

MANAGING CARE

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for Children and Families

A Newsletter of the National Child Welfare Resource Center for Organizational Improvement

From the Director...

Welcome to the first issue of *Managing Care for Children and Families*. We're proud to bring you this newsletter as part of our continuing efforts to assist child welfare leaders in improving the management and administration of child welfare services.

Each issue of *Managing Care* will focus on one of the key strategies that today's public child welfare managers are using to improve their child welfare organizations. We will examine strategies that involve new approaches to partnering with families, communities, other agencies and providers.

As we examine each strategy, we will provide a framework that identifies the major issues that managers face. We will also profile current state and county activity and provide you with information about resources available to you. We want this newsletter to assist you in your efforts to thoughtfully implement management innovations with the most current knowledge at your fingertips.

This first issue spotlights the introduction of the tools of managed care to child welfare. As it is

being implemented in social services, managed care often means developing new partnerships with those who provide or arrange for child welfare services. If crafted carefully, these new relationships can contribute to agency efforts to control costs and increase the emphasis on positive outcomes for children and families. This issue will highlight some of these efforts.

Future issues of *Managing Care* will highlight collaborative approaches

to financing comprehensive services, strategies for funding kinship care in the post-welfare reform world, and development of outcome measures.

We'd love to hear any ideas you have on how *Managing Care* could be useful to you. Please feel free to give us a call at 1-800-HELP-KID or drop us a line by e-mail at patn@usm.maine.edu

—Kris Sahonchik

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Managed Care:

New Partnerships for Child Welfare

Utilization management, at-risk contracting, critical treatment pathways—first used in health care and then in behavioral health, these managed care terms are increasingly part of our vocabulary in child welfare today. As public child welfare agencies are subject to political and fiscal pressures to implement managed care, managers are grappling with how these tools can be used to control costs without harming children and families.

As state and county public child welfare agencies move forward with managed care, many are developing new arrangements with managed care “partners.” These partners may be either private providers or public agencies.

Under these arrangements, the partners are given increased responsibility for actively managing a group of services for a target population. The partner receives a fixed amount of flexible funds to serve the population. This arrangement provides the key “managed

care” incentive: *Flexible funds* give the partner the freedom to develop new and effective services; *fixed funds* provide the financial incentive to make these kinds of changes.

There are two broad approaches to these new partnerships:

- *Child welfare managed care*—projects initiated by child welfare agencies that focus on children in the child welfare system and that use primarily child welfare funds, and
- *Interagency managed care*—projects initiated by an interagency group that focus on children involved in multiple systems and that use funds pooled across agencies.

Under *child welfare managed care* projects, the managed care partner is often given responsibility for managing a range of out-of-home and in-home services for children in the custody of the agency. The goal is to move children to permanent placements. Under *interagency managed care projects*, the partner is often expected to coordinate a range of health and social services for high-needs children and families in order to achieve a broader set of positive outcomes.

Under both of these approaches, public agencies may choose

to partner either with private providers or with public agencies.

Partnerships with private providers often are called “privatization” and usually involve developing new arrangements with providers who have the network necessary to provide a flexible group of services.

“...many public child welfare agencies maintain key roles in... investigations and assessments.”

To ensure the safety of children, however, many public child welfare agencies maintain key roles in conducting investigations and assessments, while sharing responsibilities for case management functions. Partnerships with public agencies often more clearly allow public roles to be maintained, but these agencies are also subject to constraints that inhibit their flexibility.

Examples of child welfare managed care projects illustrate the variety of arrangements being developed with managed care partners:

- In *Tennessee’s* continuum of care contracts, the Department of Children’s Services has developed new contracts with 16 of their largest individual providers. Over the past year and a half, \$50 million of the state’s \$132 million in contract funds have been shifted from buying beds to purchasing a continuum of both out-of-home and in-home services designed to achieve permanence for children in the more restrictive levels of state custody.

Contractors are paid a fixed daily rate and required to accept new children every month, with a capped total amount the state will

pay. Contractors remain responsible for the children for nine months after reunification and cannot count them as new enrollees if they return to placement.

