obtain detailed program information on the initiative that is serving the most children.

In February 1998, we mailed a copy of the survey to the child welfare director in each of the 50 states and the District of Columbia. We also

mailed the survey to child welfare officials in 43 localities we had identified as possibly implementing or considering managed care initiatives. We learned of those officials by telephoning the state child welfare directors in the 13 county-administered states and asking them to identify the applicable localities in their states.[18]

We received responses from 48 state agencies, the District of Columbia, and all the local agencies. On the basis of the returned surveys and telephone contacts with several local agency officials, we excluded from our analyses 17 counties and 1 district that either (1) were implementing a multiple-county initiative and chose to designate one county as the survey respondent, or (2) were neither implementing nor considering managed care arrangements in their child welfare systems at the time of our survey. Hence, for our adjusted population size of 76 state and local agencies, the 74 valid responses resulted in an overall response rate of 97 percent. From these responses, we obtained general information on 36 initiatives and more detailed information on the 27 initiatives serving the most children in each location.

We did not verify the information obtained through the survey. However, we conducted telephone interviews with state and local respondents to clarify responses, as needed, and obtained additional information about program and population coverage and available descriptive documentation. In addition, we obtained more detailed information about ongoing managed care efforts at four locations.

Case Study Sites

We selected four locations—Kansas, Massachusetts, Boulder County in Colorado, and Sarasota County in Florida—to obtain more detailed information about the events and activities surrounding the locations' decision to implement managed care in their child welfare systems, the process of planning and designing the initiative, the rationale behind changing service delivery and financial arrangements, contracting and subcontracting processes and management, monitoring and accountability activities, results to date, implementation challenges, and lessons learned. On the basis of the relevant literature and in consultation with child welfare experts, we selected these four locations because they were implementing different managed care models, had different circumstances leading to their initiative's design, and provided examples of both state- and local-level efforts. At each location, we interviewed officials from the

[18]We included Florida among the 13 county-administered states because, although Florida's child welfare system is administered at the state level, its 15 district offices have considerable autonomy and state legislation had authorized privatization pilots in several districts.

state and local child welfare agencies as well as representatives from the primary managed care contractors and subcontractors, and reviewed pertinent documentation. Furthermore, we coordinated our site selection and data collection efforts with researchers at the University of Chicago's Chapin Hall Center for Children, who were conducting case studies to describe how managed care is being implemented in Kansas and three other locations—Tennessee, Hamilton County in Ohio, and Lake and Sumter Counties in Florida. Where appropriate, information from Chapin Hall's four case studies is incorporated in this report.

We conducted our work between August 1997 and August 1998, in accordance with generally accepted government auditing standards.

Managed Care Is a New and Growing Strategy in Child Welfare

Nationwide, public child welfare agencies are implementing, planning, or considering managed care initiatives in 35 states. Most ongoing initiatives are serving foster care children with the most complex and costly service needs. In total, however, only a small portion of the nation's child welfare population is covered by managed care arrangements. In general, public child welfare agencies are entering into managed care arrangements with nonprofit, community-based providers who have historically served as providers in the agencies' foster care or out-of-home placement systems. These new arrangements, however, have significantly changed the roles and responsibilities of the public and private entities. Finally, for-profit managed care companies have not had a major role in implementing managed care in child welfare, with only a few locations using these organizations to manage the delivery of child welfare services.

Appendix I lists the 27 managed care initiatives about which we obtained detailed data, including their implementation date, geographic scope, size, organizational arrangement, and description of the populations and child welfare programs covered.[19]

Managed Care Initiatives Are Limited in Scope and Size

Interest in child welfare managed care is growing, as public agencies launch new efforts or consider developing initiatives in their states. However, to date these efforts tend to be small in scale, serving targeted populations of children and their families in a limited number of locations.

Use of Managed Care in Child Welfare Is New

Public agencies' exploration of managed care in child welfare is a new phenomenon. Nationally, most managed care initiatives have been operating for 2 years or less. As of March 1998, 36 initiatives were under way in 13 states and had been operating for an average of 20 months. By the end of 1998, managed care initiatives will be operating in four additional states. These numbers will continue to rise in the near future as managed care efforts are being planned or considered in another 18 states. (See table 2.1.)

[19]Some locations are implementing more than one managed care initiative. In these instances, we obtained more detailed information about the initiative serving the most children.

Table 2.1: States With Child Welfare Managed Care Initiatives Ongoing, Planned, or Under Consideration as of March 1998

	Implementing managed care		Planning to implement		Considering managed care, but no official action taken
State	As of March 1998	Number of ongoing initiatives	By the end of 1998	After 1998 or in the near future	
Alaska				X	
Arizona			X		
California	X	1			
Colorado	X	6			
Connecticut				X	
Florida	X	3			
Georgia	X	1			
Idaho					X
Illinois	X	2			
Indiana	X	3			
Kansas	X	3			
Kentucky				X	
Louisiana					X
Maryland			X		
Massachusetts	X	1			
Michigan	X	1			
Missouri			X		
Montana					X
Nebraska					X
Nevada					X
New Hampshire					X
New Jersey					X
New York	X	5			
North Carolina					X
Ohio	X	6			
Oklahoma				X	
Oregon					X
Pennsylvania					X
Rhode Island				X	
South Carolina				X	
South Dakota					X

(continued)

State	Implementing managed care		Planning to implement		Considering managed care, but no official action taken
	As of March 1998	Number of ongoing initiatives	By the end of 1998	After 1998 or in the near future	
Tennessee	X	1			
Texas			X		
Utah				X	
Wisconsin	X	3			
Total: 35 states	**13 states**	**36 initiatives**	**4 states**	**7 states**	**11 states**

Source: GAO survey.

Geographic and Population Coverage Varies Among Initiatives

The majority of the managed care initiatives have been implemented by a county or district-level child welfare agency. Of the 36 ongoing initiatives, 23 were established by local agencies. Two counties—Mesa County, Colorado, and Hamilton County, Ohio—have implemented multiple efforts. In addition, eight state agencies have implemented managed care in child welfare, including statewide efforts in four states—Georgia, Kansas, Massachusetts, and Tennessee.

Believing that managed care arrangements can contribute to better services and control costs, public child welfare agencies have targeted the most expensive and programmatically difficult populations to serve in their initiatives. Of the 27 largest initiatives about which we obtained detailed information, 25 include the hard-to-serve and most costly children. This population often consists of severely emotionally disturbed children—mostly adolescents—needing mental health services, who are either in or at risk of group or residential foster care placement. About half of the 25 initiatives serve this group exclusively. For example, Indiana's The Dawn Project targets children aged 5 to 17 who reside in Marion County and (1) are at risk of separation or are already separated from their families and living in a residential treatment center; (2) have been involved with two or more human service systems, such as child welfare, juvenile justice, special education, and mental health; and (3) have had an impairment for more than 6 months. In contrast, some jurisdictions serve all eligible populations—these include one statewide and five countywide efforts.[20] For example, Kansas' entire foster care, adoption, and family preservation program populations are being served through regional

[20]Kansas' statewide effort serves all eligible clients, and similar countywide initiatives are ongoing in Jefferson and Mesa Counties in Colorado, Albany County in New York, and Champaign and Madison Counties in Ohio.

contractors across the state; and in Jefferson County, Colorado, the managed care initiative serves all children and families in the county's child welfare system. While nearly all 27 initiatives cover children in foster care, some initiatives also include or target children in other child welfare programs, such as adoption and family preservation and support services (see app. I).

Small Proportion of Child Welfare Population Is Being Served

With few statewide efforts and most managed care activity occurring at the local level, only a small segment of the child welfare population is currently being served under managed care. In the 13 states where initiatives are in place, almost 44,000 children are being served under child welfare managed care arrangements. This represents about 8 percent of the child welfare population in those states, including both in-home and out-of-home care clients, and 4 percent of the nearly 1 million children in the child welfare system nationwide.[21] By the end of 1998, when managed care initiatives are expected to be under way in four more states, the nationwide proportion is likely to increase to about 6 percent.

The number of children served under managed care in each of the geographic areas covered by an initiative—whether a state- or county-established effort—varies greatly. Numbers range from fewer than 10 children in Oneida County, New York, to as many as 23,200 children in Illinois, with an average of about 4,300 children in state-level efforts and 500 in counties and districts. Many of these states and localities plan to expand the size of their initiatives by increasing the number of clients served, targeting new types of clients, or both.

Where state-level initiatives are being implemented, the proportion of the state's child welfare population being served under managed care ranges from 1 to 80 percent, with a median of about 6 percent. For example, Michigan's family preservation initiative is serving about 165 children at selected sites around the state, or 1 percent of the state's child welfare population. At the other extreme, the three statewide initiatives in Kansas are unique in their breadth and geographic scope, covering all 6,000 children in the state's foster care, adoption, and family preservation programs, representing 80 percent of the state's child welfare population. Excluded from Kansas' initiatives are children and families involved in a CPS investigation, a small number of noncustodial families receiving in-home services, and the juvenile offender population. More typically,

[21]According to HHS' 1997 National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families (Washington, D.C.: HHS, 1997), an estimated 1 million children were receiving child welfare services as of March 1994.

Georgia's statewide effort serves 660 children who are in therapeutic residential settings, or 3 percent of the state's child welfare total.

In the local initiatives, the proportion of a county's or district's child welfare population currently being served under managed care covers the full range, from less than 1 percent to the entire child welfare population, with a median of 20 percent. At the lowest extreme, Oneida County in New York has just begun its countywide initiative, having so far served 7 children, or less than 1 percent of the county's child welfare population; the county expects to serve 120 children by the end of the year. At the highest extreme, Jefferson County in Colorado has brought its entire child welfare population of about 1,700 children under its managed care initiative. A more typical example can be found in Albany County, New York; the 1,750 children receiving preventive services represent 20 percent of the county's child welfare population.

Public Agencies Pursue Various Managed Care Models but Continue to Rely on Traditional Partners

Public child welfare agencies have approached both the overall design of their managed care initiatives and the distribution of roles and responsibilities among initiative participants differently. Nonetheless, most of these agencies now contract with private entities to coordinate the provision of an array of child welfare services and to assume administrative tasks, such as processing claims and monitoring program activities.

Managed Care Follows Four Models

We found that the organizational arrangements among public and private entities implementing managed care generally fall into four models—public, lead agency, administrative services organization, and managed care organization.

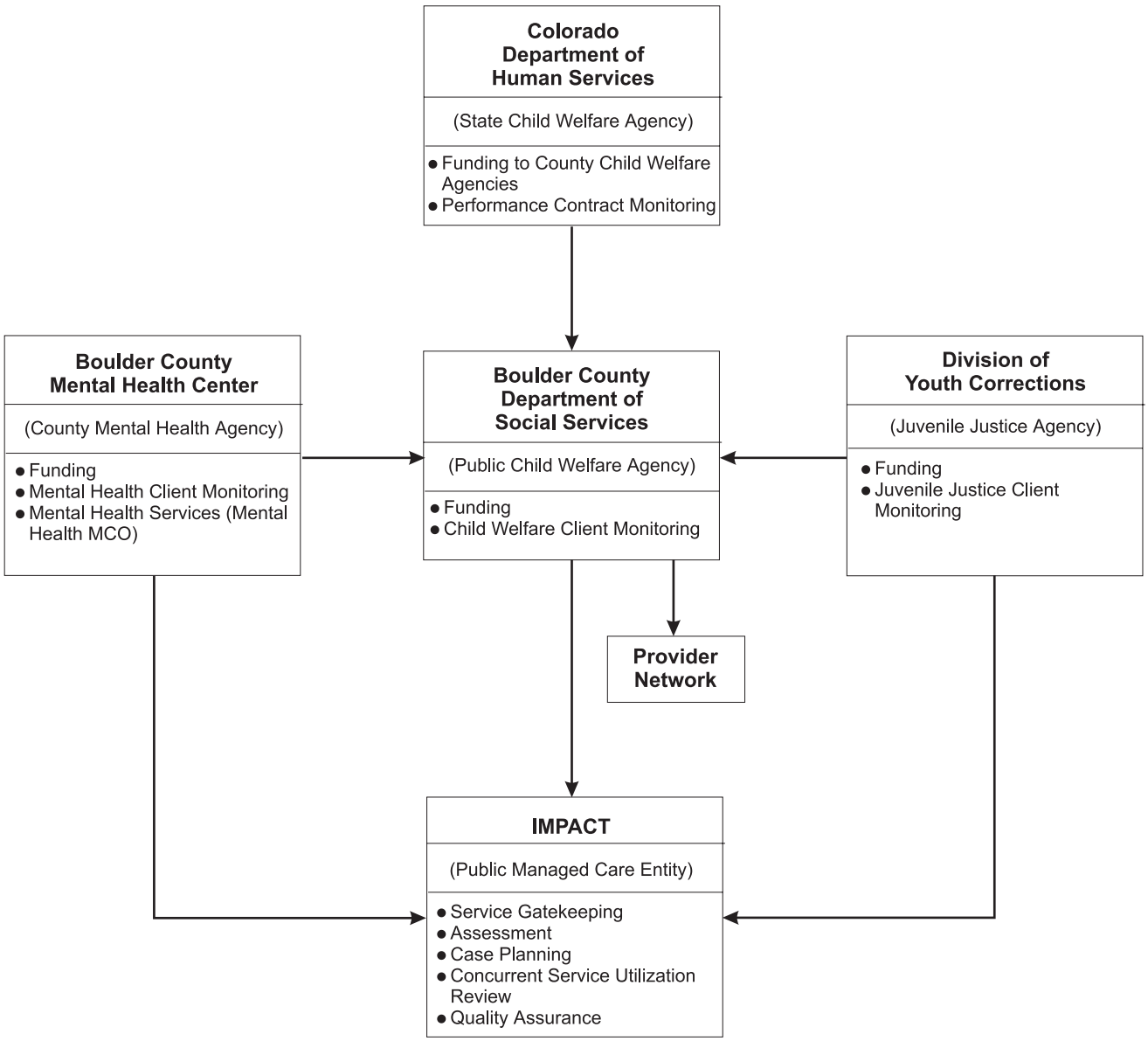
Public Model Maintains the Traditional Structure

The public model represents the least change for public child welfare agencies. While the public agency continues its role of coordinating care for children and families as well as providing services, it is both changing the way it reimburses service providers and introducing performance standards. For example, public agencies can incorporate fixed payments into existing contracts with community-based service providers. Currently, 10 of the 36 initiatives are using the public model of managed care.

Boulder County in Colorado began implementing its Integrated Managed Partnership for Adolescent Community Treatment (IMPACT) initiative in

July 1997. Three county agencies—social services, mental health, and youth corrections—jointly formed a new managed care entity to perform gatekeeping, assessment, case planning, concurrent service utilization review, and quality assurance functions for children placed out-of-home. The new public entity merged funding from the three county agencies and currently performs joint programming and placement decision-making for adolescents in need of out-of-home care in group or residential treatment settings. Although the county agencies now take an integrated approach as care coordinator, they continue to rely on the same network of public and private providers for direct services. Boulder County's new public managed care entity receives funds from the state in the form of a block grant. This is, in effect, the public agency's capitated payment for the services it provides to adolescents. In turn, the managed care entity intends to contract with community-based adolescent placement providers on a "subcapitated" basis—that is, the public managed care entity will pass on capitated payments to subcontracted service providers. Finally, the state has introduced a series of performance standards. Figure 2.1 illustrates the organizational arrangement of Boulder County's managed care initiative.

Figure 2.1: Organizational Arrangement of a Public Model of Managed Care in Boulder County, Colorado



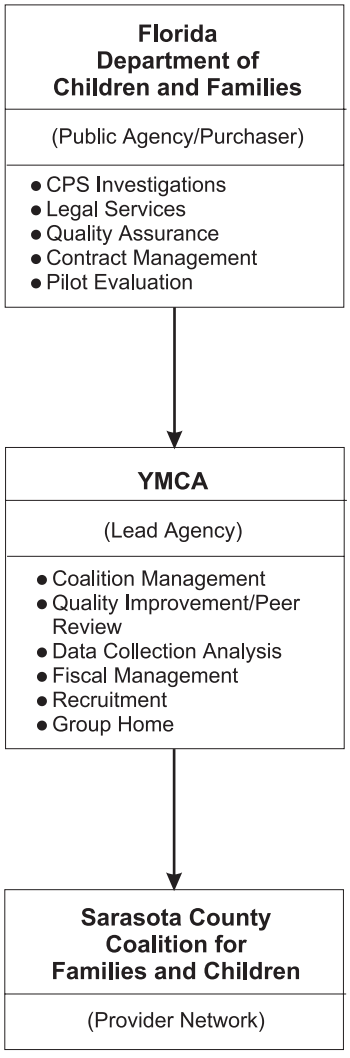
Single Provider Assumes Key Role in Lead Agency Model

Over half of the 36 initiatives—19 in all—are using the lead agency model to incorporate managed care elements into their child welfare systems. In this model, the public agency contracts with a private entity that, as the primary contractor or lead agency, assumes new responsibility for coordinating child welfare services for a defined population of children and families. The lead agency's case management functions can include assessing clients' needs, developing treatment plans, and monitoring progress toward achieving permanency or treatment goals. In addition, the lead agency is responsible for providing all the necessary services, as prescribed by the treatment plan. In this model, the lead agency provides some or all direct services itself but may also subcontract with a network of local service providers.

