

Child Welfare Special Analysis

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I. Introduction

Background and Purpose of the Child Welfare Component

Children and families served by the child welfare system need intensive and extensive physical and behavioral health services. The federal Child and Family Services Review (CFSR) process¹ expects states to provide the services needed to meet the physical health, mental health, and educational needs of all children in the child welfare system, including those living at home with their parents and those in out-of-home placements. The CFSR process also charges states with enhancing the capacity of birth parents to meet the needs of their children. Because Medicaid is the primary funding source for many of the physical and behavioral health services that children and families in the child welfare system receive, they are directly impacted by public sector managed care initiatives. It is important for states to forge linkages across systems in order to ensure child safety, permanency, and well-being. Recognizing this, since 1996 the Tracking Project has tracked and analyzed the effects of managed care reforms on children and families served by the child welfare system.² The purposes of the Child Welfare Component of the Tracking Project are to:

¹In March 2000, regulations went into effect for the Child and Family Services Review process, a new approach to federal oversight of state child welfare programs. Overseen by the Children's Bureau of the Administration for Children and Families, the review process consists of statewide self-assessments, as well as an on-site review in every state conducted by a team of federal, state, and peer reviewers. Information gathered through the review is used to examine the states' success in meeting the major goals of the child welfare system — child safety, permanency, and well-being. When states do not achieve "substantial conformity" with the required outcomes, they develop Program Improvement Plans to describe the changes they will make to reach substantial conformity.

²Support for the child welfare component of the Tracking Project was provided by the David and Lucile Packard Foundation from 1996 to 1999. In 2000, the Center for Health Care Strategies in Princeton, New Jersey began funding the child welfare component. Current support for the child welfare component comes through a cooperative agreement between the Child, Adolescent, and Family Branch of the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration and the Children's Bureau, Administration on Children, Youth, and Families of the Administration for Children and Families in the U.S. Department of Health and Human Services. Through this agreement, funds are provided to the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development to lead the child welfare component.

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- Track the impact of public sector managed care reforms on children and adolescents with behavioral health disorders who are involved with the child welfare system, and their families.
 - Identify positive policies, practices, and interagency coordination strategies that states use, within managed care initiatives, to meet the mental health treatment needs of children served by the child welfare system and their families.

Methodology of the Child Welfare Component

A specific focus on child welfare issues has been incorporated into each of the following aspects of the Tracking Project.

State Surveys

The Tracking Project incorporated items in the 1997/98, 2000 and 2003 State Surveys addressing the impact of managed care initiatives, specifically behavioral health managed care³, on children in the child welfare system and their families. Since 1996, the Child Welfare League of America (CWLA) also has been conducting state surveys to track emerging trends in management, finance, and contracting that affect child welfare service delivery. In 2000, the Tracking Project and CWLA began coordinating their survey activities. Both the Tracking Project and the CWLA surveys included similar items to assess respondents' views of the effects of health and behavioral health managed care on children and families served by the child welfare system. The primary respondents in the surveys conducted by CWLA in 2000 and 2003 are state and county child welfare administrators. Primary respondents to the Health Care Reform Tracking Project State Surveys are directors of children's mental health services in all 50 states and the District of Columbia. In two previously published reports⁴, findings from the CWLA survey are compared with Tracking Project findings. Findings from the 2003 CWLA Survey were not available at the time of this publication and, therefore, are not discussed in this special analysis. When the 2003 CWLA Survey is complete, findings from that survey will be compared with findings from the Tracking Project's 2003 State Survey in the report of the 2003 CWLA Management, Finance and Contracting Survey.⁵

³ References will be made to "behavioral health managed care" and to "child welfare managed care." Behavioral health managed care refers to systems, primarily within state Medicaid programs, that apply managed care technologies to the administration and delivery of behavioral health services. "Child welfare managed care" refers to a type of child welfare reform in which states or communities apply some managed care tools to the organization, provision, and funding of child welfare services. These child welfare reforms primarily use funds allocated to the child welfare system, and may or may not include some behavioral health services.

⁴ Stroul, B.A., Pires, S.A., and Armstrong, M.I. (2001). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 2000 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida.

McCullough, C. and Schmitt, B. (2001) *2000-2001 Management, finance, and contracting survey final report*. Washington, D.C.: Child Welfare League of America Press.

⁵ For more information about the 2003 CWLA Survey report, see www.cwla.org or contact jcollins@cwla.org.

Impact Analyses

Members with extensive experience in the child welfare system were added to the site visit teams that visited 18 states during the 1997 and 1999 Impact Analyses. These team members interviewed a range of stakeholders involved in child welfare, including state and local child welfare administrators; child welfare supervisors and caseworkers; child welfare providers; advocates; and birth, foster, and adoptive parents. In the 1999 Impact Analysis, additional interviews were conducted in the three states that were planning or implementing a child welfare managed care initiative. Child welfare findings from the 1999 Impact Analysis and these three child welfare managed care initiatives are described in a separate document⁶, as well as in a special analysis in the 1999 Impact Analysis report.

