XI. CHILD WELFARE MANAGED CARE REFORM INITIATIVES

In 1996, the David and Lucile Packard Foundation provided additional funding to enable the Health Care Reform Tracking Project to explore more fully: 1) the impact of state managed care reforms on children and families served by the child welfare system who need mental health and substance abuse services, and 2) the impact of managed care reforms in public child welfare systems on children with mental health and substance abuse service needs, and their families. This section addresses the latter, providing information on 25 state and community child welfare managed care initiatives.[1]

Methodology of the Special Child Welfare Managed Care Analysis

The 1997-98 State Survey explored whether the state child welfare system was implementing or planning to implement reforms related to the management, financing, or delivery of child welfare services at the state or county levels, and if these reforms were defined as "managed care." Responses from 36 states indicated that a child welfare system reform defined as managed care was planned or underway, and in early 1998, these sites were contacted to provide information for the study's special child welfare focus. Following these initial contacts, 11 of the 36 sites were excluded from the analysis for several reasons: 1) the key site contact did not believe the initiative could be characterized as "managed care" (i.e., it was not using managed care approaches such as utilization management, capitation or case rates, outcomes measurement, or provider networks); 2) the site did not respond to several requests for an interview; or 3) the initiative was a local multisystem demonstration initiative affecting only a small group of children. This report includes information about multisystem initiatives only if they are *statewide* or affect a large number of children.

An additional source of information about these child welfare managed care initiatives was the Child Welfare League of America's (CWLA) Managed Care and Privatization Child Welfare Tracking Project. The work of the Health Care Reform Tracking Project, especially, the special analytic work related to child welfare, is coordinated with this CWLA project, by continuously sharing information on the frequent changes that are occurring as states and communities implement child welfare managed care reforms.[2]

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[1] *Child welfare managed care*, as described in this document, refers to a type of child welfare reform in which states or communities apply some managed care approaches to the organization, provision, and funding of child welfare services. Child welfare managed care reforms primarily address the use of funds allocated to the child welfare system, and may or may not include some behavioral health services or funds.

[2] CWLA publications are available from the Child Welfare League of America Managed Care Institute at 202/638-2952.

Following site selection, telephone interviews, following a specific interview protocol, were conducted with individuals knowledgeable about the planning, design or implementation of the child welfare reform in each of the 25 sites. Through these interviews, information was collected that described the child welfare managed care initiative itself, the involvement of the child mental health system in the child welfare reform, the effects of managed behavioral health care on children in the child welfare system, coordination of behavioral health and child welfare reforms, and any state or local reforms designed to serve children in multiple systems.

Due to time and resource limitations more qualitative information from front-line child welfare workers or families was not obtained. The 1999 Impact Analysis, which involves three-day site visits to eight states, will explore more fully the experiences and views of others such as front-line child welfare workers, provider agencies, families, and other child-serving systems. Because many sites were still planning or were only beginning to implement their reforms, the results from the 25 phone interviews provide more descriptive information about project design than details about the impact on service delivery or outcomes for children and families served by these reform efforts.

A complete report on analyzing child welfare managed care initiatives has been prepared.[3] The full report includes four sections presenting the wealth of information collected through the telephone interviews and survey instruments:

- Section I describes four major approaches used by states or communities to introduce managed care techniques into their child welfare programs. Key issues examined for each approach include: goals, target population and services, implementation stage, financing strategies, management mechanisms, managed care entities, risk sharing arrangements and capitation or case rates, family involvement, and cultural competence.
- Section II describes the extent and nature of coordination between managed behavioral health care reform and child welfare managed care initiatives and the effects of this coordination on children in both systems who have serious behavioral health problems and their families.

[3]Schulzinger, R., McCarthy, J., Meyers, J., Irvine, M., & Vincent, P. (1998) Health care reform tracking project: Tracking state managed care reforms as they Affect Children and Adolescents with Behavioral Health Disorders and their Families, The 1997-98 state survey. *Special Analysis: Child Welfare Managed Care Initiatives*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. (To obtain a copy of the full analysis, contact the National Technical Assistance Center for Children's Mental Health at 202/687-5000.