Sarasota County in Florida is using a lead agency model. In January 1997, the state child welfare agency transferred to the Sarasota County Coalition for Families and Children responsibility for coordinating the care of all children and families in the child welfare system in this one county. Formed specifically for this managed care initiative, the Coalition's members are primarily community-based, nonprofit entities and include all major service providers in the county. One Coalition member—the YMCA—has been designated the lead agency responsible for managing the project and contracting with the state public child welfare agency. Where the state previously had separate contracts with each service provider, the state now has only one contract with the lead agency which itself developed new subcontracts with the Coalition service providers. The lead agency is responsible for (1) performing administrative tasks, such as disbursement and accounting of state-allocated funds and preparing required reports; (2) monitoring the quality of services provided by Coalition subcontractors; and (3) providing some direct services. Case management functions have been subcontracted to two other Coalition service providers. Of the ongoing managed care initiatives nationwide, Sarasota County is one of only two locations in the country that have contracted with private entities to manage essentially the entire child welfare system.[22] Figure 2.2 illustrates the organizational arrangement of Sarasota County's managed care initiative.

[22]According to Florida child welfare officials, a child does not enter the child welfare system until after state CPS workers investigate maltreatment reports and determine the need for system intervention. Kansas' child welfare managed care initiative is the other location and is also using the lead agency managed care model.

Figure 2.2: Organizational Arrangement of a Lead Agency Managed Care Model in Sarasota County, Florida



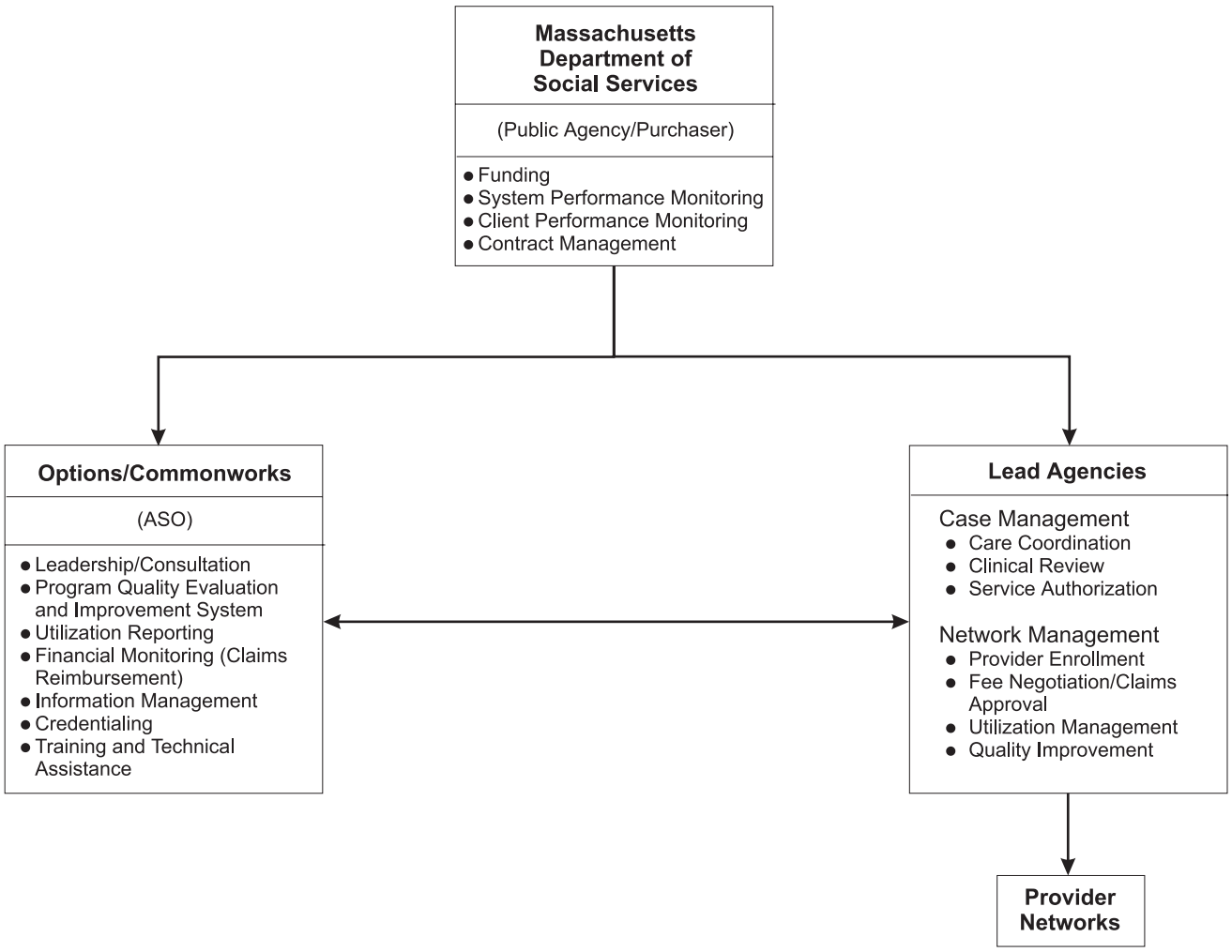
Administrative Services Organization Model Privatizes Administrative Services

Under an administrative services organization (ASO) model, the public child welfare agency contracts out the administrative or management services, including such activities as billing and reimbursement, development or operation of a data system, training, and technical assistance, separately from the service-delivery tasks. The administrative contractor, or ASO, is not responsible for the delivery of child welfare services to children and families directly. In this model, currently used in three initiatives, the management of clients' care and provision of direct services are the responsibility of the public agency or a lead agency in the public or lead agency model, respectively. For example, Massachusetts' Commonworks program is a statewide initiative whereby the state public child welfare agency has contracted with a for-profit behavioral health managed care organization to function as the ASO. On behalf of the state agency, the ASO's responsibilities include

- monitoring and reporting on the use of Commonworks services;
- implementing and monitoring an overall program quality evaluation and improvement system;
- developing and managing an information system for the entire program;
- developing the overall financial reporting system;
- developing, implementing, and managing the billing and payment system;
- tracking complaints and grievances from clients, families, providers, and the community; and
- reviewing, monitoring, and reporting on the credentialing of all direct service providers.

The ASO does not provide any direct services to children and families. The state agency contracts with a lead agency in each of six regions across the state to develop service networks and coordinate the care of adolescents in group home and residential treatment settings. The six lead agencies are responsible for coordinating the care of Commonworks' youth in their respective regions. Although the lead agencies have no compensatory arrangement with the ASO, each lead agency has a formal agreement with the ASO to discharge its respective responsibilities related to credentialing, utilization review, quality improvement, training, reporting, information systems, payment processing, and care authorizations. Figure 2.3 illustrates the organizational arrangement of Massachusetts' managed care initiative.

Figure 2.3: Organizational Arrangement of an ASO Managed Care Model in Massachusetts



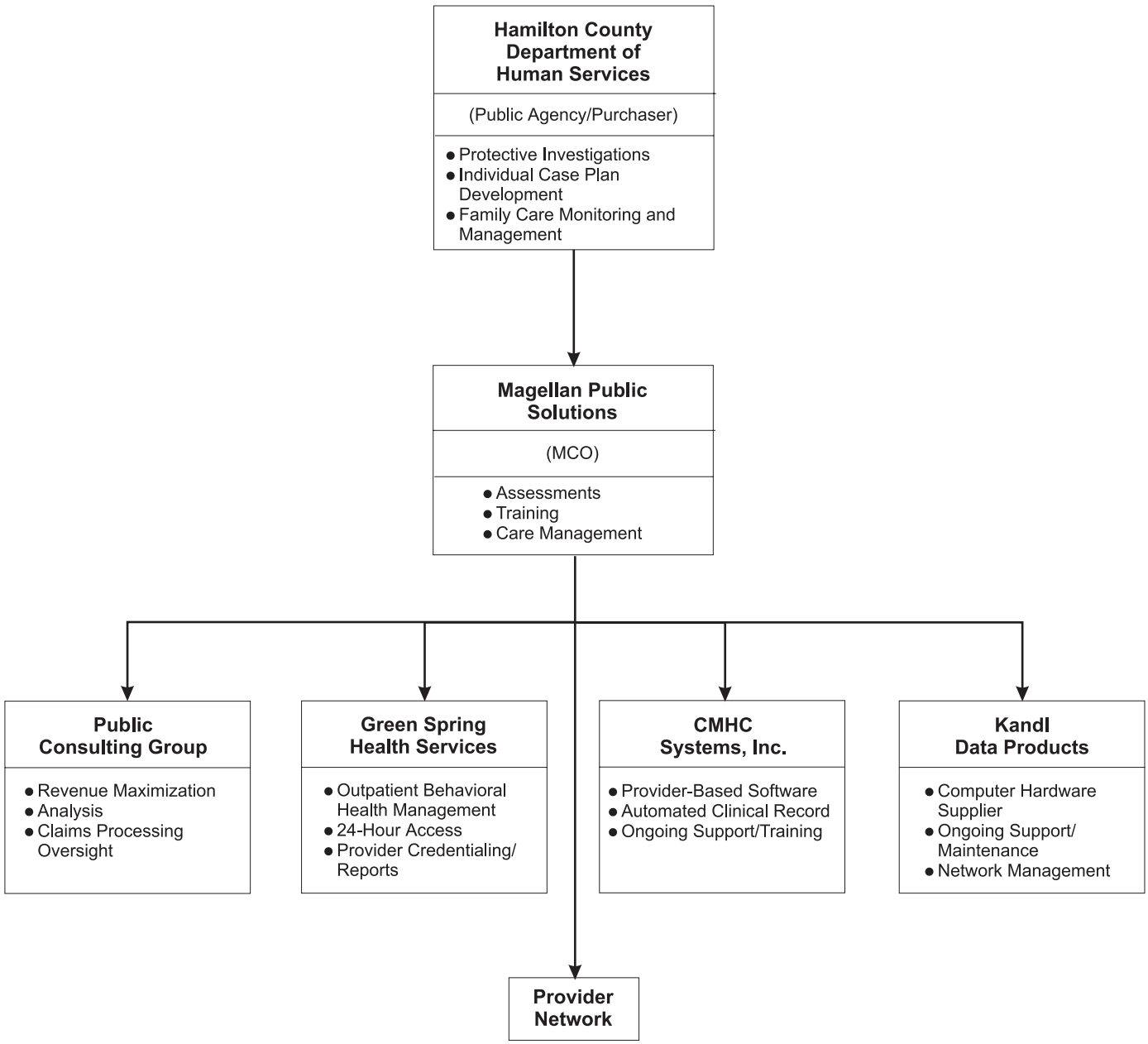
Managed Care Organization Model Is Most Similar to Health Care Model

The managed care organization (MCO) model is most similar to managed care arrangements in health care and is being used in 4 of the 36 child welfare initiatives. Under this arrangement, the public child welfare agency contracts with a private organization to perform administrative services and assume responsibility for developing and subcontracting with a network of service providers. The difference between the MCO and lead agency models is that the MCO does not itself provide services directly to children and families. Rather, the MCO arranges for the delivery of all necessary services through its provider network.

The largest MCO managed care effort under way is in Hamilton County, Ohio. In January 1998, the county child welfare agency contracted with a national for-profit MCO to (1) manage care for children and families in need of either outpatient mental health services or foster care in therapeutic, group home, and residential treatment settings and (2) build an integrated information system for three county agencies—child welfare, mental health, and alcohol and drug addiction. To carry out its administrative responsibilities, the MCO has subcontracted with four other companies to manage outpatient mental health services, maximize Medicaid funding, provide the hardware for the information systems, and manage the software and network. To fulfill its service-delivery responsibilities, the MCO has subcontracted with 22 local service providers. The MCO serves as the organizer, gatekeeper, and manager of services, but is itself precluded from providing any direct child welfare services, unless no other provider can offer the same service and the county agency approves. At the end of 5 years, the county intends to assume the operation of the managed care initiative.[23] Figure 2.4 illustrates the organizational arrangement of Hamilton County's managed care initiative.

[23]F. Wulczyn and B. Orlebeke, "Fiscal Reform for Child Welfare Systems: Four Case Studies," Chapin Hall Center for Children, University of Chicago (Jan. 1998) (draft).

Figure 2.4: Organizational Arrangement of an MCO Model in Hamilton County, Ohio



Public Agencies Continue to Rely on Traditional Partners

Most of the 36 managed care initiatives currently under way are using some version of either the lead agency or public model, as shown in table 2.2. These organizational arrangements tend to rely solely on the community-based nonprofit providers that have traditionally served children and families in the child welfare system. In some lead agency model initiatives, public agencies stipulated in the request for proposals that only those prospective bidders with previous experience in providing child welfare services within the state or locality were eligible to submit bids. Used less frequently, the ASO and MCO models introduce a new type of organization to the child welfare system—a management entity that generally is not itself in the business of delivering child welfare services. In the three initiatives implementing the ASO managed care model, one or more lead agencies are responsible for coordinating and providing direct services.

Table 2.2: Type of Managed Care Model Used in 36 Ongoing Initiatives

Model	Number of initiatives
Lead agency	19
Public	10
Managed Care Organization (MCO)	4
Administrative Services Organization (ASO)	3
Total	**36**

Source: GAO survey.

For-profit companies, including organizations with experience providing managed physical or behavioral health care, have not had a major role in developing and implementing managed care initiatives in child welfare. Of the 27 initiatives about which we obtained more detailed information, 10 currently use for-profit organizations as a service provider, managed care entity, or both, as shown in table 2.3. For-profit companies are providing traditional direct services in five of the initiatives using the public model and in one of the initiatives using the ASO model. The companies function as a lead agency in the two initiatives using the lead agency model and the other initiative using the ASO model. Many of these for-profit entities had historically provided services to children and families in their community before the managed care initiative. For example, in Massachusetts' Commonworks program, a for-profit company that was already a primary provider of mental health services was the successful bidder for one of six regional lead agency contracts. Having little or no experience in the child welfare system, some for-profit managed care companies are functioning

as ASOs or MCOs. In Milwaukee County's Safety Services Program in Wisconsin, a behavioral health managed care company linked with two nonprofit, community-based agencies to form a new entity to which the state awarded a contract to become one of four lead agencies. For-profit managed care companies are functioning as the MCO or ASO in three of the five initiatives using these models.

Table 2.3: Role of For-Profit Companies in 27 Managed Care Initiatives

Number of initiatives

Model	Total	Using for-profit company(s)	Role of for-profit company(s)
Lead agency	12	2	Lead agency and service provider
Public	10	5	Service provider
ASO	3	2	In one initiative, different companies are the ASO and a lead agency, respectively; in the other initiative, the same entity is the ASO and a service provider
MCO	2	1	MCO
Total	**27**	**10**	

Source: GAO survey.

Managed Care Initiatives Use Capitated Payments and Rely on Private Entities to Assume Case Management Responsibilites

Child welfare agencies have implemented capitated payment systems and new service-delivery strategies in their managed care initiatives. In these new financial arrangements, public agencies are developing methods to limit risk and to establish the capitated payment rate. In addition, public agency contracts with providers now require the providers to organize and coordinate a full array of services. With these changes, public agencies are using different approaches to hold providers accountable for outcomes through performance standards and by linking financial rewards and penalties to outcomes.

Capitated Payments Shift Financial Risk to Service Providers

Public agencies are implementing capitated payment systems in managed care initiatives, although they still maintain fee-for-service reimbursement methods in some of their contracts with service providers. States and counties have used a number of different methods to develop capitated contract rates and have created strategies that shift some or all financial risks to the private sector. Finally, some public agencies have pooled funds from different agencies to increase their flexibility to provide multiple services to hard-to-serve children.

Capitation Replaces Traditional Fee-For-Service Payment System

In 19 of the 27 initiatives about which we obtained detailed information, payments to providers serving children and families under managed care are fixed. In nine initiatives, payment takes the form of a case rate, or a fixed dollar amount for each referred client, and covers contracted services for all clients in the caseload regardless of the extent to which these services are used. For example, in Kansas' foster care managed care initiative, the state pays each lead agency a case rate for each referred child averaging about $13,850 a case, which is expected to cover the complete operation of the out-of-home care system, including food and shelter, child care, mental health treatment, independent living, reunification services, and case management for the children in foster care, as well as all recruiting and training of foster parents.