Promising Approaches

The Promising Approaches Series of the Tracking Project is comprised of a number of thematic issue papers, each addressing a specific aspect of managed care systems affecting children with behavioral health disorders. Two papers in the series⁷ address issues specific to children and families in the child welfare system. The first of the two papers, *A View from the Child Welfare System*, describes unique considerations for meeting the behavioral health needs of children in the child welfare system, and their families, within managed care systems. Promising approaches from four states and communities are described, and cross-site challenges and strategies are summarized.

The second of the two papers, *Making Interagency Initiatives Work for Children and Families in the Child Welfare System*, describes how the child welfare system is participating in collaborative interagency initiatives designed to serve children with serious and complex behavioral health disorders. It describes interagency initiatives in three states and communities and identifies strategies used in these sites to include the child welfare system in the initiative and to meet the behavioral health needs of children and families served by the child welfare system.

The Center for Health Services Research and Policy at George Washington University (GWU) is another partner in the Promising Approaches Series. GWU conducted a contract analysis and site visit project to provide insights on “what works” when children are enrolled in multiple public managed care initiatives (e.g., child welfare and Medicaid). Representatives from the Tracking Project and from CWLA participated in the GWU site visits and in the analysis of the findings.⁸

⁶ McCarthy, J. and Valentine, C. (2000) *1999 Child welfare impact analysis, health care reform tracking project: tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families*. Washington, D.C.: National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center.

⁷ These two documents are available on the web at www.gucchd.georgetown.edu or can be ordered in hard copy from deaconm@georgetown.edu 202/687-5000.

⁸ Mauery, D. Richard, Collins, J., McCarthy, J., McCullough, C., and Pires, S. (2003). *Contracting for coordination of behavioral health services in privatized child welfare and Medicaid managed care*. Washington, D.C.: Center for Health Services Research and Policy, George Washington University. This paper is available on the web at www.chcs.org.

Consensus Conference

The Tracking Project held a consensus conference in the fall of 2003 to develop a set of agreed-upon recommendations for policy, practice, and research related to publicly financed managed care for children and adolescents with behavioral health disorders and their families. The recommendations are based on review and analysis of findings from the Tracking Project and related research studies. Child welfare researchers and policy makers were both presenters and participants in the Consensus Conference.

II. Results of the 2003 State Survey

In this section, findings from the 2003 State Survey related to the child welfare population are summarized. When helpful, findings from previous Tracking Project surveys and impact analyses are cited for purposes of comparison.

Inclusion of Children in the Child Welfare System in Behavioral Health Managed Care Systems

The 2003 State Survey found that 74% of the managed care systems cover children in the child welfare system who are eligible for Medicaid. Thirty-nine percent (15 systems) reportedly cover the *total* Medicaid population, including Medicaid-eligible children involved in child welfare, and 61% (23 systems) cover only a *portion* of the Medicaid population. Of the 23 systems that do not cover the total Medicaid population, 57% (13 systems) cover children in the child welfare system. Thus, 28 systems (74%) in the 2003 State Survey reported serving children in child welfare. Even though the great majority of managed care systems continue to cover children in child welfare, as **Table 1** indicates, there is a 17% decline in the coverage of the child welfare population since 2000 (from 91% to 74%).

1995 State Survey	37%
1997/98 State Survey	60%
2000 State Survey	91% ⁹
2003 State Survey	74%

As suggested earlier in this report, since 2000 there has been a reported decline in coverage of Medicaid populations that can be expected to use more and costlier services, including children involved in child welfare and juvenile justice systems and children eligible for Supplemental Security Income (SSI). This decline appears to be driven largely by decreases in the coverage of these populations of children by managed care systems with integrated designs; 80% of the carve outs cover children in the child welfare system, while only 38% of the integrated systems do so.

Although this information was not gathered previously, the 2003 State Survey specifically explored coverage for a subset of children in the child welfare system — those who are in the custody of the child welfare agency. Results indicate that children in state custody are covered by the majority of the managed care systems (66%).¹⁰ In the majority (90%) of the systems covering children in state custody, enrollment of these children is mandatory rather than voluntary.

⁹ The 2000 State Survey Report indicated that 82% of the systems reportedly covered children in child welfare. This percentage referred to those systems that did not cover the total Medicaid population. When the systems covering the total Medicaid population are included, the percentage covering children in child welfare in the 2000 State Survey increased to 91%.

¹⁰ This percentage assumes that the 15 systems covering the total Medicaid population cover children in state custody. In addition, of the 13 systems that do not cover full Medicaid population, but do cover child welfare, 77% (10 systems) cover children in state custody. Thus 25 of the 38 systems (66%) responding to this question cover children in state custody.