- Section III describes how four states use, or plan to use, managed care techniques to implement Title IV-E waivers.
- Section IV presents a summary of positive findings and concerns about these child welfare managed care initiatives, an overview of lessons learned, and recommendations for further study.
- Appendix A includes a list of all sites interviewed and provides detailed summary profiles of each site. The interview protocol also is included as an appendix.

A summary of the key findings from the special analysis of child welfare managed care initiatives follows.

General Trends

Descriptive information from the 25 sites indicates a number of general trends:

- Child welfare managed care tends to be limited to subsets of populations and/or services rather than to be a comprehensive system reform. Many reform initiatives are being conducted first as pilots or in specific geographic areas, rather than as statewide initiatives.
- Few child welfare managed care reforms involve waivers of any type; only one site reported the use of a Medicaid waiver and four reportedly are using IV-E waivers.
- Most initiatives are in the planning or early implementation stage. Only four sites had been in operation more than one year at the time of the interviews.
- State and county public child welfare agencies are not all going down the same track, but instead are experimenting with several different approaches to better serve children and families:
  - A fairly comprehensive managed care approach (13 of 25 sites)
  - Managed care for the provision of mental health services only (4 of 25 sites)
  - Privatization (2 of 25 sites)
  - Multisystem initiatives (7 of 25 sites)
- While respondents recognized that managed care is a way to achieve cost efficiency, other goals that can lead to improved service delivery and outcomes for children and families, such as averting unnecessary out-of-home placement or achieving permanency, also are driving these reform efforts.

Target Populations and Services

The target populations that the reforms tend to focus on are primarily children in out-of-home placements and their families (23 of 25 sites). Most, but not all, of the reforms serve young children, as well as older youth. The majority of the reforms serve children with serious emotional disturbances (15 of 25). Children at risk of placement are served in 19 of the 25 reforms.

Services included in almost all the reforms are placement services, and most incorporate family preservation and support, as well as adoption. The child welfare program that appears to be least affected by the reforms is child protective services (CPS). Although some aspects of CPS assessment and service delivery are included in the reforms, the responsibility for investigation and determination of abuse or neglect is rarely turned over to private agencies. At least some mental health services are covered by most of the reforms.

Management Mechanisms

Most of the child welfare reforms use a variety of management mechanisms that are generally considered part of managed care technology. It appears that the reform efforts are changing how eligibility is determined—many are using teams of workers, rather than a single individual, to decide eligibility and determine the required level of care. The majority of the child welfare managed care reforms create or contract with provider networks and assure comprehensive case management. Many rely on utilization reviews to determine if children are receiving appropriate services. Virtually all reforms intend to track outcome-related data by reviewing expenditures and a variety of additional indicators.

Managed Care Entities

Public child welfare agencies frequently retain responsibility for serving as the managed care organization (MCO) (8 of 25 sites), rather than contracting that function to a private organization. Organizations outside of the public child welfare system that do serve as MCOs are usually not-for-profit or local collaboratives. Only one site reported contracting with a for-profit organization to serve as the MCO. Three reported using for-profits as administrative service organizations (ASOs). At the time of the interviews, 7 of the 25 sites had not yet determined what type of entity would serve as the MCO.

Funding

Child welfare funds are used in all 25 of the initiatives, with many also including Medicaid (16 sites) and mental health (12 sites) funding sources. Other child-serving agencies contribute less to the child welfare reforms. More than half of the sites interviewed are relying on case rates to provide flexibility and, in some instances, to share risk with lead agencies or a managed care entity. Only 3 of the reform efforts cited the use of capitation financing. Most of these involved states offering a capitated budget to counties and shifting the risk (or part of it) for costs above the capitated budget to the county.

Family Involvement and Cultural Competence

Although respondents identified family involvement in planning many of the child welfare reform initiatives, this involvement tended to be peripheral (focus groups, public meetings) rather than placing families as partners in decision making. Respondents in

9 of the 25 sites believed that the historical practice of parents having to relinquish custody to obtain treatment services for their children would be reduced as a result of the child welfare managed care reform. Respondents also indicated that most of the reform initiatives have provisions to address the inclusion of culturally diverse and indigenous providers.