Eight initiatives use a capitated rate—a fixed payment for all contracted services for a defined client population, such as those residing within a designated geographic area, with no limits on duration of care. Unlike the case rate, each new client does not generate a new stream of dollars; rather, the capitated rate is fixed regardless of how many children are served. In Sarasota County, Florida, for example, the lead agency receives a capitated rate of about $4 million, over a 1-1/2-year period, for providing

all the child welfare services that any county resident in the state's child welfare system might need.[24]

Different Methods Are Used to Limit Providers' Financial Risk

A single entity that assumes the total cost of providing a defined scope of services to a defined population of potential users over a specified time period inevitably assumes financial risk as well. Of the 19 ongoing initiatives using capitated payments, only 2 initiatives—the Sarasota County initiative and the Lake and Sumter County initiative in Florida—have transferred full financial risk to the respective private lead agency. In nearly all the remaining capitated arrangements, public and private agencies alike have created risk-limiting mechanisms to address the unknowns associated with the size of the population needing services and the scope and duration of those services. Absent good historical data on service use and costs as well as experience with a capitated payment system, public child welfare agencies have explored different ways to limit the financial risk carried by the initiative's service providers. We found that public agencies are using two approaches—one fixes only a part of the provider payment and reimburses some services through the fee-for-service method, and the other uses specific contract provisions to limit the size of the financial risk assumed by the providers.

In five initiatives, public agencies have established a fixed rate for only a part of the contracted services. Services not included under this partial fixed rate are reimbursed on a fee-for-service basis. For example, in the Kids Oneida project in Oneida County, New York, the lead agency receives a prepaid, monthly case rate of $2,500—amounting to $30,000 a year—which is expected to cover the full range of services needed to keep children and adolescents with serious emotional, behavioral, or mental health issues in the community or at home. However, the federally eligible behavioral and mental health services that the lead agency provides or purchases may be billed for Medicaid reimbursement on a fee-for-service basis.

According to our survey of ongoing managed care efforts, seven initiatives include contract provisions that limit providers' losses when costs exceed the fixed rate. Mechanisms to limit a provider's losses can take several forms, including those where the public agency and provider share excess costs and others where the public agency bears the excess costs alone. One risk-sharing mechanism limits the provider's losses to a percentage of

[24]Two initiatives use a combination of case and capitated rates for different contracts. Seven of the remaining eight initiatives plan to implement some type of capitation in the future.

total costs, with either public dollars alone paying any further costs or the provider sharing some of the cost overruns. For example, during the first year of Kansas' foster care managed care initiative, the lead agency contracts contained a 10-percent margin so that the contractor was responsible for all additional costs up to 10 percent above the case rate and the state was to pay for all excess costs beyond that. Under this arrangement, the lead agency would pay all costs up to 110 percent of the case rate and the state would pay anything over that amount.

Other techniques address the serious financial burden associated with the catastrophic costs of certain groups of children or circumstances beyond the provider's control, such as an unexpected increase in the number of abuse and neglect reports. One technique is to set aside a pool of funds, known as a risk pool, for use if the cost of care exceeds some targeted amount. For example, in Champaign County, Ohio, the county and its foster care contractor created a risk pool set at a value equal to 10 percent of the contract value, or about $24,000. The contractor funds 40 percent of the pool, and the county funds 60 percent. The risk pool covers catastrophic costs over $32,400 per child, so that costs in excess of this amount are charged to the risk pool; however, once the risk pool is depleted, the county pays the cumulative costs over the $32,400 per child amount.

To prevent a fixed payment system from penalizing extraordinarily hard-to-serve children, some managed care initiatives exempt these populations from their rates. This can be accomplished by either not referring certain clients to the managed care entity or allowing the costs associated with serving only these clients to be reimbursed on a fee-for-service or per diem basis. Without such exemptions, the prohibitively high service costs for these clients could place such a drain on the managed care entity's resources that it would not be able to provide the caliber of services these hard-to-serve children need. Furthermore, serving these high-need children could significantly reduce the resources available to serve more typical clients. For example, in both Kansas' foster care managed care initiative and Boulder County's managed care initiative in Colorado, developmentally disabled children are excluded from the population served by the respective managed care entities. These children have unusually high service needs, including hospitalization and in-home medical care. Moreover, in Kansas, each lead agency can now exclude a designated number of referred cases—ranging from 24 to 35—for which it has 60 days to decide whether a referral will be served outside the case rate on a fee-for-service basis. This change was effected to ameliorate

financial problems lead agencies experienced while serving children with high service needs within the contract case rate, which was initially developed without data on actual service costs.

Financial risk is also associated with uncertainty about the size of the population to be served. One mechanism to limit this type of risk is for the public agency to guarantee the provider a minimum or maximum number of cases. According to our survey of ongoing managed care initiatives, seven initiatives have such measures in place. For example, in the Kids Oneida initiative in Oneida County, New York, the lead agency must accept all county referrals as long as its capacity has not been reached.

Public Agencies Use Different Methods to Establish Capitated Payment Rates

Setting capitated payment rates for child welfare services was a new exercise for states and local agencies. Consequently, they used a variety of methods. In some initiatives, the public agency used the competitive bidding process as the forum to negotiate a contract rate for services. In Kansas' foster care managed care effort, for example, each of the five regional lead agency contracts has its own case rate. The state provided prospective bidders with a dollar amount that was based on previous expenditures for purchased services, staff, other operating expenditures, and services funded through other parts of the agency, such as mental health and child care. Equipped with this information, private entities vying for the lead agency contracts proposed their own annual case rates covering a 4-year period. These rates then became the case rate for those successful contractors. In Massachusetts' Commonworks project, the state negotiated a 3-year contract rate with the managed care company that was awarded the ASO contract; the rate was based on the annual projected operating costs for the specified administrative services.

In other initiatives, the public agency used historical data to set the contract rate and did not, as a rule, negotiate the rate with the contractors. For example, in Florida's managed care initiative in Lake and Sumter Counties, the lead agency's case rate was developed by examining the actual cost for the care of children sheltered in Lake County over a 2-year period, including multiple cost categories, such as out-of-home care, administrative services, and therapeutic services for children and families entering care. Costs were also categorized according to whether children were entering foster care or receiving only protective services, and bundled into a single 2-year case rate.[25] In Massachusetts, the state's

[25]B. Peacock, Implementation Study Report on the Child Welfare Privatization Projects, Florida Department of Children and Families (Jan. 1998).

contract with the lead agency in each of six regions across the state has two components. One is a negotiated annual fee for the lead agency to coordinate and oversee its service provider network and is intended to cover staff costs and training. The second component is a case rate for direct services that is the same for each lead agency and, for the first year, was partly based on an actuarial model using 1995 expenditure and utilization data for youth in group care, and also including an educational subsidy.

In other initiatives, the state allocated a portion of its child welfare services budget directly to the managed care entity. Such was the case in Colorado, where the state allocates child welfare funds to counties through a block grant. In Boulder, Jefferson, and Mesa Counties, the block grant, in effect, created the capitated contract rate for each county's public managed care model. For the Sarasota County managed care initiative in Florida, the state carved out the county's share of a multicounty district's annual operating budget, generally using the same methodologies it uses to allocate budget line items to districts.[26] The allocation method is based on caseload size; actual dollar amounts from about 14 different budget components, including out-of-home care, sexual abuse treatment, and independent living services; and operating expenses and salaries associated with the cost of 37.5 public positions. Once the county's budget allocation was determined, the state withheld about 10 percent of the total to fund an evaluation and seven new public positions in the county to perform quality assurance and title IV-E eligibility determination functions. The remaining budget dollars became the lead agency's contract rate.

Regardless of the method for setting rates, the public agency often expects the contractor to supplement the contract rate with funds from other sources, especially federally reimbursable programs such as Medicaid. For example, in Massachusetts' Commonworks program, the lead agencies are expected to tap Medicaid and state education sources, as well as private funding sources, to fund related services. The state also encouraged the lead agencies to enter into public-private partnership agreements to help subsidize the cost of coordinating their provider networks because the state will reimburse no more than 75 percent of these costs, or a maximum of $100,000. For Wisconsin's Safety Services Program in Milwaukee County, the state expects each of the four lead agencies to supplement state funding by referring clients who are eligible under Medicaid to their

[26]Florida administers its child welfare system through and distributes funding to 15 state-operated districts, which comprise multiple counties. Sarasota County is one of seven counties in District 8.

HMO for applicable services and securing Medicaid funds for targeted case management to partially support staff costs.

Pooling Funds Increases Flexibility

The child welfare system relies on many different programs from multiple agencies with many funding streams. Because of restrictions on eligibility and prohibitions on certain uses of funds, public and private agencies often face problems accessing needed services. To reduce service access problems sometimes associated with these categorical programs and increase flexibility in the use of funds, agencies in some locations have agreed to pool or blend funds from various sources for their managed care initiative. In four states where counties administer the child welfare system, the state distributes child welfare funds to county child welfare agencies through a capitation method that fixes the level of funding, for example, a block grant.[27] "Blockgranting" state funds in this way loosens the restrictions on the use of the funds and thus increases counties' flexibility. In Colorado, for example, the state's capped allocation to counties now typically includes categorical child welfare budget line items for out-of-home placement, subsidized adoptions, and child care and county administrative costs related to child welfare services. Boulder County's managed care initiative—serving adolescents at imminent risk of placement in group or residential care referred from the child welfare, mental health, and juvenile justice systems—further pooled its capped child welfare allocation with funding from the mental health agency and youth corrections agency to finance its IMPACT initiative.

Funding from both child welfare and mental health funding streams are often pooled, especially for the hard-to-serve and high-cost children. Under its public managed care model, the Wraparound Milwaukee program in Wisconsin blended Medicaid, child welfare, and federal grant funds into a single buying pool to purchase individualized, family-based services to help children placed in residential treatment centers return to their family, a foster home, or other living arrangement in the community. The county child welfare agency agreed to pay a monthly case rate of $3,300 per child out of its institutional placement budget. In addition, the state health care financing agency agreed to pay a monthly case rate of $1,459 to pay for all mental health and substance abuse services for Medicaid-eligible children, who make up about 80 percent of the initiative's clientele. Along with a federal grant from SAMHSA's Center for

[27]In response to our survey, the states of Colorado, New York, Ohio, and Wisconsin indicated they have "blockgranted" funds for child welfare services to counties. In addition, Alameda County is implementing a managed care initiative as one of five counties in California experimenting with blended funding strategies.

Mental Health Services, these child welfare and Medicaid dollars form the funding pool from which the public managed care entity pays the cost of residential treatment, group and foster care, and all other services, except physical health care, which is outside the capitated contract rate and still obtained by families on a fee-for-service basis.

Service Delivery Changes Are Designed to Coordinate Care, but Public Agencies Retain Critical Functions

Managed care contracts usually require the managed care entity to provide, create, or purchase a wide range of services to meet clients' needs. If not providing services directly itself, the primary contractor may develop and subcontract with a network of service providers to make available all the services referred clients might need. Under managed care, public agencies have increasingly privatized case management tasks, such as treatment planning and case monitoring, and expect the managed care entity to serve as the single point of entry to the service system.

States and localities have retained certain functions that officials believe are critical to meeting their legal responsibility for the safety of children in the child welfare system. Although most of the 27 initiatives have transferred case management responsibilities to private entities, public agencies maintain a large presence during strategic points in a child's service history. These include the points at which a child enters and exits the child welfare system and when key decisions are made about changes in a child's service plan.

Primary Contractor Is Responsible for Ensuring Access to a Wide Range of Services

Managed care initiatives are trying to better coordinate care and ensure access to a wide range of services to address concerns about service fragmentation and gaps that have historically plagued the child welfare system. Where public agencies have contracted out the care coordination function to a lead agency or MCO, that primary contractor assumes responsibility for ensuring the availability and provision of all contracted services as well as any additional services that may be necessary to meet individual client needs. If a child or family has a unique service need that traditional services cannot meet, the primary contractor must develop new strategies to meet it. Whether using existing services or creating new ones, the primary contractor—regardless of whether it is a public agency in the public model or a private organization in the lead agency model—can either deliver services itself or contract with a network of service providers.

Service Networks Provide the Framework for Full Array of Services

The creation of an organized and coordinated network of service providers is the foundation of managed care initiatives. These configurations of service providers have been formed in one of two ways—through a self-initiated process prior to the formation of the managed care project or as a required component of the initiative itself. The self-initiated process often begins with a group of community providers establishing itself as a service coalition or consortium in anticipation of state or county reform. By either becoming an MCO itself or designating one of its members as the lead agency to perform management services, a provider group assumes responsibility for coordinating the care of a defined population of children and families. In Indiana's The Dawn Project in Marion County, four community mental health centers in the county formed a new nonprofit MCO. The MCO contracts with case managers and service providers who collectively provide or develop the necessary services for children and youth with serious emotional disturbances who are already in or at risk of out-of-home placement. In the lead agency model being used in Sarasota County, Florida, all the major local vendors that had traditionally provided contracted child welfare services, such as parenting classes, therapy, in-home visitation, family support services, therapeutic foster care, and residential services, formed a coalition; one member—the YMCA—serves as the lead agency, and the coalition operates as the provider network.

In still other initiatives, the primary contractor had to build a network of service providers as a condition of its managed care contract with the public agency. In both Massachusetts' Commonworks program and Tennessee's Continuum of Care contracts, for example, the primary contractors are responsible for forming a network of either existing or new providers and, through this network, providing all the appropriate services to meet the needs of clients accessing the network.

New Approaches to Case Management Are Designed to Better Coordinate Care

Under child welfare managed care arrangements, contracted private providers are attempting to develop coordinated networks of service providers and are assuming more case management responsibilities. While some private entities were already performing some case management functions before these initiatives were implemented, in 21 of the 27 ongoing managed care initiatives, the public agency has shifted more case management responsibilities to private contractors. In the lead agency and MCO models, in particular, the private sector is now performing such case management tasks as developing the treatment plan that identifies the treatment goals and needed services, as well as arranging for the provision of these services either by the case manager's own organization or through

the provider network. Case managers also track clients' progress toward achieving their treatment goals, assess the appropriateness of each service, and update the treatment plan, as needed.

In an effort to better match services with client needs, many of the ongoing initiatives use a team approach to case management to avoid the duplication, time delays, and fragmentation that often result when different service systems are not involved in the treatment planning and decision-making process. In some initiatives, the treatment team consists of those individuals who are regularly in direct contact with the child, including the case manager, therapist, parents or guardians, school officials, and other service providers, depending on the child's problems. Together, the treatment team develops an individualized service plan and reviews, revises, and implements any necessary changes. For example, in Sarasota County's managed care initiative in Florida, where the lead agency subcontracts with two coalition service providers to establish case management teams, the subcontractor provides a case manager and a therapist, who bring in the foster parents, and, when appropriate, a guardian ad litem,[28] to work exclusively with families and complete assessments, case plans, concurrent planning, and case reviews. Having both a case manager and therapist on the team means that mental health services are routinely made available to each family and child in care.

In other initiatives, case management teams are interdisciplinary with representatives from multiple agencies to better address the varied needs of hard-to-serve children who often have long histories of involvement with multiple agencies. For example, the managed care initiative in Boulder County, Colorado, is an interagency collaboration under the public managed care model. The local child welfare, mental health, and juvenile justice agencies formed a new managed care entity to perform joint gatekeeping, assessment, placement case planning, concurrent utilization review, and quality assurance functions for the targeted population of adolescents in need of group or residential placement. Youth in need of such a placement are referred to an interagency team comprising public agency administrators from child welfare, community corrections, health, community services, mental health, youth corrections, and probation, and facilitated by staff from the managed care entity. This team makes the final decision on whether and where the referred adolescent should be placed and reviews the child's progress every 90 days. The day-to-day case management responsibilities are handled by the

[28]A guardian ad litem is an attorney or trained volunteer who represents the child in court, investigates the case, and monitors case progress.

managed care entity's intensive case managers, who monitor and assess the adolescent's movement toward placement goals in conjunction with the county child welfare caseworker.

Public Agencies Retain Certain Child Welfare Functions

Although public agencies are privatizing the management and coordination of care for children who are victims or at risk of abuse and neglect, they continue to retain certain tasks they believe are critical to meeting their legal responsibility for the safety and well-being of children in the child welfare system. In all 27 initiatives, the public agency continues to conduct all CPS functions related to investigating reports of child abuse and neglect and recommending to the courts whether a child needs to enter the child welfare system for protective or any other services. A child enters the managed care system on the basis of a referral from the public child welfare agency to the managed care entity. To ensure that managed care providers do not deny access, some contracts explicitly state that the primary contractor can neither reject a referral nor eject an accepted case.