Involvement of Child Welfare Stakeholders in Planning, Implementing and Refining Behavioral Health Managed Care Systems

Significant involvement of state child welfare staff in planning, implementing, and refining behavioral health managed care systems, which showed an increase in earlier surveys, has reportedly decreased since 2000 (**Table 2**). The 2000 State Survey found significant involvement of child welfare stakeholders in 46% of the systems, as compared with 21% in 2003. Half of the systems reported some involvement, and 29% report no involvement at all by state child welfare staff in managed care systems. This decrease could be the result of fewer managed care systems covering children in the child welfare system; however, it also might be related to the greater maturity of managed care systems, an acceptance of managed care as “business as usual,” familiarity with how it works, and less concern about molding, crafting, and changing the system. All other stakeholder groups (See **Table 16**), except state juvenile justice staff, also reportedly lost ground in terms of being significantly involved in planning, implementing, and refining the managed care system.

	None	Some	Significant
1997/98 State Survey	7%	56%	37%
2000 State Survey	11%	43%	46%
2003 State Survey	29%	50%	21%

Discrete Planning for Children in the Child Welfare System

Similar to the trend regarding the involvement of child welfare stakeholders in managed care systems, in 2003, 25% fewer systems reported that they are engaged in a discrete planning process for children in the child welfare system (**Table 3**). Although there was a 24% increase between 1997/98 and 2000, the percentage of systems with a discrete planning process in 2003 dropped to 47%, almost equal to the 1997/98 level in which 48% of the systems reported discrete planning for the child welfare population. This, too, may be attributable to the relative maturity of the systems, and consequent decrease in the perceived need to plan or refine system operations.

1997/98 State Survey	48%
2000 State Survey	72%
2003 State Survey	47%

Special Provisions for Children in the Child Welfare System

Although the percentage of managed care systems that incorporate special provisions for children and adolescents in the child welfare system has dropped from 87% in 2000 to 63% in 2003, the majority of systems continue to include some special provisions. The special provisions reported most frequently for children in the child welfare system in 2003

(Table 4) were interagency treatment and service planning, intensive case management, an expanded service array, and the wraparound services/process. Only 33% of the systems reported offering family support services for families involved in the child welfare system, and just 15% identified higher capitation or case rates as a special provision.

Even though certain special provisions are offered in nearly two-thirds of the systems, the fact that only 15% of the systems reportedly provide fiscal incentives through higher capitation or case rates raises the question as to whether managed care systems actually have the resources and incentive to ensure access to the special provisions that exist. One purpose of risk adjusted rates is to better match the level of risk taken by the managed care entity to the level of need of a high-risk, high-need population. Although the impact analyses clearly showed that children in the child welfare system need and use an extensive amount of services, the 2000 and 2003 surveys both found few systems adjusting rates for this population (15% or fewer).

Provisions	Percent of Systems with Provisions
Interagency treatment/service planning	51%
Intensive case management	51%
Expanded service array	46%
Wraparound services/process	46%
Family support services	33%
Higher capitation or case rates	15%
Flexible service dollars	26%
Other	5%

Mental Health Screening for Children Entering State Custody

The 2003 State Survey explored the extent to which managed care systems are responsible for screening children who enter state custody to identify mental health problems and treatment needs. Fewer than half of the systems (43%) reported that they are responsible for screening these children (Table 5).

Table 5			
Percent of Managed Care Systems Responsible for Screening Children in the Child Welfare System who Enter State Custody to Identify Mental Health Problems and Treatment Needs			
	2003		
	Carve Out	Integrated	Total
Systems are responsible for behavioral health screening of children in child welfare entering state custody	45%	38%	43%
Systems are not responsible for behavioral health screening of children in child welfare entering state custody	50%	25%	39%
NA — Children in child welfare state custody are not covered	5%	37%	18%

When asked to report the extent to which the mental health screening actually is conducted, 77% of the systems with responsibility for screening children entering custody indicated that most children are screened, 15% reported that some children are screened, and 8% indicated that few children are screened. None of the systems with this responsibility indicated that no children entering custody are screened.

Education and Training

The 2003 State Survey found that education and training about the goals and operations of the managed care system reportedly are being provided for the child welfare system in 61% of the systems. A similar percentage of the systems are providing education and training to other child-serving systems as well. While the Tracking Project found an increase in education and training of child welfare and other key stakeholders on the goals and operations of managed care systems from 1997/98 and 2000, less education and training seems to be occurring since 2000 with respect to almost all stakeholder groups. This is demonstrated in **Table 6**.