Behavioral Health Services

The public mental health system is usually primarily responsible for the provision of *acute* behavioral health care services for children in the child welfare system (16 of 25 sites). However, the child welfare system is involved in almost one-third of the sites, with either primary responsibility for acute care services (in 2 sites) or sharing it with the mental health agency (in 6 sites). For *extended* behavioral health care, the public mental health system is not as involved, according to child welfare respondents, characterized as primarily responsible in less than half of the sites (10 of 25). In 11 of the sites, the child welfare and mental health systems shared responsibility for extended care services, and in 3 sites the child welfare agency assumed primary responsibility for extended behavioral health care.

Coordination of Child Welfare and Behavioral Health Reforms

There is some coordination between child welfare and behavioral health managed care initiatives in many of the 25 sites, however, very few are totally integrated. Respondents indicated that lack of coordination between the two can lead to numerous problems, such as duplication, service gaps, cost shifting, disagreements about payment responsibilities, confusion for families, and inconsistent rates and policies for providers who contract with both systems.

Respondents indicated that most behavioral health care reform initiatives in their states and communities include and provide at least some services for children in the child welfare system (22 of 25 sites).[4] However, 19 of the 25 respondents also said that Medicaid funds—separate from and outside of the behavioral health managed care initiative—remain available to fund mental health services for children and youth in the child welfare system.

It appears that in about half of the sites, each system (child welfare and behavioral health) was involved in planning the other system's reform initiative. However, neither appears to be adequately tracking the impact of managed care on other child-serving systems.

[4] In the 1997-98 State Survey, of the 43 state behavioral health managed care reforms analyzed, 26 reforms (60%) reportedly included children in state custody.

Title IV-E Waiver Demonstrations

Title IV-E waiver demonstrations are being used as a vehicle for testing a managed care approach in 4 of the 25 sites. Respondents cited numerous positive anticipated outcomes from these demonstrations. Most of these four sites employing managed care strategies in implementation of their IV-E waivers are basing their efforts on system of care values and principles and have incorporated a wraparound philosophy and process in the delivery of services. They support flexibility in service delivery that is community based, centered on the needs of each individual child, and family focused.

In the July 10, 1998 Federal Register, at least five of the 17 new state IV-E waiver requests include managed care approaches in their implementation plans.

Findings and Lessons Learned

Initial positive findings as well as concerns are evident from the findings of this study; however, they reflect expectations more than actual outcomes as many respondents felt it was “just too early to tell”.

Initial positive findings suggest that managed care reforms in child welfare systems:

- Secure greater flexibility for child welfare systems and opportunities to leverage child welfare funds in new ways
- Promote greater concern about accountability to the public and decision makers
- Increase attention to achieving more concrete outcomes for child welfare systems and the children and families they serve
- Promote a more efficient service delivery system and influence providers to offer a greater array of home and community-based services
- Provide opportunities for child welfare agencies to work in partnership with a broader group of child-serving agencies, promoting a greater sense of shared responsibility among agencies to serve children and their families
- Increase access to services for children and families
- May reduce the practice of relinquishing custody of children in order to obtain services
- Reduce reliance on out-of-home care

Initial concerns about child welfare managed care initiatives include the following:

- Insufficient tracking mechanisms to determine outcomes and possible cost shifting among child welfare and mental health agencies
- Insufficient family involvement in design, planning, and program implementation
- Insufficient current data to make decisions about setting case or capitation rates
- Concern that case rates may be too low

- No special (higher) case rates for children with serious behavioral problems
- Loss of control in decision-making
- Changing role for child welfare staff from service provider/manager to monitor
- Fear of accepting or sharing risk

Respondents were eager to share lessons learned and ideas about how to plan and implement child welfare reforms so that others could benefit from their experience. Foremost in their suggestions was the need to allow adequate planning time and to build partnerships with all stakeholders. Other advice included: set realistic, clear, common goals and objectives; collect adequate data to make informed decisions; avoid risk arrangements until two years of data are available; implement the reform in stages, allowing time to incorporate changes as needed; learn from criticisms and difficulties; focus the reform on assisting the family, rather than on an individual child; practice "managing care" rather than "managed care" in the traditional sense; clearly define the new responsibilities of child welfare and other involved agencies; build strong relationships with providers; set outcome measures with all stakeholders and monitor the impact of the reform.