The public agency also maintains its presence by participating in the primary contractor's treatment planning process and requiring approval when the contractor decides to make changes in the level of care, such as moving a child from residential care to family foster care. In several initiatives, public agency staff are members of the case management team that reviews, revises, and implements the child's treatment plan. The public worker's role on the treatment team in some initiatives is to review and approve the case manager's service plan for the child and family, any significant deviations from the plan, and decisions calling for discharge from care or transfer to a different level of foster care placement or to an in-home service provider. For example, in Sarasota County's managed care initiative in Florida, a public worker attends all case review meetings where case plans may change significantly, including the treatment goal and decisions to discharge a case or pursue termination of parental rights to free a child for adoption. This worker does not participate in case plan choices or recommendations, but is there to listen, observe, and intervene when he or she perceives a child's safety may be jeopardized because of the case review decisions.

While primary contractors are generally free to subcontract any of the contracted services, the public agency can exercise some control over these subcontracts. For example, in Massachusetts' Commonworks program, the state requires that if a lead agency also administers a

residential care program, then at least 75 percent of placement services must be subcontracted out to avoid conflicts of interest regarding placement decisions among direct service providers in the network and to help maintain diverse programming and placement options. In several initiatives, the public agency controls which agencies are in the provider network. In the TrueCare Partnership initiative in Hamilton County, Ohio, for example, the MCO has contracted and negotiated reimbursement rates with local service providers to carry out its service-delivery responsibilities; however, the county selected the first group of providers through a competitive process and must approve any elimination or addition to the provider network.

Quality Assurance Strategies Are Designed to Balance Costs and Quality

Public agencies are developing strategies to protect against the inherent incentive in managed care to withhold or provide reduced services. These strategies attempt to hold managed care providers accountable for achieving the outcomes public agencies are pursuing by setting performance standards and linking financial rewards and penalties to outcomes. In addition, public agencies plan to evaluate the effectiveness of their initiatives to determine whether managed care is accomplishing the desired objectives and resulting in efficiencies.

Performance Standards Hold Managed Care Partners Accountable

Public agencies have instituted performance standards as a means of holding their contracted service providers accountable for outcomes. In 23 of the 27 managed care initiatives about which we obtained detailed information, the public agency requires service providers to meet specific performance standards. In a majority of these 23 locations, the public agencies were using performance standards in contracts before implementing managed care initiatives. However, in most cases, these agencies are now incorporating performance standards into more contracts. In addition, service providers in eight ongoing initiatives are being held accountable for their performance for the first time.

Public agencies are using multiple performance standards to balance the twin goals of controlling costs while ensuring quality of care and the overall safety of children. Taken together, a set of goals and objectives with related performance standards can help ensure desired outcomes are achieved. While some standards are based on system outcomes, such as reducing overall costs of placements or achieving permanency more quickly, other standards are more client-specific and appropriate for every child, such as ensuring that immunization schedules are met. Moreover,

some standards address cost efficiencies and the savings associated with speedier exits from foster care or transfers to less costly but appropriate levels of care. For example, if a goal is to achieve cost efficiencies, the performance standard may call for decreased residential care costs shown as a percentage less than an established baseline amount. Or, if an objective is to ensure that children are reunited with their families in a timely manner, a performance standard may require that a percentage of children in out-of-home care be returned to their families within a specified period of time. Other standards focus on the quality of care, which is often measured by whether children remain in safe, stable settings and their well-being is sustained and nurtured. For example, in addressing children's safety, the performance standard could prescribe a percentage of all children that are returned to their families with no findings of maltreatment for a specified period of time. Furthermore, an indicator of placement stability in out-of-home care could be a standard setting the maximum number of times a percentage of children experience changes in their placement setting. In addition, promoting families' well-being could manifest itself in a standard of a certain percentage of families that show improvement in parenting skills and capacity.

Public agencies in most ongoing managed care initiatives are incorporating multiple performance standards for their service providers, as illustrated for Kansas' foster care managed care initiative in table 3.1.

Table 3.1: Performance Standards Contained in Lead Agency Contracts for Foster Care Managed Care Initiative in Kansas

Outcome or goal	Performance standard
Children are safe from maltreatment	95 percent of children in the care and supervision of the contractor will not experience confirmed abuse or neglect while in placement (raised to 98 percent for year 2)
	80 percent of children will not experience confirmed abuse or neglect within 12 months after reuniting with their families
Children experience a minimal number of placements	90 percent of children referred to the contractor will have no more than three placement moves subsequent to referral (lowered to 70 percent for Year 2)
	65 percent of all children will be placed with at least one sibling
Children maintain family, community, and cultural ties	70 percent of children referred after the implementation date will be placed within their contract regional boundaries
	75 percent of youth, aged 16 and over, released from custody will have completed high school, obtained a general equivalency diploma (GED), or be participating in an educational or job training program
Children are reunited with their families in a timely manner	60 percent of children placed in out-of-home care will be returned to their families within 6 months of referral to the contractor (lowered to 40 percent for year 2)
	90 percent of children who are reunited with their families will not reenter out-of-home custody within 1 year of return home
	65 percent of children will achieve permanency within 1 year of referral to the contractor (new standard added for year 2)
Clients will be satisfied with services	80 percent of parents and youth (aged 14 and over) will report satisfaction with services as measured by the Client Satisfaction Survey upon case closure

Source: Kansas Department of Social and Rehabilitation Services.

Financial Incentives and Disincentives Are Linked to Outcomes

Some initiatives offer bonuses as a financial incentive for the managed care entity to meet performance standards. For achieving cost savings or successfully returning a child to the family, for example, the contractor

can earn additional funds in several ways. In Massachusetts' Commonworks initiative, the lead agency receives a bonus payment of $1,000 for each youth who has been discharged for 6 months and not readmitted to the program during that period. In the TrueCare Partnership initiative in Hamilton County, Ohio, the MCO can earn two kinds of performance bonuses. First, the MCO can earn as much as about $100,000 per year in bonuses for meeting 20 individual performance indicators related to (1) service outcomes for referred families, such as improved functioning, timely receipt of behavioral health services, and success in ensuring children's safety and reducing risk of harm; and (2) management services, including maintenance of a competent provider network, revenues maximized, and client satisfaction with network providers' services. Second, the MCO can earn an additional bonus up to a maximum of $33,000 a year by meeting all its performance standards and reducing costs by more than 15 percent.[29]

Similarly, some contractors can be penalized for poor performance. Continuing with the Hamilton County example, the MCO can incur financial penalties totaling about $63,000 if it fails to meet the various performance indicators related to service outcomes for families and management services. In several initiatives, another disincentive to poor treatment planning and discharging children from care prematurely is to hold contractors financially responsible for those children who must reenter care within a specified period of time. For example, in Kansas' foster care managed care initiative, the lead agency must pay for all costs if a child who was returned to the family reenters foster care within 12 months of the discharge. Hence, while the lead agency initially received a fixed case rate for each referred child, the state provides no additional funds beyond this amount if the child must once again be removed from the family during the year following discharge.

Another method public child welfare agencies use to help ensure that managed care entities do not inappropriately limit the amount or types of necessary service to children and families is to restrict profit levels or require that cost savings be reinvested in services. Ongoing managed care initiatives limit contractors' ability to profit at the public's expense in several different ways. First, in Massachusetts, state regulations limit surplus revenues to 5 percent for the lead agencies and their network providers in the Commonworks managed care initiative. Second, contract language can limit a provider's gains with a risk-sharing mechanism similar to the one that limits losses. In the Kansas foster care initiative example,

[29]Wulczyn and Orlebeke, "Fiscal Reform for Child Welfare Systems."

where the lead agency was financially at risk for up to 110 percent of the contract rate in the first year, the contract also allowed a 10-percent margin for retaining any cost savings. Under this arrangement, the lead agency could keep any savings after spending 90 percent of the contract rate; any additional savings reverted to the state. Such a limitation on both losses and gains is sometimes referred to as a "risk-reward corridor."

Other managed care initiatives include contract provisions requiring providers to reinvest "profits" in the program. For example, in Sarasota County's managed care initiative in Florida, the lead agency must reinvest any realized savings in primary prevention programs or enhanced child welfare services. In Boulder County's public managed care initiative in Colorado, the state stipulates that the county can use up to 5 percent of its capped child welfare allocation to reduce its share of the state-required local match, but any additional savings must be reinvested in additional child welfare services. Under this arrangement, the county plans to reinvest any savings in innovative community-based services to shorten or eliminate the need for residential placement; reward and enhance selected providers' capabilities to serve adolescents effectively; and develop and maintain a countywide management information system that will integrate clinical, fiscal, and outcome data on children in placement.

Finally, public agencies are concerned about the critical time immediately following a child's discharge from foster care. To better safeguard against reentry into care, some locations are offering providers incentives—in the form of additional funds or as a supplement to the contract rate—to deliver aftercare services to recently discharged children and their caregivers. For example, in the Commonworks program in Massachusetts, the state has incorporated funding specifically for aftercare services into the lead agencies' case rate during the first year so that, once a child is discharged from foster care, the lead agency's case rate changes from $4,000 to $400 per month for up to 6 months.

Independent Review Will Assess the Efficacy of Managed Care Initiatives

External or independent reviews will help determine whether system reforms under managed care arrangements are effective, accomplishing desired objectives, and resulting in efficiencies. Most of the 27 initiatives about which we obtained detailed information intend to collect information to assess the time it takes to achieve permanency goals as well as the cost of providing services under managed care. In addition to these efforts, many initiatives include an evaluation component that will examine project outcomes, performance quality, and cost efficiency in

various ways. Some initiatives—for example, both Massachusetts' Commonworks program and Alameda County's Project Destiny initiative in California—will conduct independent longitudinal evaluations. A systemwide evaluation is planned in Kansas, where the state has contracted for a 4-year external review of its entire child welfare system, including its three statewide managed care initiatives and services provided by both public and private employees.

In some initiatives, public child welfare agencies plan internal evaluations of their managed care efforts. In Tompkins County, New York, the county child welfare agency will conduct an annual program review of its Youth Advocate Program and the lead agency's services. The objective is to determine the extent to which client milestones and targets are achieved, and to use the program review results to help modify program goals and performance standards. Other initiatives will be evaluated by the managed care entities themselves, as in Wisconsin's Safety Services Program in Milwaukee County, where the contracted lead agency is responsible for designing and implementing a 2-year plan, subject to the state's approval, to evaluate program effectiveness and the quality of the services delivered.

A final approach is to measure the extent to which foster and biological parents as well as older children are satisfied with the services they receive under managed care arrangements. As part of either an independent evaluation, performance standards, or ongoing quality assurance monitoring, collecting information directly from clients will help identify outcomes related to managed care's effect on children and families. For example, in Boulder County's managed care initiative in Colorado, client satisfaction data will be collected from adolescents and families served—through focus groups of those receiving services under the initiative—as a component of the overall quality assurance plan. This information will add qualitative texture to the quantitative outcomes and assessment data.

The Move to Managed Care Is Not Without Challenges

Public officials considering managed care for their child welfare system face three difficult challenges. First, when implementing managed care, public agencies have found that they need to accomplish a number of tasks, of which developing a capitated, prospective payment system is most crucial. Second, client service and outcome data are critical to setting adequate payment rates and monitoring both client and provider outcomes. Developing the management information systems needed to store and retrieve these data represents a difficult task for public agencies. Third, managed care requires both public and private agencies to assume new roles and responsibilities. Staff from both sectors must alter long-standing practices and develop new skills. Despite these challenges, public officials are encouraged by early—though limited—positive results.

Public Agencies Face Initial Start-Up Tasks

Before managed care arrangements can be implemented, both public and private agencies have found they need to accomplish a number of start-up tasks. First and foremost, public agencies have sought solutions to the fiscal challenges of developing a prospective, capitated payment system when the major federal source of support for child welfare services—particularly foster care—is the service reimbursement method of title IV-E. Second, in developing their managed care initiatives, public agencies have brought together key participants in the system—many of whom have little experience in such joint efforts. Third, because applying managed care principles to child welfare is new, public agencies have developed different strategies to build expertise in this area. Finally, private providers participating in new initiatives need to anticipate significant start-up costs that may not be covered in their contracts.

New Financing Systems Are Difficult to Develop and Require Adjustments

In a managed care environment, the use of prospective, fixed-payment arrangements between public agencies and private service providers can be difficult and presents states with fiscal challenges because the federal government retrospectively reimburses states for many child welfare services. The managed care environment—in which public agencies pay service providers in advance of services but obtain reimbursement from federal title IV-E funds only after the services have been delivered—strains public agencies' ability to maintain an adequate cash flow. In some states as well, state law mirrors federal law and prohibits advanced payments from the state's funding category for out-of-home placements. States have found ways, however, to address this problem. Some states, for example, initially make nonfederal funds available for advance payments to managed care entities. In Massachusetts, the state advances general

revenue dollars to the Commonworks' lead agencies and later replaces the advances with reimbursements from the federal foster care and Medicaid programs.

Public agency officials also expressed concern that federal prohibitions against the use of title IV-E funding for services other than out-of-home care may increase the state's liability for funding a greater share of capitated contracts. When a child returns home, federal reimbursement for foster care costs ceases; however, the child and family may continue receiving unreimbursable in-home services. As managed care entities provide aftercare services and become more successful at returning and keeping children at home, the state's portion of the contract rate will increase as the federal share decreases. In this scenario, the state will also realize savings in its out-of-home costs; however, these savings may be more than offset by the state's obligation to continue paying contractors for in-home services under the fixed rate. This was the case in the Lake and Sumter County managed care initiative in Florida, where the state was paying the lead agency a case rate of about $15,000 over a 2-year period for each child entering foster care. The state based this rate on a daily cost of about $21 per child and expected to finance this rate, in part, by submitting claims for federal title IV-E foster care reimbursement. However, the lead agency had the flexibility to use its case rate dollars to fund treatment and in-home services, and sometimes returned children home or completed successful adoptions in less than 2 years; the state was then left paying more of the daily per diem amounts with its own funds and could no longer claim federal title IV-E reimbursement because the children were no longer in out-of-home care. Finding this financial risk unacceptable, the state abandoned the case rate after a year in favor of a capitated rate for the entire caseload and not for each referral.

Of the 13 states where initiatives are currently being implemented, HHS has waived the categorical funding restriction in title IV-E for one state. Ohio secured a federal waiver to receive a quarterly block grant of title IV-E funds that can be spent on in-home services, such as home-based therapy and other community-based support services. Fifteen counties volunteered to participate in this demonstration, including Hamilton County where the county has contracted with an MCO to manage care for children and families in need of therapeutic, group, and residential care. A few of the 10 states that have received an HHS waiver of certain title IV-E restrictions plan to use it in part to implement managed care initiatives. Furthermore, other states with ongoing managed care initiatives, including

Kansas and Florida, are now seeking similar relief from title IV-E restrictions and have submitted waiver proposals to HHS.

Once a financing system is established, agency officials have found that adjustments are often necessary as they gain experience with managed care. For the second year of Kansas' foster care managed care initiative, for example, the state modified the lead agencies' risk-sharing mechanism to offset an increase in the lead agencies' case rate.[30] Unlike the first year of the contract, lead agencies' financial liability is no longer limited by a 10-percent margin; instead they must pay all costs above the case rate. In addition, each lead agency can now exclude a designated number of referred cases—averaging about 3 percent of each lead agency's total caseload—from the case rate and bill the state for those cases on the more traditional fee-for-service basis instead. According to state officials, these changes were necessary because of potential cash flow problems associated with the risk-sharing mechanism and the realization that the cost of serving some children and families was higher than the initial case rate anticipated. The payment method was changed altogether in the Lake and Sumter County managed care initiative in Florida, although the rate is still fixed. Because the state found the case rate too costly when the number of children requiring a foster care placement grew at a steeper rate than anticipated, the state changed the payment method to a capitated rate—that is, a fixed fee that is no longer linked to each child the state refers to the lead agency but instead covers the estimated total number of children residing in the two counties who may require foster care services.

Key Stakeholders' Buy-in Is Important

The child welfare system includes many different individuals and groups—such as public and private agencies, courts, community organizations, child advocates, and foster parents—all with different roles and perspectives. Public agencies have found that involving these key participants to build consensus concerning program design issues is an important step in developing managed care initiatives. In hindsight, program officials agreed that more inclusive, early involvement would have helped address misconceptions and reduce tensions surrounding managed care and would have facilitated program implementation by ensuring that stakeholders were informed about and supportive of the planned system reform. While public agencies took steps to involve key stakeholders when the managed care initiatives were being developed, officials agreed that they could have done better in this regard. For

[30]Technically, the state did not increase the lead agencies' case rate, but supplemented it by a fixed dollar amount.

example, Boulder County's IMPACT initiative in Colorado is built on a premise of interagency collaboration among the various public agencies that serve the targeted population of adolescents in need of group care or residential treatment. Although the directors from each of these agencies are stakeholders in the public managed care entity, setting broad policy and procedures, caseworkers were not involved in the initiative's development, resulting in some duplication of efforts between agency caseworkers and the new intensive case managers.