Table 6			
Education and Training on Managed Care Provided to Child-serving Systems			
Child-Serving System	1997/98	2000	2003
Child Welfare System	67%	72%	61%
Juvenile Justice System	Not Asked	63%	58%
Other Child-Serving Systems	64%	72%	45%

Decreased education and training on managed care may be related to the fact that most managed care systems are no longer in early implementation stages, and that child-serving systems may have greater familiarity with their goals and operation.

The 2003 State Survey found that there has been a slight increase in training and education provided to MCOs in order to increase their knowledge base related to serving children and adolescents in the child welfare system (a 5% increase from 52% of the systems in 2000 to 57% of the systems in 2003). This is consistent with an increase in training for MCOs regarding other populations of children served. However, training about other populations reportedly increased more significantly. For example, training about children with serious emotional disorders increased by 16% to 71% of the systems, and training related to youth in the juvenile justice system increased by 15% to 51% of the systems.

Service Coverage in Behavioral Health Managed Care Systems

Managed care systems cover a wide variety of mental health services. The following services are those most likely to be covered (reportedly covered by 80% or more of the systems):

- Assessment and diagnostic evaluation (95%)
- Outpatient psychotherapy (95%)
- Inpatient hospital services (95%)
- Medical management (87%)
- Home-based services (85%)
- Crisis services (85%)
- Day treatment/partial hospitalization (85%)
- Case management services (80%).

The following services, which are critical services for children/adolescents in the child welfare system, are those least likely to be covered by managed care systems (reportedly covered by less than 50% of the systems):

- Crisis residential services (44%)
- Behavioral aide services (41%)
- Therapeutic group homes (38%)
- Respite services (36%)
- Therapeutic nursery/preschool (26%)

Coverage of therapeutic foster care and residential treatment, two services frequently used by the child welfare system, increased slightly (by less than 4%) in 2003, and they still remain outside of managed care in approximately 40% of the systems. The 2000 State Survey found that 57% of the managed care systems covered therapeutic foster care and residential treatment; whereas in 2003, therapeutic foster care reportedly is covered by 59% of the systems, and residential treatment is covered by 61% of the systems.

Because therapeutic foster care, residential treatment, and most of the services in the category “least likely to be covered” by the managed care system are critical service components for children in the child welfare system, in many states, children in the child welfare system must access these services from sources outside of the managed care system. In most states, the child welfare system itself may be the provider or the purchaser of these services. This again underscores the need for close coordination between the child welfare and managed care systems, particularly if a state is engaged in a child welfare managed care initiative that includes similar services.

Financing

■ Funding Sources for Behavioral Health Managed Care

The Tracking Project has consistently found over time that, in comparison to the large proportion of managed care systems to which state Medicaid (100%) and state mental health agencies (50%) contribute funds, the proportion of managed care systems to which other child-serving agencies contribute financing is relatively small. The percentage of managed care systems that include child welfare funds has increased slightly from 21% in 2000 to 29% in 2003, although this represents a decrease from the proportion of systems (32%) that included child welfare funds in 1997/98. However, the child welfare system continues to contribute funds in a greater percentage of the managed care systems than does education (11%), juvenile justice (11%), mental retardation/developmental disabilities (13%), and health (16%).

■ Use of Medicaid Outside of Managed Care Systems

The Tracking Project has found that over the past decade, states consistently have reported that some Medicaid dollars for children's behavioral health services are left outside of the managed care system in fee-for-service arrangements. This was reported to be the case in all of the managed care systems (100%) in the 2003 sample.

The child welfare system reportedly uses Medicaid dollars outside of the managed care system for children's behavioral health services more than other child-serving systems (**Table 7**). In both 2000 and 2003, the child welfare system had access to "outside" Medicaid funds in 72% of the managed care systems. Even though the child welfare system contributes some funds in 29% of the managed care systems according to 2003 results, substantial resources are being kept within child welfare systems to meet behavioral health treatment needs beyond what is provided through managed care systems. When children in the child welfare system require services outside of the managed care system, the child welfare system generally uses Medicaid funds under its control and other resources to provide these services. While having access to multiple funding streams creates a safety net for children in the child welfare system, it also presents an opportunity for cost shifting and fragmentation and can lead to confusion for families seeking services.

Child-Serving System	Percent of Managed Care Systems
Child welfare agency	72%
Mental health agency	67%
Education agency	67%
MR/DD agency	67%
Substance abuse agency	58%
Juvenile justice agency	56%
Health agency	44%

■ Cost Shifting

Drawing conclusions about cost shifting remains problematic due to the fact that the percentage of managed care systems that actually track or monitor cost shifting among child-serving agencies, which was low in 2000 (16%), has decreased even further in 2003 to 11%. Perceptions about the direction of cost shifting remain consistent with 2000 findings. Cost shifting is perceived by respondents to the Tracking Project surveys to flow both ways — from the managed care system to other child-serving systems (36% in 2000, 38% in 2003) and from other child-serving systems into managed care systems (43% in 2000, 44% in 2003).