In Sarasota County, Florida, on the other hand, the community-based providers collectively designed the service-delivery model and actively supported the state legislation that authorized the initiative, without the involvement of the state child welfare agency. Hence, according to officials, the state agency was not initially prepared to implement the state legislation and experienced great difficulty in resolving with the lead agency such contract issues as the contract rate, data reporting requirements, and public workers' role in overseeing children under the lead agency's care. However, at the state agency's suggestion, the lead agency convened a stakeholders' group, including community leaders and business representatives, to provide oversight and advice. This action has resulted in increased community involvement and support for the initiative through donated space and equipment.

The courts also play a critical role in determining outcomes for children in the child welfare system, yet they are often a forgotten player in reform efforts. As independent judicial bodies, the courts may view themselves as outside the child welfare service-delivery system and not necessarily bound by the same policies or priorities. However, children in out-of-home care often cannot be transferred to a different level of care or discharged from foster care—both key strategies for controlling costs under child welfare managed care—without the court's approval. While public agencies have involved the courts as they developed their initiatives, the extent of judicial involvement has not always been sufficient to guarantee support for system reform efforts. In Kansas, public officials acknowledged the lack of adequate judicial involvement in their foster care managed care initiative. According to officials at one lead agency, the local judge has disagreed with some of their recommendations to discharge children from care and, as a result, children are staying in out-of-home care longer and incurring more costs than the lead agency had projected for its case rate.

Building Expertise Takes Many Forms

Because managed care in child welfare is new, public agencies have had to develop strategies to find both information and sources of assistance. Information on managed care can be obtained from national associations or provider organizations, private consultants, or internal resources in other public agencies with experience in managed care. For example, in both Massachusetts and Sarasota County, Florida, the state hired a private consultant to help develop various aspects of its managed care initiative, particularly how to set capitated contract rates. In both Massachusetts and Boulder County, Colorado, public agency staff looked at their state's experience with managed care in behavioral health care—which serves a similar clientele—to learn more about that system's capitation and service-delivery arrangements. Anticipating the arrival of managed care, private service providers also sought information about the subject to better position themselves—by developing or becoming part of a provider network, for example—as players in states' system reform efforts, often with assistance from national organizations, such as the Child Welfare League of America.

Public agencies have looked to and adapted their own successful practices and relationships as starting points for their initiatives. With its history of interagency collaboration, especially between the child welfare and mental health agencies, Boulder County in Colorado decided to build on this relationship to launch its IMPACT initiative. The county established a new public managed care entity comprising representatives from the agencies that might be involved in the lives of the target population of adolescents in need of group or residential care, such as child welfare, mental health, youth corrections, health, and probation. In Sarasota County, Florida, community-based service providers were active in shaping the managed care initiative, having had a tradition of working together. They formed their own coalition, comprising all major service vendors in the county. Thus, a provider network with a designated lead agency was already in place when state legislation authorized a limited number of community-based pilots. Finally, in Massachusetts, a strong and established service provider network existed in the predecessor to the Commonworks program. The state, therefore, decided to build upon this existing framework and also to contract with an ASO to be responsible for standardizing all operating procedures.

Providers Also Face Financial Challenges When Implementing Contracts

Participating in managed care initiatives is a new experience for most community-based service providers. Service providers we interviewed told us they are eager to participate in this new phenomenon because they

believe managed care is part of child welfare's future and do not want to be excluded from initial efforts. As financing for services becomes fixed under new payment arrangements, one critical issue facing community-based providers is the potential financial strain—both from start-up and ongoing operational costs—involved in their new efforts. As they assume new roles as managed care entities, providers often need to hire additional management and frontline personnel as well as purchase buildings, equipment, and other capital to manage both their provider networks and the new caseloads of children and families. However, public agencies do not always make start-up funds available in the new contracts. For example, neither the lead agency contracts in Kansas' foster care managed care initiative nor the one in Sarasota County, Florida, included start-up moneys. This prevented providers from using the dollars spent on start-up acquisitions to fund a risk pool or required them to seek additional in-kind donations from community organizations.

Providing start-up funds can help alleviate potential financial pressure on new managed care entities and enable them to focus more attention on serving and coordinating the care of children and families. This was the case in Alameda County's small Project Destiny initiative in California, where the county awarded a separate contract to the lead agency, providing funds to support start-up costs, such as those associated with developing the consortium of care providers, training, and any other unanticipated costs.

While public agency officials admit that they expect their providers to find other sources of funding, such as Medicaid and charitable contributions, to support their managed care initiatives, some contractors may have difficulty attracting financial support from their usual contributors because of misconceptions about financial arrangements under managed care. In Kansas, for example, the public agency expected foster care contractors to supplement the case rate with their usual in-kind contributions from philanthropic organizations. However, according to one provider, these organizations were at first reluctant to continue their monetary contributions because they had incorrectly assumed that the new managed care contract provided sufficient funds to cover the lead agency's service costs.

Community-based service providers, who formerly contracted with the public agency and now find themselves part of a provider network under subcontract with a lead agency or MCO, are not immune from financial strains under managed care either. In particular, small providers we

interviewed expressed concern about their financial viability in a managed care environment when client referral patterns fluctuate and payments are capitated. For example, in Massachusetts' Commonworks program, lead agencies have developed their own provider network and, in some regions, have expanded the number of providers to make available the full array of services needed by the adolescents in their care. As a result, lead agencies have not utilized the services of some providers as often as the state agency had in the past and, faced with empty beds in the fee-for-service payment method still in place for subcontractors, these underutilized providers lost revenues. In addition, without the capacity to serve a substantial volume of clients as larger providers might, several small community-based providers expressed reservations about the lead agencies' plans to subcapitate payments and transfer financial risk to providers, especially given the high and costly service needs of Commonworks' target population of adolescents in need of group or residential care.

Management Information Systems Are Needed

For managed care initiatives to effectively develop and adjust capitated payment rates, track service use, and monitor program and child outcomes, public agencies realize that client-level data on services and outcomes are needed. However, public child welfare officials believe that developing management information systems is the most difficult task they face.

Managed Care Is a Data-Dependent System

The successful ongoing operation of managed care arrangements is linked to the extent to which public agencies have timely and accurate information on services and outcomes. These data form the basis for two important activities central to managed care. First, as state child welfare agencies move from a process-monitoring environment to a performance-based approach, information on client outcomes is needed to develop and revise performance standards. Second, payment rates must reflect the accurate overall costs for providing services to children and families in the child welfare system. Aggregate client-level information on service use and costs is necessary to establish capitated rates.

Although most of the initiatives use performance standards in their managed care contracts, performance-based management in general is a new focus for many child welfare agencies. Setting appropriate standards and determining how to measure performance against those standards can be a daunting task for some public agencies. Massachusetts'

Commonworks program, for example, identified performance goals for treatment planning, recidivism, family functioning, education, and independent living but did not evaluate providers on these outcomes for the first year because the outcome measures had yet to be developed. In conjunction with the state agency, the new ASO is expected to develop the measures and collect baseline information for comparison the second year.

As public agencies gain more experience with managed care and develop the capacity to collect better information, public officials recognize that adjustments to existing performance standards and payment rates will be necessary. For example, in Kansas' foster care managed care initiative, the state set initial performance levels not on the basis of past program performance but on what public agency officials believed could reasonably be expected of the new lead agencies. Realizing that these expectations might be unrealistic, the state chose not to penalize the lead agencies for failing to meet performance standards. Indeed, when the lead agencies fell short of first-year goals, such as reuniting families in a timely manner, the state lowered the standard the following year by narrowing the gap between its original expectation and contractors' actual performance.

As we described earlier, establishing payment rates for providers also requires public child welfare agencies to continually revisit and adjust price levels and, in some cases, risk-sharing provisions as more current information is collected. The absence of quality client and service-cost information can, potentially, delay the implementation of capitated rates and create financial strains for both public and private agencies. In Massachusetts' Commonworks program, for example, the state delayed for a year applying the case rate and transferring financial risk to the lead agencies. Instead, the state opted to collect and analyze baseline cost and service-use data as well as minimize financial pressures on lead agencies so they could focus on service-delivery issues during the first year. Financial strain was a problem for the lead agencies in Kansas' foster care managed care initiative because the case rate did not reflect the true cost of serving children with high service needs. On the basis of accumulated first-year cost data, the state modified the risk-sharing formula by increasing lead agencies' case rates in the second year, eliminating the 10-percent risk-reward corridor, and permitting lead agencies to charge the state actual service costs for a limited number of cases.

Management Information Systems Are a Continuing Challenge

Program officials responsible for the initiatives we surveyed view the development of a management information system as the most difficult task they face in their move to managed care. We found that public agencies are implementing their managed care initiatives without appropriate information systems in place. In many instances, providers and public agencies are working with multiple and incompatible information systems. For example, in the managed care initiative in Sarasota County, Florida, the lead agency is directly connected to the state's two child welfare client and service information systems for submitting required management reports, and has its own internal system that is networked with subcontracted service providers to input and track client-level data. Because these three systems are not integrated, lead agency staff must enter duplicate information into each system and physically locate the three computer terminals side-by-side to ensure consistent data. In contrast, Kansas implemented its foster care initiative without an information system in place and relies on handwritten reports submitted by the lead agencies to generate automated reports for the state to manage the initiative. Despite their limits, according to state officials, these management reports contain more information about program performance than was previously available.[31]

Public agencies are approaching the development of their information systems in a variety of ways that reflect the complexity of new systems and in-house expertise. One approach is to purchase a custom-designed system. For the TrueCare Partnership initiative in Hamilton County, Ohio, for example, one major component of the MCO's contract is to develop a comprehensive management information system for the initiative's public partners—the child welfare, mental health, and alcohol and drug agencies—that will integrate client-level data to meet both the public agencies' and service providers' information needs. Another approach is for in-house staff to develop the information system. This has been the case in the Lake and Sumter County managed care initiative in Florida, where the lead agency's information system personnel have developed a database to track all service and placement data regarding program clients to measure outcome achievement. Yet another approach to developing an information system is to adapt an existing system. Boulder County's IMPACT initiative is using a temporary system to track client and aggregate outcomes data until the county can purchase or custom build a more comprehensive, integrated management information system with anticipated project savings within the next year. For the short term, county staff have modified a system originally designed to track

[31]Wulczyn and Orlebeke, "Fiscal Reform for Child Welfare Systems."

adolescents in a previous pilot project that also targeted adolescents in out-of-home care.

Roles and Responsibilities Change Dramatically

Under managed care, public agencies are adjusting to new responsibilities while shifting some traditional functions to the private sector. These public agencies now focus their attention more on oversight and monitoring, and have reconfigured staff resources for contract monitoring and quality assurance purposes. Private agencies, assuming many of the responsibilities traditionally held by public agencies, are now faced with learning various state and federal requirements; preparing and monitoring other service provider contracts; and attracting, training, and retaining a larger workforce.

New Responsibilities Demand a Culture Change and Staff Adjustment

Many of the public agencies implementing managed care initiatives have shifted most of the day-to-day casework responsibilities to private contractors, while developing the capacity and expertise to perform system oversight and monitoring activities. To accomplish this change, some locations reduced the number of public caseworkers and created new positions that reflect their new role. Gaining employees' acceptance of these changes was a difficult task, according to about half the agency officials we surveyed. Comfortable with the traditional service-delivery system and concerned about the safety and well-being of their caseloads of children and families, some workers have resisted the loss of their control over service decisions for clients and must learn new skills and abilities to perform new quality assurance and contract management duties. In some instances, workers were not fully prepared to assume their new duties because public agencies had not taken steps to ensure staff support or to train until after implementation was under way.

Former state child welfare caseworkers have assumed new positions, performing quality assurance activities and managing the new lead agency contract for the managed care initiative in Sarasota County, Florida. The state replaced 37.5 positions with 7 new positions—filled by public foster care, adoption, and protective services caseworkers whose jobs had been eliminated—to oversee the lead agency contract. Of these seven positions, three are quality assurance workers, responsible for monitoring the contractor's case management activities to ensure that issues related to the child's safety are adequately addressed; they accomplish this function by reviewing case files and provider-prepared court paperwork as well as attending case review meetings. A fourth position is for a contract

manager, who monitors the lead agency's compliance with the terms and conditions of the contract. Finally, three public employees perform tasks related to determining children's eligibility for the federal foster care program and claiming federal reimbursement. The transition in public workers' responsibilities has not been easy for either the public employees or provider staff, according to officials, as the public workers received no training for their new positions and focused most of their initial efforts on providing technical assistance and training to the providers' staff about federal and state documentation and procedural requirements rather than on quality assurance.

Kansas' foster care managed care initiative has changed public employees' approach to casework. State caseworkers are still responsible for a caseload of children and their families but have shifted their emphasis from day-to-day case management to intake, assessment, and child protection, and now function as service managers who monitor the services provided by the contractors. In addition, the state has altered the structure of its contract management staff. Now, some of the contract managers are Area Contract Specialists physically located in each of the state's 12 area offices. As the state caseworker's direct liaison with the lead agency, an Area Contract Specialist receives reports for management and oversight purposes and responds to questions about contract operations.

Private Entities Are Assuming Public Functions

Private service providers under contract in the managed care initiatives we reviewed have assumed many of the responsibilites formerly held by public child welfare agencies and, in some instances, have had to adjust to the rapid growth of staff that accompanied the expansion of providers' duties. Understanding and monitoring existing federal and state requirements and managing provider networks are among their new duties.

As case management functions have shifted to private providers, the providers have taken on new administrative tasks that enable states to continue claiming federal reimbursement for eligible activities now performed by contractors. Some contracts require the service provider to provide the information the public child welfare agency needs to file claims for federal title IV-E reimbursement of the costs associated with feeding and housing an eligible child in out-of-home care, as well as certain administrative costs related to that child's placement, such as case management and licensing of foster homes. The tasks necessary to

determine administrative costs can be very time consuming yet necessary where the public agency is financing the capitated payments with federal title IV-E dollars. Such is the case in Sarasota County's managed care initiative in Florida. The state had previously established a method for determining administrative costs under its traditional, publicly operated service system, based on the assumption that caseworkers' activities were reimbursable under title IV-E. However, the lead agency's service-delivery approach includes a mixture of Medicaid-funded functions—such as clinical therapy—that title IV-E does not cover. To help determine eligible administrative costs for this initiative, the state requires the providers' staff to perform a time study for 2 weeks each quarter, when individual workers record their various job activities in 15-minute increments. According to lead agency officials, this requirement is a new activity that has unexpectedly reduced staff time available for serving children and families.

Another new administrative function for lead agencies is managing their subcontracts with network providers. Whether changing the nature of existing relationships or developing new ones, lead agencies—whose general experience has been in directly providing services to children and sometimes their families—must develop new capacities and expertise to ensure network providers are qualified; expand, contract, or reconfigure the network, when necessary; and monitor network providers' performance and compliance with their contract requirements. Lead agencies' relationships with network providers may become strained when, in the interest of cost efficiency or service quality, referral patterns to individual providers fluctuate or nonperformers are dropped from the network.

As private contractors have assumed the lead agency role, the nature of their relationships with other community-based service providers has changed. Where previously providers contracted directly with the public agency, some now find themselves managing a network made up of former competitors. For example, for Kansas' foster care managed care initiative, many of the community-based service providers were among the 16 bidders for the lead agency contracts, but only 3 of them won contracts. Many of the unsuccessful bidders became network subcontractors, and according to several providers' staff, the stress of the competitive process left some network providers resentful of the lead agency's new oversight role. Conversely, where there may have been fierce competition in the past for the public agency's business, increased collaboration among providers may reduce the uncertainties of a competitive market. This has been the

case in the managed care initiative in Sarasota County, Florida, where the major service providers no longer view themselves as competitors, according to providers' staff, but are now collaborative partners in the self-formed Coalition that is the provider network. In yet another scenario, lead agencies have had to establish new relationships—sometimes straining existing relationships—when new providers were brought into the network. In order not to jeopardize the stability of existing placements when Massachusetts' Commonworks program was implemented, the state, among other strategies, required the lead agencies to expand their provider network to include those group or residential care providers already serving youth who were transferred to the lead agency's care. Expanding the network in this way meant purchasing fewer services from other network providers and possible financial jeopardy for some of them, according to providers' staff, which strained their relationship with the lead agency.

Once community-based service providers, regardless of their size, became lead agencies, they found that they needed to expand—sometimes very rapidly—to accommodate their new responsibilities and new caseloads of children and families. For many of these lead agencies, hiring and training a larger workforce amid various other start-up activities became a difficult task. For example, in Kansas' foster care managed care initiative, the lead agencies' caseloads more than doubled in a matter of months and they took on multiple areas of major new responsibilities. For example, they had to accept all referrals, develop and manage a provider network, manage cases of children that now also include their families, track and report outcomes, and consider the financial risk of the case rate. These responsibilities were combined with the basic business of expansion—hiring, training, and acquiring space and equipment. In addition, lead agencies had difficulty recruiting and retaining new workers because of tremendous competition for social workers when the state kept most of its social work staff and, therefore, did not provide a pool of former state workers that lead agencies had expected to choose from.[32]

Early, Though Limited, Positive Results Encourage Public Officials

While only a few locations are beginning to collect data and report results, preliminary results indicate some cost savings and improvements in the quality of care from the implementation of managed care. Public agency officials responsible for the ongoing initiatives are encouraged by improvements in the amount of services provided, overall service

[32]Wulczyn and Orlebeke, "Fiscal Reform for Child Welfare Systems."

availability, and increased public support for children in the child welfare system.

Early Cost Savings Are Seen in Some Managed Care Initiatives

Some initiatives report cost savings resulting from the managed care entity's success in reducing or averting the need to place children in the most costly out-of-home settings, such as residential care. The public agencies involved attribute this success in part to the better coordination of services that match client needs. For example, in Wisconsin's Wraparound Milwaukee program in Milwaukee County, the publicly operated HMO has reduced the number of children in residential treatment and, as a result, costs are almost 40 percent less per child than under the previous system. Moreover, the program's Mobile Crisis Team's gatekeeping functions and development of treatment plans have resulted in a 55-percent reduction in inpatient hospital days as well as nearly 200 fewer children in need of residential care between 1994 and 1997. Furthermore, reinvestment of moneys saved from reducing the use of residential treatment has enabled the project to serve 44 percent more children with the same moneys.

Child Welfare Officials Are Encouraged by Other Managed Care Effects

Child welfare officials are encouraged by other service-delivery improvements as well. Most agency officials we surveyed believe children and families are receiving more services that better match their needs under managed care. For example, in Sarasota County's managed care initiative in Florida, the lead agency subcontracts with service providers whose caseworkers are seeing clients more frequently and providing more intensive services in the family's home than public workers did prior to the managed care initiative. Managed care has also improved services by making them available to those who would otherwise not receive the services they need. Kansas' foster care initiative, for example, includes one lead agency with a provider network dedicated to serving children and families in the extremely rural, westernmost part of the state. Historically, these children were hard to serve because of their remote location, but they now have available to them a provider network offering an array of services.

Other initiatives also report improvements that have resulted in children and families achieving permanency goals more quickly under managed care, but they have yet to document reduced costs. For example, in Illinois' Performance Contracting initiative in Cook County, private foster care agencies are more aggressively moving children toward permanency

by providing services, such as aftercare and counseling, that enable children to rejoin their families, be adopted, or live with subsidized guardians. After 3 months of operation, the initiative has yet to realize any cost savings because of the additional state dollars invested in services for foster care contractors to find children permanent homes. However, the state projects that almost two-thirds more children will be in permanent living arrangements at year's end over the previous year's total because providers are now more effectively managing their cases.

In still other initiatives, early results are mixed. While private contractors have met performance standards in some areas, they have fallen short in others. Kansas' foster care managed care initiative, for example, reported that, after the first 10 months of operation, its lead agencies successfully surpassed performance standards related to the quality of children's care, such as ensuring that children are safe from maltreatment and in stable placements. However, they were less successful in meeting standards that could result in cost efficiencies, such as reuniting families in a timely manner. After its first year of operation, according to state officials, managed care had not yet resulted in improvements in the rate that children leave foster care for more permanent living arrangements, or yielded cost savings.

Finally, public officials believe managed care is increasing community awareness and support for the vulnerable population, particularly at-risk adolescents, that resides within their boundaries. For example, the managed care initiative in Boulder County, Colorado, targets adolescents in or at risk of residential treatment whose likely permanency goal is to live in the community and not with their families. According to initiative officials, building community-based networks of care has increased community concern and involvement with these adolescents, which county officials believe will facilitate reintegration into the community.

Observations and Agency Comments

Observations

Child welfare agencies face growing caseloads of children and escalating costs. At the same time, they must ensure that these children remain safe and search for the most appropriate permanent living arrangements. In addition, program officials and policymakers alike have been frustrated with many of the characteristics of the current service delivery system that is intended to provide care for these children and their families. They observe a system that often keeps children in care longer than necessary, in part, because of fragmented services and few financial incentives to provide better services to move children out of care faster. Many public officials responsible for the care of these children are looking to managed care as a way to change how their state or locality approaches the financing and delivery of child welfare services.

While there is no single managed care approach, in general, states and localities are (1) experimenting with capitated payments to transfer financial risk to providers and (2) managing children's care through a single point of entry to a full array of services. Simultaneously, they are introducing quality assurance strategies to maintain a balance between the desire to control costs and to ensure service quality and children's safety. In what has been a publicly managed system, however, new contractual arrangements are shifting financial and service coordination responsibilities to the private sector in some states. Where public agencies opt to retain these responsibilities, they are changing their approach to coordinating children's care and purchasing needed services.

Public agencies experimenting with managed care view it as a strategy that promotes flexibility in a fragmented service-delivery system while attempting to ensure accountability for controlling costs and improving service outcomes. Because they anticipate legislative and policy changes that may reduce child welfare budgets, public and private agency officials alike have felt a sense of urgency to proactively pursue or prepare themselves for system reform. Even so, implementing managed care is a dynamic process that will require time to evolve and evaluate its efficacy. To date, the application of managed care arrangements in the child welfare system is still in its infancy and remains largely untested.

States and localities expect to continue refining their initiatives as service and cost data become available and evaluations assess the efficacy of managed care to improve service outcomes for children and families. As more children are served under managed care arrangements, however, three outstanding issues need resolution. First, public agencies need to address the cash flow problems associated with an approach that requires

public agencies to provide prospective, capitated payments to service providers but receive reimbursement for the federal share of costs only after the delivery of services. Where there is greater funding flexibility—either through blended or pooled funding arrangements or federal waivers, for example—public agencies stand a better chance of reducing or eliminating the service access problems often associated with different eligibility requirements in categorical funding streams. Second, the need for good service and cost data is paramount if public agencies expect to set reasonable and appropriate contract rates and performance standards. Public agencies must continue to develop and adapt their management information systems in order to make additional changes or provide their managed care partners feedback that could further improve policies and procedures for serving children and families in an effective, yet cost-efficient, manner. Finally, public agencies must continue to develop and refine strategies to hold their private partners accountable for achieving desired outcomes and developing the capacity to continuously measure and report their progress toward meeting performance goals. Such efforts are necessary to enable public agencies to report to policymakers at all levels on the effectiveness of the new system in meeting the needs of children and families.

HHS and Public Agency Comments

We obtained comments on a draft of this report from HHS and state and county public child welfare officials responsible for the managed care initiatives in the four case study sites. HHS provided two general comments and additional technical information, which we incorporated in the report as appropriate. First, HHS acknowledged that the federal role in child welfare managed care has been limited. However, it said that ACF has initiated and participated in a number of activities, such as internal training sessions and national conferences, that provided information about managed care concepts. Second, HHS noted that states' Statewide Automated Child Welfare Information Systems (SACWIS) should provide data states need to implement managed care. We agree that SACWIS could provide some necessary information; however, most states are still developing their systems, and SACWIS' overall usefulness in managed care is unknown. Responsible child welfare officials from the four case study sites generally agreed with the report's findings and provided additional technical information about their child welfare managed care initiatives, which we incorporated in the report as appropriate.

Ongoing Child Welfare Managed Care Initiatives

Table I.1 includes the 27 managed care initiatives about which we collected more detailed information from our survey of state and local officials. Where locations had multiple initiatives, we asked respondents to provide additional information about only their largest initiative, as determined by the number of children served. As of March 1998, multiple initiatives were reported as ongoing in four locations—Illinois; Kansas; Mesa County, Colorado; and Hamilton County, Ohio.

Table I.1: Information About 27 Ongoing Child Welfare Managed Care Initiatives, as of March 1998

Location and project name	Date implemented	Geographic scope	Number of children served		Managed care model[a]	Covered population and child welfare program(s)
			Total	Percentage of location's total child welfare population		
State-level initiatives						
Georgia Multi-Agency Team for Children (MATCH)	July 1994	Statewide	660	3	Public	Residential treatment services for severely emotionally disturbed children
Illinois Performance Contracting	July 1997	One county	23,200	40	Public	Relative foster care in Cook County
Indiana The Dawn Project	May 1997	One county	106	1	MCO	Wraparound services for seriously emotionally disturbed children, aged 5 to 17, who have been impaired for more than 6 months and involved with multiple service systems in Marion County
Kansas Foster Care Privatization	Mar. 1997	Statewide	4,950	66	Lead agency	All foster care
Massachusetts Commonworks	Jan. 1997	Statewide	683	2	ASO with lead agency	Foster care for adolescents needing group care or residential treatment
Michigan Interagency Family Preservation Initiative	Oct. 1995	Selected sites	166	1	Lead agency	Wraparound services for seriously emotionally disturbed children involved with multiple service systems
Tennessee Continuum of Care Contracts	July 1996	Statewide	2,500	21	Public	Foster care for older children with moderate to severe emotional and behavioral problems
Wisconsin Safety Services Program	Jan. 1998	One county	750	10[b]	Lead agency	Family preservation services for noncourt families in Milwaukee County

(continued)

Location and project name	Date implemented	Geographic scope	Number of children served: Total	Number of children served: Percentage of location's total child welfare population	Managed care model[a]	Covered population and child welfare program(s)
Local-level initiatives						
Alameda County, Calif. Project Destiny	Apr. 1997	Countywide	24	1	Lead agency	Foster care for seriously emotionally disturbed children in residential treatment
Boulder County, Colo. Integrated Managed Partnership for Adolescent Community Treatment (IMPACT) pilot	July 1997	Countywide	270	30	Public	Foster care for adolescents needing group care or residential treatment
El Paso County, Colo.	Sept. 1997	Countywide	85	50	ASO with lead agency	Foster care for children placed by Child Placement Agencies
Jefferson County, Colo. Child Welfare Pilot	Oct. 1997	Countywide	1,687	100	Public	All child welfare services
Mesa County, Colo. Child Welfare Pilot	Jan. 1998	Countywide	320	40	Public	All child welfare services
District 4, Fla. Privatization Pilot	Oct. 1997	Districtwide	318	[c]	ASO with lead agency	Foster care and independent living services for adolescents
District 8, Fla. Sarasota County Privatization Pilot	Jan. 1997	One county	420	30	Lead agency	All children needing protective services, foster care, and adoption services in Sarasota County
District 13, Fla. Bridges Program	Jan. 1997	Two counties	88	[c]	Lead agency	Children needing foster care and adoption services in Lake and Sumter Counties
Albany County, N.Y.	Jan. 1989	Countywide	1,750	20	Public	Children needing preventive services
Broome County, N.Y. Child Welfare Care Management	Oct. 1996	One site	10	<1	Lead agency	Children needing family preservation services, foster care, and independent living services; pilot on hold
Oneida County, N.Y. Kids Oneida	Jan. 1998	Countywide	7	<1	Lead agency	Wraparound services for seriously emotionally disturbed children in or at risk of out-of-home placement
Onondaga County, N.Y. Family Support Center Program	Oct. 1994	Countywide	155	[c]	Public	Children needing emergency foster care services

(continued)

Location and project name	Date implemented	Geographic scope	Number of children served: Total	Number of children served: Percentage of location's total child welfare population	Managed care model[a]	Covered population and child welfare program(s)
Tompkins County, N.Y. Youth Advocate Program	July 1996	Countywide	10	10	Lead agency	Wraparound services for youth in residential or institutional placements
Champaign County, Ohio Human Services/Adriel School	Oct. 1995	Countywide	21	20	Public	Foster care for children needing nonrelative, out-of-home placement
Crawford County, Ohio Out-of-County Placement	Jan. 1997	Countywide	17	1	Lead agency	Foster care for children placed outside the county in therapeutic family foster home, group care, or residential treatment
Hamilton County, Ohio TrueCare Partnership	Jan. 1998	Countywide	3,220	35	MCO	Foster care and independent living services for children in outpatient mental health and therapeutic placements
Madison County, Ohio Adriel Out-of-Home Care Placements	Jan. 1996	Countywide	27	50	Lead agency	Foster care for children needing nonrelative, out-of-home placement
Dodge County, Wis.[d] Family Partnership Initiative	Aug. 1997	Nine-county area	40	5	Lead agency	Wraparound services for adolescents in child care institutions or juvenile corrections
Milwaukee County, Wis. Wraparound Milwaukee	June 1996	Countywide	600	8	Public	Wraparound services for children in or at risk of residential treatment

(Table notes on next page)

[a]Organizational arrangements among public and private entities generally fell into one of the following managed care models: (1) public model, which maintains the traditional management and service-delivery structure while the public agency incorporates managed care elements into its own practices and existing contracts with service providers; (2) lead agency model, where the public agency contracts with a private entity that is responsible for coordinating and providing all necessary services—either directly itself or by subcontracting with a network of service providers—for a defined population of children and families; (3) administrative services organization (ASO) model, where the public agency contracts with a private organization for administrative services only, and direct services are structured as in the lead agency or public models; and (4) managed care organization (MCO) model, where the public agency contracts with a private organization as in the lead agency model, but the MCO arranges for the delivery of all necessary services by subcontracting with other service providers and does not itself provide direct services.

[b]Percentage is of Milwaukee County's child welfare population; although Wisconsin has a county-operated child welfare system, the state child welfare agency operates this managed care initiative in Milwaukee County.

[c]Data were not readily available.

[d]Nine-county initiative includes Columbia, Dodge, Green Lake, Jefferson, Ozaukee, Sauk, Sheboygan, Washington, and Winnebago Counties; Dodge County completed our survey for the participating counties.

Source: State and local agency officials' responses to GAO survey and follow-up telephone conversations, as well as documentation describing the initiative, where provided.

GAO Survey of State and Local Public Agencies

This appendix presents our survey of state and local public agencies regarding their use of managed care arrangements in child welfare programs. Each question includes the summary statistics and the actual number of respondents that answered the question. In each case, we use the format that we believe best represents the data, including frequencies, means, and ranges.

U.S General Accounting Office

Questionnaire to States and Localities about Managed Care Arrangements in Child Welfare

The U.S. General Accounting Office (GAO), an agency of the Congress, is studying the use of managed care arrangements in child welfare programs, including child protective services (CPS), family support and preservation, foster care, and adoption. As part of this study, we are surveying the state welfare agency in each of the 50 states and the District of Columbia, as well as county and district agencies that administer their own child welfare programs. The purpose of this survey is to obtain information that will help us determine the number of state, county and district managed care initiatives in child welfare nationally, and the types of arrangements that are being implemented.

To assist us, we ask that you complete and return this questionnaire to us within the next two weeks. When responding, you may consult with others who are also familiar with these topics, if you think it will help you give a more precise answer. The questionnaire should take an hour or less to complete. It asks you to provide information about...

-o- the number of managed care initiatives in child welfare in your state, county or district,

-o- the types of managed care arrangements used in these initiatives,

-o- the types and content of contracts established with providers,

-o- the financial arrangements between government and the other organizations in the managed care network, and in particular, risk sharing, that is, who assumes responsibility for losses, and

-o- the results of managed care initiatives.

The information you provide will inform the Congress about innovative ways of managing child welfare programs and thus increase their understanding of state and local managed care initiatives.

Please return the questionnaire to us in the enclosed pre-addressed business reply envelope. Alternatively, you may fax your completed questionnaire to us to the attention of David Bellis on (202) 512-5804.

If you have any questions or comments about this questionnaire, please call David Bellis in Washington, DC on (202) 512-7278 or Karen Lyons in Sacramento, CA on (916) 486-6442. In the event that the business reply envelope is misplaced, or your fax fails to get through, please return the questionnaire to:

U.S. General Accounting Office
Attn: David Bellis IS/Rm. 5D52
441 G Street, NW
Washington DC 20548

PASTE ID # HERE

Please enter the name, title, and telephone number of the person completing this questionnaire.

_____
Name

_____
Title

_____
(Area Code) Number

Definitions

Child welfare services include services provided by the child protective services (CPS), family support and preservation, foster care and adoption programs. They also include independent living services.