Findings from the CWLA 2000 Survey indicate that child welfare respondents view cost shifting differently. Similar to the Tracking Project respondents, very few states claimed to have the ability to actually track cost shifting to or from the child welfare system; however, child welfare respondents in the CWLA 2000 Survey were more likely to believe that managed care leads to a shift of costs to the child welfare system.

Clinical Decision Making Criteria

In the majority of systems (82% in 2000, 89% in 2003), medical necessity criteria continue to be sufficiently broad to allow for consideration of psychosocial and environmental factors in determining the appropriate types, levels, and duration of treatment and supports. This is critically important for the child welfare system because multiple factors must be considered in treatment planning and in planning for permanent placements.

Criteria for making clinical decisions also continue to be standardized statewide in half of the managed care systems (54% in 2000, 50% in 2003) and to differ with each MCO in the other half. When criteria differ with each MCO, continuity of care becomes compromised for children and families served by the child welfare system due to the multiple placement changes experienced by many children in this system. When children move to a different area that is covered by a different MCO, they may not be considered eligible for the same services and supports that they had access to through the previous MCO.

Access to Behavioral Health Services

■ Initial Access to Services and Access to Extended Care Services

As **Table 8** indicates, improvement in initial access to a basic level of behavioral health services (in comparison to pre-managed care) continues to be reported by most of the managed care systems (85% in 2003). Improvement in access to extended care services (services beyond short-term stabilization) reportedly increased significantly since 2000 (36% reported improvement in 2000, 62% in 2003). Shorter waiting lists for behavioral health services were reported in about half of the systems in both 2000 and 2003, and the percentage of systems whose waiting lists have gotten longer has decreased from 20% in 2000 to 9% in 2003.

The Tracking Project has not explored access to services by separate populations and, therefore, cannot determine whether children and families served by the child welfare system experience the same improvements in access to services that were reported for the total population served. However, if this significant improvement applies to children in

the child welfare system, it has positive implications for both improved services for children and reduced costs for the child welfare system, which frequently pays for extended care services not covered by managed care.

	2000		2003	
	Better	Worse	Better	Worse
Initial access to behavioral health services	70%	15%	86%	6%
Access to extended behavioral health services	36%	14%	62%	6%
Waiting lists for behavioral health services	48%	20%	50%	9%
Note — The remaining managed care systems reported no change in these three areas.				

The 2003 State Survey found that almost all systems (95% in 2003) are covering both acute and extended care services (**Table 9**). Extended care was defined for survey respondents as care extending beyond short-term stabilization. This represents continuing good news for the child welfare system, since many children involved with child welfare require extended care behavioral health services, and especially because the child welfare agency is the primary agency providing extended care services outside of managed care (83% in 2003). However, because in almost all the systems both managed care and the child welfare systems are responsible for some behavioral health extended care services, coordination between the systems is critical.

Child-serving System	1997/98	2000	2003
Acute Care Only	26%	9%	5%
Acute and Extended Care	74%	88%	95%
Extended Care Only	0%	3%	0%

■ Access to Behavioral Health Inpatient Services

The 2003 State Survey results show continuing trends in access to behavioral health inpatient services. A small percentage of systems continue to report that initial access is more difficult (20% in 2000, 11% in 2003). In 2003, almost two-thirds (63%) reported that initial access to inpatient care is easier. The percentage of systems reporting that average lengths of stay are shorter increased from 63% in 2000 to 80% in 2003. No system reported that average lengths of stay are longer.

In both 2000 and 2003, respondents reported a number of problems resulting from decreased access and truncated inpatient lengths of stay. Several of these problems that have a direct impact on the child welfare system were reported with less frequency in 2003 than in 2000, suggesting some improvements. Inappropriate use of child welfare emergency shelters was cited by 21% of the systems reporting in 2000 but by only 6% of the systems in 2003. Children in the child welfare system discharged without a safe

placement dropped from 8% of the systems in 2000 to 3% (only 1 system) in 2003. The most frequently reported problem in 2000 associated with changes in access to inpatient care was children being discharged without needed services (33%). This too decreased in 2003 to 13% of the systems reporting.

The decrease in problems related specifically to the child welfare system is encouraging; however, the findings about shorter lengths of stay in inpatient care continue to have major implications for the child welfare system due to the serious emotional problems faced by many children involved with child welfare. Survey results underscore the need: 1) for child welfare workers and families to coordinate discharge plans carefully with the managed care system, and 2) to create alternatives to hospitalization, such as step-down services and family and community supports. In the majority of managed care systems (62% in 2000, 73% in 2003), a variety of alternatives to hospitalization reportedly are being developed.

■ Eligibility Based on Placement Setting

Respondents in the 2000 and 2003 State Surveys were asked whether there were any types of placements in which children in the child welfare or juvenile justice systems would lose eligibility for (and, thus, access to) services from the managed care system. Respondents for approximately three-quarters of the systems (73% in 2000, 79% in 2003) indicated that there are placements that result in loss of access to services through the managed care systems. The types of placements that typically make children ineligible for services from the managed care system are detention, incarceration, and placement in state-operated facilities. Ten percent of the systems (four states) responded that children are ineligible for the managed care system if they are in residential treatment facilities (RTFs), and one state indicated that when a child enters foster care he loses eligibility for managed care. Two states described geographic reasons for losing eligibility, e.g., if a child moves to an area of the state not covered by a managed care plan. Nursing homes and private institutions that use seclusion and restraint were each identified by one state as placements that cause children to lose eligibility for managed care.

Policies like this demonstrate how difficult it can be for children in both the child welfare and juvenile justice systems to obtain consistent and continuous care. Policies and practices that force change in type of coverage, providers, and services can lead to ineffective services, increased trauma, and poor outcomes for children and families.

Interagency Coordination

The 2000 and 2003 State Surveys assessed the impact of managed care systems on interagency coordination at both the service delivery and system levels, and results in both surveys demonstrated a promising trend — coordination at both the service and system levels is improving.

For approximately two-thirds of the systems (60% in 2000, 67% in 2003), respondents indicated that coordination between physical health and behavioral health services has improved. This is extremely important for the child welfare system, in which a major goal is child well-being, and coordinating services to meet both a child's physical health and mental health needs is a priority. Respondents also indicated improvement in coordination between mental health and substance abuse services (in 52% of the systems in 2000 and

63% in 2003) and improved interagency coordination among child-serving systems in general (65% in 2000, 68% in 2003). It is noteworthy that in 2003, coordination in each of these areas reportedly is worse in only 0% to 3% of the systems. For the remaining systems, managed care has had no effect on coordination.

The 2003 State Survey included an item specifically exploring the effect of managed care systems on interagency coordination between the mental health and child welfare systems in comparison to pre-managed care. In almost two-thirds of the systems (61%) coordination between the two systems reportedly has improved; no system indicated that coordination had worsened in comparison to pre-managed care. In 39% of the systems, managed care reportedly has had no effect on coordination between the child welfare and mental health systems.

Cultural Competence

It has been well documented that there is a significant over-representation of children of color in the child welfare system. Additionally, children of color tend to be in more restrictive placements and to stay in care/custody longer. The level of cultural competence of managed care systems, as one system serving these children, could potentially impact the problem of over-representation.

The 2000 and 2003 State Surveys explored whether cultural competence requirements had changed in managed care systems as compared with the previous system. At both points in time, respondents indicated that in the majority of systems (64% in 2000, 78% in 2003) cultural competence requirements under the managed care system were stronger than in the previous system. In 2000, the most frequently cited strategy used to enhance cultural competence in managed care systems was cultural competence requirements in RFPs and contracts (found in 85% of the systems); however, fewer systems reportedly have such requirements in 2003 (61%). Other strategies noted in 2000 remain fairly consistently used among managed care systems in 2003. These include: translation services (82% in 2000, 86% in 2003), inclusion of culturally diverse providers in networks (64% in 2000, 58% in 2003), and outreach to culturally diverse populations (58% in 2000, 61% in 2003). Strategies that were used less frequently by managed care systems in 2000 generally continue to be noted less frequently in 2003; for example, only about a third of the systems track utilization and outcomes by culturally diverse groups (36% in 2000, 31% in 2003).

Family Issues

In the child welfare system, successful prevention of placement and reunification of families and children depend upon adequate services for both children and parents. A very significant finding in both the 2000 and 2003 State Surveys is that in two-thirds of the systems, the service delivery focus reportedly is on families, in addition to the identified child. This reflects a continued improvement over the findings in the 1999 Impact Analysis in which respondents in all nine systems in the sample felt that managed care focused treatment planning and services on the identified child, rather than on the entire family. The 2000 and 2003 State Surveys also found that about half of the systems pay for services to family members, even if only the identified child is covered. While this is a hopeful sign, it also means that in half of the systems, finding funds to provide services for family members continues to be an issue.