Managed care: An arrangement between a state, county, or district and non-government entities for the provision of child welfare services that includes at a minimum: a pre-set or fixed reimbursement amount for a set of child welfare services for a pre-defined population, or stipulations for sharing losses such that providers will assume some of the responsibility when the actual cost of services to a population exceeds a pre-set amount. The arrangement, in addition to fixed reimbursement and stipulations for sharing losses, may also include the use of performance goals, or ongoing reviews of the extent to which clients use services.

Background

1. **This question and all those that follow are asking about only managed care initiatives that include child welfare services. Also, most of the questions that follow contain the phrase "your state's, county's or district's;" if you are a state official please answer only for your state, unless you are a state official responsible for a district, in which case answer only for your district; if you are a county official please answer only for your county.**

   Which of the following best describes your official position at present? (CHECK ONE.) **(n=73)**

   1. **[22]** employed as a county child welfare official **(IF CHECKED, GO TO QUESTION 4.)**
   2. **[32]** employed as a state child welfare official in a state that administers child welfare programs at the state level **(IF CHECKED, GO TO QUESTION 4.)**
   3. **[8]** employed as a state child welfare official in a state where child welfare programs are generally administered at the district level **(IF CHECKED, GO TO QUESTION 4.)**
   4. **[11]** employed as a state child welfare official in a state where child welfare programs are generally administered at the county level

2. Are state funds for child welfare services distributed to county child welfare agencies through a capitated method that keeps the level of funding fixed, such as a block grant? (CHECK ONE.) **(n=11)**

   1. **[4]** Yes
   2. **[7]** No

3. As of today, has your **state** begun to serve clients under any managed care initiatives? Please do not include managed care initiatives being administered locally. (CHECK ONE.) **(n=11)**

   1. **[2]** Yes---> On what date did your **state** begin serving clients under a managed care initiative? (ENTER DATE.)

      ___/___/____
      Mo. Day Yr.
      (IF "YES," GO TO QUESTION 7.)

   2. **[9]** No **(IF "NO," GO TO QUESTION 5.)**

4. As of today, has your state, county or district begun to serve clients under any managed care initiatives? (CHECK ONE.) **(n=62)**

   1. **[25]** Yes---> On what date did your state, county or district begin serving clients under any managed care initiative? (ENTER DATE.)

      ___/___/____
      Mo. Day Yr.
      (IF "YES," GO TO QUESTION 7.)

   2. **[37]** No

5. Is your state, county or district considering or planning to serve clients under any managed care initiatives in the future? (CHECK ONE.) **(n=47)**

   1. **[30]** Yes---> On what date will you begin serving clients under any managed care initiative? (ENTER DATE.)

      ___/___/____
      Mo. Day Yr.

      or [ ] Don't know

   2. **[17]** No **(IF "NO," STOP! PLEASE RETURN THIS QUESTIONNAIRE.)**

6. Consider the managed care initiative that is closest to being ready to serve clients in your state, county or district. In what stage of the planning process is this initiative? (CHECK ONE.) **(n=29)**

   1. **[12]** We have just started thinking about managed care arrangements and have not taken any official action
   2. **[8]** We have formed agency working groups to plan managed care initiatives
   3. **[7]** We are developing RFPs
   4. **[2]** We have distributed RFPs and are evaluating proposals
   5. **[0]** We have selected contractors

(STOP! PLEASE RETURN THIS QUESTIONNAIRE.)

7. Currently, how many different managed care initiatives are serving clients in your state, county or district? (ENTER NUMBER.) **(n=27)**

   _____ initiatives
   1 initiative = 22 2 initiatives = 1
   3 initiatives = 4

Types of Managed Care Arrangements

Each of the four questions that follow below contains a description of a particular way in which states, counties or districts might arrange themselves with other organizations to administer and deliver child welfare services under managed care. Each question then asks how many, if any, of your state's, county's or district's managed care initiatives **come close to, or match** this description.

The **definitions** below may help you answer the questions on managed care models that follow these definitions.

Case management tasks include tasks such as the development of the child's treatment plan, arranging for the provision of client services, or tracking client progress.

Direct services include those services related to basic care, such as providing food, clothing, and shelter; those related to health care such as medical, dental, and mental health services; as well as educational services, family-based services, independent living services, aftercare, recreation and cultural activities, and transportation.

Administrative functions include billing and reimbursement, the development and/or operation of management information systems, training, technical assistance, and tracking and reporting on the services used by clients.

8. **The MCO Model**

   In the first type of managed care arrangement, here called the MCO model, the public child welfare agency privatizes most or all case management tasks and direct services by entering into a pre-set or fixed payment agreement with a nonpublic organization, sometimes called a "managed care organization" (MCO). Generally, MCO's conduct case management for referred clients. MCO's **do not provide direct services,** but arrange for the delivery of services by subcontracting to other organizations who provide direct services to clients. In addition, MCO's can perform some administrative functions, such as reimbursing service providers and tracking the services used by clients.

   How many, if any, of your state's, county's or district's managed care initiatives fit, or come close to, this description? (ENTER NUMBER.) **(n=2)**

   _____ initiatives

   1 initiative = 1 3 initatives = 1
   (MORE MODELS ON THE NEXT PAGE.)

9. **The Lead Agency Model**

In the second type of managed care arrangement, here called the lead agency model, the public child welfare agency privatizes some case management tasks and most or all direct services by entering into a pre-set or fixed payment contract with a nonpublic service provider, often called a "lead agency." Usually, the public agency shares case management tasks with the lead agency. Unlike the MCO, the lead agency **does provide some direct services** to clients itself. It also subcontracts with other organizations, including provider networks and coalitions, for the provision of direct services. Lead agencies sometimes perform administrative functions such as reimbursing service providers and tracking services used by clients.

How many, if any, of your state's, county's or district's managed care initiatives fit, or come close to, this description? (ENTER NUMBER.) **(n=15)**

_____ initiatives

1 intiative = 12 2 initiatives = 2 3 initiatives = 1

10. **The ASO Model**

In the third type of managed care arrangement, here called the ASO model, the public child welfare agency assigns some or many of the administrative functions that had been performed previously by either the public agency or its service providers, to a separate organization. To accomplish this, the public agency enters into a pre-set or fixed payment contract with a nonpublic organization, often called an "administrative services organization" (ASO). **The ASO does not perform case management tasks or provide direct services.** The public child welfare agency can either perform case management tasks itself, or contract with a lead agency to perform these tasks. For direct services, the public agency can either contract directly with service providers, or contract with a lead agency to arrange for services through subcontracts.

How many, if any, of your state's, county's or district's managed care initiatives fit, or come close to, this description? (ENTER NUMBER.) **(n=3)**

_____ initiatives

1 initiative = 3

11. **The Public Agency Model**

In the last type of managed care arrangement we will consider, here called the public agency model, the public child welfare agency continues to perform case management and administrative tasks and to provide direct services as it did before. Now, however, the public agency incorporates managed care principles into its own practices, such as using performance standards and tracking service use by clients. In addition, where the public agency had previously contracted with nonpublic organizations to provide direct services, these contracts may now include provisions that incorporate managed care principles, such as pre-set or fixed payments, risk sharing or sharing losses, and incentives for meeting performance goals. In addition, the public child welfare agency **does not** contract with nonpublic organizations to perform case management tasks or to arrange for or provide direct services, roles that an MCO or lead agency would normally play. The public agency also **does not contract** with nonpublic organizations that perform administrative functions, such as an ASO would perform.

How many, if any, of your state's, county's or district's managed care initiatives fit, or come close to, this description? (ENTER NUMBER.) **(n=10)**

_____ initiatives

1 initiative = 10

Number of Children Receiving Care

12. At present, approximately how many children, including both those in out-of-home care and those not in such care, are in the child welfare system in your state, county or district? (ENTER NUMBER.) **(n=23)**

Mean = 9464 children
Range = 54 - 58,000

13. About what percentage of the children in the child welfare system are being served at present by managed care initiatives in your state, county or district? (ENTER THE PERCENTAGE.) **(n=24)**

Mean = 23.5%
Range = 0% - 100%

Your Largest Initiative

14. All of the questions in this section of the questionnaire refer to the **largest** managed care initiative that your state, county or district has implemented, that is, **the initiative under which the most children are being served.**

    (IF YOUR STATE, COUNTY OR DISTRICT HAS ONLY ONE INITIATIVE, GO TO QUESTION 15.)

    Again, consider all of the children in the child welfare system in your state, county or district at present. About what percentage of these children, at present, are being served by the **largest** managed care initiative in your state, county or district? (ENTER THE PERCENTAGE.) **(n=7)**

    Mean = 33.3%
    Range = 1% - 66%

15. In the space below, please enter the name of your largest initiative. (ENTER NAME.) **(n=26)**

    Name of initiative:_____

    _____

16. Consider the managed care arrangements described on the two preceding pages, that is, the MCO model, the lead agency model, the ASO model, and the public agency model. Which of these best describes your state's, county's or district's largest managed care initiative? (CHECK ONE.) **(n=27)**

    1. **[2]** The MCO model
    2. **[12]** The lead agency model
    3. **[3]** The ASO model
    4. **[10]** The public agency model

17. Is your state's, county's or district's largest managed care initiative primarily state-wide, county-wide, district-wide, or taking place at only one or a few local sites? (CHECK ONE.) **(n=25)**

    1. **[4]** State-wide
    2. **[17]** County-wide
    3. **[2]** District-wide
    4. **[2]** Taking place at only one or a few local sites

18. On what date did your state, county or district begin serving clients under your largest managed care initiative? (ENTER DATE.) **(n=27)**

    ___/___/____
    Mo. Day Yr.

Introducing and Implementing Your Largest Initiative

19. In Part A, please tell us whether or not your state, county or district obtained information on, or assistance with, managed care initiatives from each of the sources listed below. If "Yes," please tell us in Part B, how much this information or assistance helped your state, county or district in developing your **largest** managed care initiative.

	PART A: Did you obtain information about, or assistance with, managed care from each of the sources listed below? (CHECK ONE FOR EACH SOURCE.)			Part B: How much did the information or assistance you obtained from each source help you to develop your largest managed care initiative?			
	No (1)	Yes (2)		Helped very much (1)	Helped moder-ately (2)	Helped some-what (3)	Help-ed a little or not at all (4)
1. Public interest groups, advocacy groups, professional associations, or foundations that specialize in formulating child welfare policy **(n=26)**	**6**	**20**	If yes --->	**9**	**5**	**4**	**2**
2. Public child welfare officials from your state or other localities within your state **(n=25)**	**2**	**23**	If yes --->	**14**	**4**	**4**	**1**
3. Public child welfare officials from other states or localities outside your state **(n=24)**	**11**	**13**	If yes --->	**4**	**5**	**3**	**1**
4. Public officials from your state or localities within your state employed outside the child welfare system **(n=24)**	**11**	**13**	If yes --->	**6**	**3**	**4**	**1**
5. Public officials from other states or localities in other states employed outside the child welfare system **(n=23)**	**15**	**8**	If yes --->		**2**	**6**	
6. Caseworkers and supervisors from your state's or locality's child welfare agency **(n=25)**	**7**	**18**	If yes --->	**9**	**6**	**3**	

	PART A Did you obtain information about, or assistance with, managed care from each of the sources listed below? (CHECK ONE FOR EACH SOURCE.)			Part B How much did the information or assistance you obtained from each source help you to develop your largest managed care initiative?			
	No (1)	Yes (2)		Helped very much (1)	Helped moder-ately (2)	Helped some-what (3)	Help-ed a little or not at all (4)
7. Federal government officials, including those from the Department of Health and Human Services (DHHS) **(n=23)**	**13**	**10**	If yes --->	**3**	**5**	**2**	
8. Service providers or organizations representing service providers **(n=24)**	**2**	**22**	If yes--->	**12**	**7**	**2**	
9. Academic resource centers **(n=24)**	**13**	**11**	If yes --->	**4**	**5**	**2**	
10. Private non-academic consultants **(n=27)**	**9**	**18**	If yes --->	**11**	**5**	**1**	**1**

20. Listed below are some factors that might influence a state's, county's or district's **decision to introduce** managed care initiatives. Was each a major factor, a minor factor, or not a factor at all, in your state's, county's or district's decision to introduce your largest managed care initiative? (CHECK ONE FOR EACH.)

	A major factor (1)	A minor factor (2)	Not a factor (3)
1. Actions of the state legislature **(n=25)**	**11**	**4**	**10**
2. A court order or some other action of the legal system **(n=25)**	**4**	**5**	**16**
3. Actions of the executive branch of state government **(n=25)**	**4**	**5**	**16**
4. Citizens' attention being directed at the child welfare system **(n=25)**	**4**	**9**	**12**

	A major factor (1)	A minor factor (2)	Not a factor (3)
5. The potential for greater flexibility in the payment for and delivery of child welfare services **(n=26)**	**23**	**2**	**1**
6. Rising costs of providing child welfare services **(n=26)**	**22**	**2**	**2**
7. Rising caseloads **(n=26)**	**12**	**9**	**5**
8. Other major factors (PLEASE SPECIFY.) **(n=11)**	**11**		

21. Listed below are some tasks that are related to the **implementation** of managed care initiatives. Please indicate how easy or difficult it was for your state, county or district to perform each of these tasks during the implementation of your largest managed care initiative. If your state, county or district did not perform a task, please check not applicable. (CHECK ONE FOR EACH.)

	N/A Not applica-ble (1)	Very easy (2)	Some-what easy (3)	As easy as difficult (4)	Some-what difficult (5)	Very difficult (6)
1. Developing and adapting a management information system for the initiative **(n=26)**	**4**			**4**	**8**	**10**
2. Reaching consensus among child welfare officials about the model to be implemented **(n=26)**	**2**	**5**	**6**	**10**	**2**	**1**
3. Achieving acceptance from public child welfare workers of moving to managed care **(n=26)**	**1**	**1**	**2**	**10**	**9**	**3**
4. Reaching consensus within your agency on a reimbursement rate for direct services **(n=26)**	**2**	**5**	**9**	**3**	**6**	**1**
5. Reaching consensus among child welfare providers on a reimbursement rate for direct services **(n=26)**	**1**	**3**	**9**	**3**	**5**	**5**
6. Reaching consensus within your agency on performance standards for direct services **(n=26)**		**3**	**11**	**6**	**6**	
7. Reaching consensus among child welfare providers on performance standards for direct services **(n=26)**			**11**	**4**	**9**	**2**

22. For each of the programs listed below, please indicate whether or not your state's, county's or district's largest managed care initiative **serves clients of that program**? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Child Protective Services **(n=23)**	**[3]**	**[20]**
2. Family Foster Care **(n=24)**	**[18]**	**[6]**
3. Therapeutic Family Foster Care **(n=24)**	**[18]**	**[6]**
4. Group Home, Residential or Institutional Care **(n=26)**	**[23]**	**[3]**
5. Adoption **(n=22)**	**[8]**	**[14]**
6. Family Preservation and Support **(n=20)**	**[9]**	**[11]**
7. Independent Living **(n=21)**	**[10]**	**[11]**
9. Other (PLEASE SPECIFY.) **(n=4)**	**[4]**	

23. Again, think about the largest managed care initiative in your state, county or district. Within the jurisdiction served by this initiative, is eligibility for any of the services provided by the initiative restricted on the basis of the age of the child, the location of the child's residence, whether or not the child is a new entrant to a child welfare program, the type of placement setting the child is in, or whether or not abuse or neglect has already occurred in the child's case history?

	Is eligibility to any service provided by your largest managed care initiative restricted on the basis of ...? (CHECK ONE FOR EACH.)	
	Yes (1)	No (2)
1. The age of the child **(n=26)**	**4**	**22**
2. The location of the child's residence **(n=27)**	**13**	**14**
3. Whether or not the child is a new entrant to a child welfare program **(n=26)**	**4**	**22**
4. The type of placement setting the child is in **(n=26)**	**13**	**13**
5. Whether or not abuse or neglect has already occurred **(n=24)**	**3**	**21**

Case Management

24. Have any of the private organizations participating in your largest managed care initiative been assigned the function of performing case management tasks, such as developing the treatment plan, arranging for the provision of services that clients need, or tracking client progress? (CHECK ONE.) **(n=27)**

    1. **[6]** No (IF "NO," GO TO QUESTION 27.)