Survey findings for both 2000 and 2003 indicated that managed care systems have had no effect on the pre-existing practice of families having to relinquish custody in order to access behavioral health services for their children in most systems (83% in 2000, 81% in 2003). In a small percentage of the systems (13% in 2000, 16% in 2003) managed care reportedly has improved this situation. Managed care reportedly has exacerbated the practice of relinquishing custody in order to receive services in only one or two systems. In 2003, the General Accounting Office (GAO) reported that more than 12,000 families have relinquished custody of their children to the child welfare or juvenile justice systems in order to obtain mental health services. The GAO report cites private health insurance and Medicaid rules as contributing to this problem, although, consistent with the Tracking Project findings, it does not identify managed care itself as a causal factor.¹¹

Inclusion of Child Welfare Providers in Behavioral Health Managed Care Systems

In both the 2000 and 2003 State Surveys respondents indicated whether various types of providers were included in managed care system provider networks. An extremely important finding is that only about half of the systems (53% in 2000, 54% in 2003) reportedly include child welfare providers (i.e., providers who traditionally have provided behavioral health services to children and families in the child welfare system), a finding with both fiscal and clinical implications. If a preferred provider is not in the managed care system network, the child welfare agency may be faced with the decision of either paying for that provider's services, or obtaining care from a provider in the network who may not be familiar with the child being referred or may not be generally knowledgeable about children in the child welfare system and their unique treatment needs. The inclusion or exclusion of child welfare providers also may affect continuity of services if children are forced to change providers as they move in and out of the child welfare system.

Accountability and Data

■ Tracking Utilization of Behavioral Health Services by Children in Child Welfare

Although most of the managed care systems track the use of behavioral health services by children in the child welfare system, there has been a slight decrease in tracking of this system information since the 2000 State Survey (74% in 2000, 63% in 2003). Although these data could be used in determining system performance and in making decisions about needed services, more systems track this information than those who actually use it for system planning. This gap between the information that is tracked on the child welfare population and its use for system planning narrowed somewhat in 2003 (35% of the systems used the data for system planning in 2000, 42% in 2003). While the reasons for not using these data in system planning were not determined by the state surveys, information gathered during the impact analyses indicated that it may be due to the form in which the data are gathered, the timeframes in which data are generated, and the lack of staff capacity to analyze the data.

¹¹ *Child welfare and juvenile justice — Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services.* (April 2003). Washington, D.C.: US General Accounting Office, Report #GAO-03-397.

III. Summary and Conclusions

Findings from the 2003 State Survey

Findings from the 2003 State Survey reflect both positive and negative changes related to children in the child welfare system who have behavioral health needs and their families.

- Findings that might be characterized as potentially having a **negative impact** on the child welfare population include the following:
 - Fewer systems than in 2000 reportedly, involve child welfare stakeholders significantly in planning, implementing, and refining managed care systems (down 25% to 21% of the systems).
 - Fewer systems have discrete planning processes for children in the child welfare system (down 25% to 47% of the systems).
 - Fewer systems incorporate special provisions for children in the child welfare system (down 24% to 63% of the systems)
 - Fewer systems include requirements in RFPs and contracts related to cultural competence (down 24% to 61% of the systems)
 - Fewer managed care systems reportedly include children in the child welfare system (down 17% to 74% of the systems).
 - Fewer managed care systems reportedly provide education or training for the child welfare system about managed care (down 11% to 61% of the systems).
 - Fewer systems track utilization of services by children in the child welfare system (down 11% to 63% of the systems).
 - Tracking of cost shifting, which was reported by only 16% of the systems in 2000, decreased slightly in 2003 with only 11% reportedly tracking it.
- Potentially **positive changes** found in the 2003 survey include the following:
 - More systems reported improved initial access to behavioral health services (up 15% to 85% of the systems)
 - More systems reported improved access to extended care behavioral health services (up 26% to 62% of the systems)
 - Problems that have a direct impact on the child welfare system related to reduced access and lengths of stay in inpatient care (e.g., inappropriate use of child welfare emergency shelters) were reported by 15% fewer systems in 2003 than in 2000 (3% - 13% of the systems).
 - A slight increase (5%) was reported in the percentage of managed care systems which reportedly provide training for MCOs to expand their knowledge about serving children in the child welfare system (57% of the systems)
 - Two-thirds of the systems (67%, a 7% increase) reported improved coordination between physical health and behavioral health services.

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- In other areas important to children and families in the child welfare system, 2003 findings indicate **little or no change** from previous surveys:
 - Approximately half of the systems continue to include child welfare providers.
 - About half of the systems pay for services for family members even if only the identified child is covered.
 - The child welfare system continues to have access to Medicaid funds outside of managed care in 72% of the systems.
 - Few systems risk-adjust rates for children in the child welfare system.
 - Approximately 60% of the systems continue to cover two services frequently used in the child welfare system — therapeutic foster care and residential treatment.
 - The percentage of managed care systems that include funds from child welfare has remained fairly consistent since 1997/98 with a slight decrease in 2000 (currently 29% of the systems include child welfare funding).
 - Approximately 75% of the systems continue to report that there are placement types (e.g., detention and state operated facilities) in which children in the child welfare or juvenile justice systems would lose eligibility for services from managed care.
 - Respondents' perceptions about cost shifting have remained consistent. About one-third report cost shifts from managed care to other systems, and about 40% report cost shifts to the managed care system.
 - The following new information gained in 2003 (not included in previous state surveys) helps to further elucidate issues related to children and families in the child welfare system in the context of behavioral health managed care systems:
 - For the first time, respondents indicated whether a subset of children in the child welfare system — those who are in state custody — were included in the managed care system. Approximately two-thirds of the systems (66%) include children in custody. In most states that cover children in custody, their enrollment is mandatory rather than voluntary.
 - The 2003 State Survey also found that 42% of the managed care systems are responsible for screening children who enter state custody to identify mental health problems and treatment needs.
 - Previous surveys queried respondents about whether interagency coordination had improved since the implementation of managed care. The 2003 State Survey asked specifically about coordination between the mental health and child welfare systems in comparison to pre-managed care. Almost two-thirds of the respondents (61%) report that coordination between the two systems has improved.

Continuing Challenges

- The Tracking Project has used a variety of methods to gather information over a 10-year period. This comprehensive, long-term view of publicly financed managed care provides a context within which to view the 2003 State Survey findings, as well as a perspective on the remaining challenges for making managed care work for children and families in the child welfare system. Some of the challenges, noted in previous phases of the Tracking Project that continue to exist, include the following:
 - Many systems have not yet created a structure or systematic strategies for reaching out to parents involved with the child welfare system in order to include them in service

planning for their own children and to request their input on system level issues.

- Many systems continue to focus primarily on the identified child. Family supports and services for other members of the family (so important for families involved with the child welfare system) often require referral and/or other community resources, which may or may not be available.
- Ensuring continuous care by not requiring children to change plans and providers when they change placements remains a challenge in many systems.
- Some managed care plans do not have sufficient service capacity or an adequate provider network to meet the needs of children and families in the child welfare system. Services such as crisis response and support, therapeutic foster care, respite care, residential care, post-adoption services, treatment for sexual abuse victims and for sexual offenders, and substance abuse treatment for parents are needed for families in the child welfare system.
- The capacity to track outcomes for children and families served by the child welfare system and to measure the effectiveness of services provided is lacking in many systems.
- Because Medicaid is the primary funding source for most managed care systems, it is a continuing challenge for states and communities to serve children who are not eligible for Medicaid. Thus, it is difficult to provide behavioral health services and supports for families involved in child protective services whose children are not eligible for Medicaid or not in state custody.

Strategies to Better Service the Child Welfare Population

Some of the strategies, noted in previous phases of the Tracking Project, that help make managed care work for children and families in the child welfare system are described below.

■ **System-level strategies** include the following:

- A commitment to serving children and families in the child welfare system. This involves viewing the child welfare system as a key partner; creating formal structures to ensure that child welfare system mandates, laws, and policies are accommodated; and addressing the child welfare outcomes of safety, permanency and well-being. It also means that MCOs/BHOs and providers understand the special needs of children and families in the child welfare system. When this commitment exists, the child welfare system often contributes resources to the system.
- The managed care system is based on values and principles that support a family-centered, strengths-based approach.
- Institutionalized problem solving strategies and communication structures between the managed care system and the child welfare system are in place to address problems that inevitably occur.
- Systems that sustain their efforts describe long-term collaborative relationships among the systems as key to their success. Trust, respect, persistence, and dedication are words used to describe relationships among child welfare, mental health, and Medicaid agencies that work well together. Top-level commitment to these relationships is essential.

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- Funding strategies are in place to maximize federal funds, share costs and savings across systems, resolve issues among public agencies and MCOs regarding who pays for what services, set comparable provider rates across systems, and pay for services not covered by the managed care system.
 - In managed care systems that work well for children and families in the child welfare system, the child welfare agency is no longer alone in providing behavioral health services. The managed care system shares the expertise and the responsibility for developing a behavioral health care system that will work for children and families in the child welfare system.

■ **Individual child and family-level strategies** include the following:

- Systems have developed strategies to enhance community-based care options and reduce the child welfare system's historic reliance on out-of-home care and residential placement.
- Child welfare service plans (that address safety, permanency, and well-being) are incorporated into behavioral health treatment plans. MCOs/BHOs and behavioral health providers are conscious of safety and permanency issues. Child welfare service plans also reflect the behavioral health services needed to support achieving child/family safety and permanency.
- Children in the child welfare system experience many transitions — into the child welfare system (and often into an out-of-home placement), among different placements while in custody (between foster homes, from foster homes to group homes or residential treatment), reunification with their families and sometimes re-entry into foster care, to an adoptive home or guardianship arrangement, and to independence and reliance on the adult system. Managed care systems that work well for this group of children recognize these many transitions and plan ahead for them. For example, when children in custody are admitted for inpatient care, the BHO care manager is immediately involved in discharge planning and arranging community-based services that will support the permanency plan developed by the family, child welfare agency and the court.