    2. **[21]** Yes

25. Consider all of the cases that received case management in the jurisdiction currently being served under your largest managed care initiative **on the day before** this initiative was implemented. Of these cases, about what proportion, if any, were cases for which case management was performed at that time by a private organization under contract or subcontract to your state, county or district? (CHECK ONE.) **(n=19)**

    1. **[9]** None

    2. **[4]** A few

    3. **[2]** Some

    4. **[1]** About half

    5. **[2]** Most

    6. **[1]** All or almost all

26. Consider all of the cases that are currently receiving case management in the jurisdiction being served under your largest managed care initiative. Of these cases, about what proportion, if any, are cases for which case management is being performed by a private organization under contract or subcontract to your state, county or district? (CHECK ONE.) **(n=18)**

    1. [**0**] None
    2. [**2**] A few
    3. [**2**] Some
    4. [**1**] About half
    5. [**3**] Most
    6. [**10**] All or almost all

Monitoring for Compliance

27. Have any of the private organizations participating in your largest managed care initiative been assigned the function of monitoring the initiative's service delivery contractors' compliance with contract requirements? (CHECK ONE.) **(n=27)**

    1. [**18**] No (IF "NO," GO TO QUESTION 30.)
    2. [**9**] Yes

28. Consider all of the contractors that your state, county or district used to provide child welfare services to the jurisdiction currently being served under your largest managed care initiative **on the day before** this initiative was implemented. Of those contractors, about what proportion, if any, were having their compliance with contract requirements monitored at that time by a private organization under contract or subcontract to your state, county or district? **(n=9)** (CHECK ONE.)

    1. [**7**] None
    2. [ ] A few
    3. [**1**] Some
    4. [ ] About half
    5. [ ] Most
    6. [ ] All or almost all
    7. [**1**] N/A - None were having their compliance monitored

29. Consider all of the contractors your state, county or district currently uses to provide child welfare services to the jurisdiction being served under your largest managed care initiative. Under the initiative, of these contractors, about what proportion, if any, have their compliance with contract requirements monitored by a private organization? (CHECK ONE.) **(n=9)**

    1. [**3**] None
    2. [**1**] A few
    3. [**1**] Some
    4. [ ] About half
    5. [**1**] Most
    6. [**3**] All or almost all

Bidding and Contracts for the Largest Initiative

30. Consider all of the contracts your state, county or district issued under your largest managed care initiative. Were most of these contracts awarded as a result of requests for proposals (RFPs), or were most awarded as sole source contracts? (CHECK ONE.) **(n=26)**

    1. [**11**] Most were awarded as a result of requests for proposals
    2. [ ] About half were awarded as a result of RFPs, about half were sole source contracts
    3. [**9**] Most were sole source contracts
    4. [**6**] Other (PLEASE SPECIFY.)

(IF YOU CHECKED ITEM 3 OR 4, GO TO QUESTION 33.)

31. In general, when your state, county or district issued a request for proposals from contractors for your largest managed care initiative, was the number of qualified bidders that responded more than sufficient, sufficient, or insufficient to guarantee that a competitive bidding process would take place? (CHECK ONE.) **(n=11)**

    1. [**2**] A much more than sufficient number
    2. [ ] A somewhat more than sufficient number
    3. [**6**] A sufficient number
    4. [**3**] A somewhat insufficient number
    5. [ ] A very insufficient number

32. Was each of the following types of organizations eligible to respond to your request for proposals? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Private non-profit organizations **(n=11)**	[**11**]	[ ]
2. Public agencies **(n=10)**	[**6**]	[**4**]
3. Private for-profit organizations **(n=11)**	[**9**]	[**2**]
4. Other (PLEASE SPECIFY.)	[ ]	

33. Under your state's, county's or district's largest managed care initiative, has each of the following types of organizations been awarded contracts either as a result of request for proposals or on a sole source basis? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Private non-profit organizations **(n=24)**	[**22**]	[**2**]
2. Public agencies **(n=17)**	[**4**]	[**13**]
3. Private for-profit organizations **(n=20)**	[**10**]	[**10**]
4. Other (PLEASE SPECIFY.)	[ ]	

34. Consider the contracts for **delivery of services** that your state, county or district has with organizations that are participating in your largest managed care initiative. Is each of the following payment methods used in any of these contracts? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Per diem, that is, a fixed daily amount to be paid for each day any eligible client uses any contracted service **(n=21)**	**13**	**8**
2. Fee for service, that is, a fixed amount to be paid for each specific service provided, with the amount varying according to the specific service provided **(n=21)**	**10**	**11**
3. Full case rate, that is, a fixed amount per client to be paid to cover all contracted services for all clients in the caseload, regardless of the extent to which these services are used **(n=22)**	**8**	**14**
4. Partial case rate, that is, a fixed amount per client to be paid to cover only a portion of contracted services for all clients in the caseload, regardless of the extent to which these services are used **(n=21)**	**4**	**17**
5. Fully capitated rate, that is, a fixed payment in advance for all contracted services for an unspecified number of clients with no limits on the duration of care **(n=22)**	**9**	**13**
6. Partially capitated rate, that is, a fixed payment in advance for some portion of the contracted services for an unspecified number of clients with no limits on the duration of care **(n=20)**	**2**	**18**
7. Other methods used (PLEASE SPECIFY.) **(n=1)**	**1**	

35. Listed below are descriptions of some provisions that can be placed in contracts to guarantee that financial risk will be shared by state or local governments and the contractors involved in managed care initiatives.

Consider the contracts your state, county or district has with the organizations participating in your largest managed care initiative. Is each of the following provisions used in any of these contracts to guarantee that financial risk will be shared? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Sharing of service costs with the state or locality when costs exceed the contracted case or capitated rate **(n=24)**	[9]	[15]
2. Sharing with the state or locality any of the contracted funds that were unspent, or that the contractor would consider "profit" or "reinvestment" **(n=23)**	[10]	[13]
3. A ceiling on the total number of clients that can be served **(n=23)**	[6]	[17]
4. A stipulation that a minimum number of clients must be served **(n=23)**	[9]	[14]
5. Other (PLEASE SPECIFY.) **(n=4)**	[4]	

Goals of Managed Care Initiatives and Future Plans

36. In your largest managed care initiative, do the contracts that your state, county or district has with direct service providers include any specific performance standards that the contractor is required to meet? (CHECK ONE.) **(n=27)**

    1. [4] No (IF "NO," GO TO QUESTION 39.)

    2. [23] Yes

37. Consider the contractors that provide direct services under your largest managed care initiative. Are any of these contractors required by your state, county or district to meet specific performance standards in each of the areas listed below? Although the areas below use the words "rate" and "proportion," if you have standards in these areas that are expressed as numbers, you should still check "Yes" for that area. (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. The proportion of children that will receive services without being removed from their present home **(n=20)**	**8**	**12**
2. The rate of adoption **(n=21)**	**5**	**16**
3. The rate of reunification **(n=22)**	**13**	**9**
4. The average length of time it takes for adoption to occur **(n=21)**	**6**	**15**
5. The average length of time it takes for reunification to occur **(n=21)**	**13**	**8**
6. The rate of reoccurrence of abuse or neglect in reunified families **(n=20)**	**13**	**7**
7. The proportion of children transferred from a more costly to a less costly, yet appropriate, level of care **(n=22)**	**15**	**7**
8. Standards that relate to the well-being of the child, such as the rate of school absenteeism, the extent of drug or alcohol use, or the proportion of medical or counseling appointments kept. **(n=21)**	**15**	**6**

	Yes (1)	No (2)
9. In the space below, please list any other areas in which there are performance standards **(n=13)**	**13**	

38. Consider all the contracts that your state, county or district had with direct service providers in the jurisdiction currently being served under your largest managed care initiative **on the day before** this initiative was implemented. Of those contracts, about what proportion, if any, at that time contained at least one performance standard that the contractor was required to meet? (CHECK ONE.) **(n=22)**

1. [**8**] None
2. [**2**] A few
3. [**5**] Some
4. [**1**] About half
5. [**2**] Most
6. [**4**] All or almost all

39. Consider all the contracts your state or locality currently has with direct service providers under your largest managed care initiative. Of these contracts, about what proportion, if any, contain at least one performance standard that the contractor is required to meet? (CHECK ONE.) **(n=27)**

1. [**3**] None
2. [ ] A few
3. [**2**] Some
4. [**2**] About half
5. [**1**] Most
6. [**19**] All or almost all

40. Listed below are three ways of describing a relationship between clients and the services they receive. Consider the jurisdiction currently served by your largest managed care initiative. Compared to **before** the implementation of the largest initiative in that jurisdiction, did each of the following increase, decrease, or remain the same, under your largest managed care initiative? (CHECK ONE FOR EACH.)

	Greatly increased under managed care (1)	Somewhat increased under managed care (2)	Remained about the same (3)	Somewhat decreased under managed care (4)	Greatly decreased under managed care (5)	Unable to determine (6)
1. The amount of services each client receives **(n=25)**	**7**	**13**	**1**			**4**
2. The number of clients receiving services **(n=26)**	**3**	**7**	**12**	**1**		**3**
3. The number of clients receiving a level of service that is considered the appropriate level **(n=26)**	**7**	**11**	**3**	**1**		**4**

41. In the jurisdiction currently being served by your largest managed care initiative, has your state, county or district compared the time it takes for childrens' permanency goals to be met under the initiative to the time it took in that jurisdiction before the initiative was introduced? (CHECK ONE.) **(n=26)**

    1. **[8]** Yes (IF "YES," GO TO QUESTION 43.)
    2. **[18]** No

42. In the jurisdiction currently being served by your largest managed care initiative, does your state, county or district plan to compare the time it takes for childrens' permanency goals to be met under the initiative to the time it took in that jurisdiction before the initiative was introduced? (CHECK ONE.) **(n=18)**

    1. **[12]** Yes
    2. **[6]** No

43. Consider the jurisdiction currently being served under your largest managed care initiative. Based on either the comparison you have made or on your impressions, compared to **before** the implementation of the largest managed care initiative in that jurisdiction, does it take, on average, more time, about the same time, or less time for children's permanency goals to be met under your largest managed care initiative? (CHECK ONE.) **(n=24)**

    1. [ ] Much more time under managed care
    2. [ ] Somewhat more time under managed care
    3. **[2]** About the same time under managed care as before
    4. **[7]** Somewhat less time under managed care
    5. **[3]** Much less time under managed care
    6. **[12]** Unable to determine

44. In the jurisdiction currently being served by your largest managed care initiative, has your state, county or district compared the average expenditures per child under the initiative to the average expenditures per child in that jurisdiction before the initiative was introduced? (CHECK ONE.) **(n=26)**

    1. **[14]** Yes (IF "YES," GO TO QUESTION 46.)
    2. **[12]** No

45. In the jurisdiction currently being served by your largest managed care initiative, does your state, county or district plan to compare the average expenditures per child to the average expenditures per child in that jurisdiction before the initiative was introduced? (CHECK ONE.) **(n=12)**

    1. **[10]** Yes
    2. **[2]** No

46. Think about the jurisdiction currently being served under your largest managed care initiative. Also consider the average total expenditure per child, **before** the implementation of the initiative in that jurisdiction, to provide the same programs and kinds of services now provided by your largest managed care initiative.

    Based on either the comparison you have made or on your impressions, under your largest managed care initiative, is the average total expenditure per child for the same programs and kinds of services, higher, lower, or about the same as it was before this initiative was implemented? (CHECK ONE.) **(n=26)**

    1. **[2]** Much higher per child than before
    2. **[5]** Somewhat higher per child than before
    3. **[7]** About the same as before
    4. **[6]** Somewhat lower per child than before
    5. **[1]** Much lower per child than before
    6. **[5]** Unable to determine

47. Does your state, county or district have plans to expand your largest managed care initiative in each of the following ways? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Expand the initiative to more locations **(n=22)**	**5**	**17**
2. Expand the initiative to reach more clients of the same type in existing locations **(n=23)**	**10**	**13**
3. Expand the initiative to reach new types of clients in existing locations **(n=25)**	**13**	**12**
4. Introduce, or expand, the use of performance standards in contracts with service providers under the initiative **(n=24)**	**20**	**4**
5. Introduce, or expand, the use of risk sharing provisions in contracts with service providers under the initiative **(n=24)**	**19**	**5**
6. Other (PLEASE SPECIFY.) **(n=2)**	**2**	

48. If you have any other comments about your state's, county's or district's managed care initiatives, or any other topics mentioned in this questionnaire, please write them below or on the back of the page. **(n=11)**

Thank you very much for completing this questionnaire.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 28 1998

Mr. Mark V. Nadel
Associate Director
Income Security Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Nadel:

Enclosed are the Department's comments on your draft report, "Child Welfare: Early Experiences Implementing a Managed Care Approach." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, CHILD WELFARE: EARLY EXPERIENCES IMPLEMENTING A MANAGED CARE APPROACH (GAO/HEHS-98-233)

General Comments

The department appreciates the opportunity to comment on the General Accounting Office's (GAO) draft report, which describes State efforts to implement managed care in their child welfare systems. The following comments are provided in response to general issues raised in the report and are intended to provide additional clarification or information to you for GAO's consideration.

Federal Role in Child Welfare Managed Care Is Limited (page 33)

Now on p. 23.

Although the role of the Departments' Administration for Children and Families (ACF) staff in addressing managed care issues and providing technical assistance has decreased over the past 2 years, there have been a number of activities ACF has initiated and participated in:

- There have been four internal training sessions for ACF staff (central office and regional offices) on the topic of managed care and child welfare. The purpose of these sessions was to provide information to central office and regional offices staff in order for these staff to assist States interested in implementing managed care concepts. The topics of these sessions focused on basic terminology, concepts, and requirements of managed care and how these managed care concepts could be translated to child welfare. Also, this training was done in collaboration with the Department's Health Care Financing Administration, the Child Welfare League of America, the National Association of Public Child Welfare Administrators, the national resource centers funded by ACF, the Chapin Hall Center for Children at the University of Chicago, and managed care organizations.

- The ACF regional offices conduct regional conferences and have either incorporated the topic of managed care into their conferences or have held separate meetings on managed care or privatization.

- The Chapin Hall Center for Children at the University of Chicago sponsored a 2-day Child Welfare Leadership Institute on managed care and child welfare. The ACF provided support for this training by identifying potential State invitees. Additionally, staff from two ACF regional offices and from ACF's central office attended.

- In addition to activities supported by ACF, there have been a number of requests for training and technical assistance made by State agencies over the past several years to a network of national resource centers funded by ACF. These resource centers have

provided consultation and training on managed care and child welfare issues, as well as Medicaid and behavioral health issues. They have also collaborated with the Child Welfare League of America and the National Association of Public Child Welfare Administrators on several forums for States.

- The ACF also incorporated the topics of managed care and other forms of privatization in national conferences for ACF staff and for states and ACF grantees. These conferences were held in 1997 and 1998. The topics included programmatic and financial reforms, and the information needs and programmatic needs of implementing these systems of care.

With regard to the use of title IV-E of the Social Security Act waiver authority, it should be noted that the use of these waivers to test various managed care techniques is consistent with the demonstration nature of these projects, as required by the statute. While it is true that waivers can facilitate managed care, the primary goal of the demonstration projects, in this case, is to determine what, if any, benefits are to be accrued as a result of a State's implementing managed care within its boundaries. The results of States' evaluations will ultimately provide this information. Our concern is that as written in the report (page 34), it can be inferred that department's "stated purpose" differs from that of the Congress and, consequently, is preventing States from utilizing a mechanism which may assist them in facilitating manage care within their child welfare systems. We would also note that to date waiver demonstration projects for four States have been approved by the Department which include managed care elements within their project structure.

Now on p. 23.

The ACF has recently formed a workgroup composed of primarily central office and regional offices staff for the express purpose of reviewing managed care financial issues raised by State agencies. The department's intention is to provide clarification of departmental regulations and policies and, where appropriate, recommend the development of new policies.

Management Information Systems Are Needed (page 100)

Now on p. 64.

The report emphasizes the importance of public agencies having access to timely and accurate information on services and outcomes. Service and cost data are necessary for agencies to formulate policies and strategies to support their managed care initiatives. Under title IV-E of the Social Security Act, Congress authorized funding of statewide Automated Child Welfare Information Systems (SACWIS). These systems are designed to gather the type of data required by States which are implementing managed care. Additonally, SACWIS must meet the requirements of the Adoption and Foster Care Analysis and Reporting System (AFCARS). Data in AFCARS can provide trend analyses on entry and exit rates, placement characteristics and circumstances associated with removal and discharge.

Currently, forty-seven States and the District of Columbia are involved in various stages of SACWIS development. Twenty-four States are partially (6) or fully operational (18),

nineteen are in the implementation phase, and four are in the planning phase. In Fiscal Year 1997, States claimed $333 million for SACWIS-related expenditures. We anticipate ongoing claims for current operating expenditures as well as significant prior quarter adjustments for previous costs incurred by States. The GAO report should be amended to include this information, particularly given GAO's statement that management information systems are needed. Congress should be informed of the amount of funds and major technical assistance effort the Department has expended to support the development of SACWIS on a nationwide basis. The major technical assistance effort consisted of a million dollar project to provide model automated systems and to provide on-site technical assistance to selected states.

GAO Contacts and Staff Acknowledgments

GAO Contacts

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