- *Kansas* is currently privatizing all direct child welfare services. Under the foster/group care/reunification initiative, the state has chosen one contractor in each region to be responsible for providing a complete range of out-of-home and in-home services and for achieving a set of outcomes for children in child welfare custody. Starting in the spring of 1997, contractors will be paid a flat case rate per child and will be responsible for providing services the family or child needs within that rate for twelve months after permanent placements.

Kansas has also privatized its adoption services, giving one statewide vendor responsibility for children in custody with adoption as a goal. The vendor receives a one-time payment per child and is responsible for all out-of-home placements, recruitment, matching and support services for eighteen months post-adoption.

- Under the *Massachusetts* Commonworks project, the state has given one lead agency in each region responsibility for providing community-based residential care, specialized foster care and family support services for up to 800 adolescents, aged 12 - 18, in state custody. Under contracts in place since July, 1996, contractors are expected to move the children to permanent placements or independent living as well as to implement other operating principles, such as maintaining and educating youth in least restrictive environments.

Massachusetts contractors are paid an intake fee, a fixed semi-monthly amount for each child in custody, and a lower standard semi-monthly amount for up to six months of home-based services after discharge. They also receive an outcome

A Language All Its Own

Managed care brings a whole new set of terminology to the child welfare world. These are some of the terms that are used most often:

At risk: The chance of not being fully reimbursed for service provided. Upon accepting a case rate or capitated rate, the contractor is liable for the cost of services, regardless of their extent.

Case Rate and capitation: Reimbursement mechanisms under which a provider receives a fixed amount of payment per person in exchange for furnishing a cluster of services over a specified period of time.

Performance contracting: A contracting system that establishes a link between payments and the contractor's performance in attaining specified outcomes.

Practice protocols: Instruments that are used to link symptoms, diagnoses, interventions and outcomes. Examples are assessment and decision making tools that assess a child's or family's condition and determine appropriate interventions and their expected outcomes.

Quality assurance: A formal set of activities and programs designed to ensure quality of care. Quality assurance programs include processes for reviewing utilization and quality and a structure to carry out education and corrective actions to remedy deficiencies. Programs also include standards for provider qualifications, record keeping, access to care and communication with children and families served.

Reconciliation: A process intended compensate contractors for the cost of serving high risk children or families by adjusting rates based on the contractor's cost experience with that child or family.

Utilization: The extent to which children and families being served by a contracted entity obtain services over time.

Utilization management: A system for reviewing the appropriateness of utilization.

bonus for children who do not return to placement for six months after home-based services are completed.

- Under *Florida's* privatization projects, four districts have established contracts with providers. These range from a contract with a coalition of providers to provide out-of-home and in-home services to all children in the child welfare system for a capitated rate to a contract with one agency to provide this full range of services to all children entering shelter care for the first time for a fixed case rate.

State child welfare agencies are also developing new partnerships with county child welfare agencies. In this model, states are putting county agencies—which have traditionally been responsible for a range of out-of-home and in-home services—in a new role by stabilizing or capping the amount of funds the state will provide and by making these funds more flexible.

The state encourages counties to move children to less restrictive, more effective community-based settings and to develop preventive services. County agencies are allowed to keep savings generated by their efforts to invest in services. *Ohio* will be implementing this approach with county agencies under its recently-

approved child welfare waiver. And under *Iowa's* child welfare decategorization projects, the state has provided flexibility and incentives to county decategorization projects that are collaborations between child welfare, juvenile courts and local governing authorities.

Under *interagency managed care projects*, an interagency group often

sets up a new arrangement with a private or a public partner to provide integrated services to high-needs children and families. The interagency approach to managed care has the potential to coordinate managed care efforts across systems as projects move towards integrating Medicaid, mental health, and social service funds in a single pool managed by the same entity.

Following are some examples of inter-agency managed care efforts:

- In *Hamilton County, Ohio*, the interagency Family and Children First Council created and contracts with a new non-profit entity, FCF Management, Inc. to provide integrated social services to 286 high-needs children and their families. Since June, 1995, this private, non-profit entity has been managing a network of providers, including both care management agencies that provide individualized case management services and direct service agencies that provide services for enrolled children and families.

“The interagency approach...has the potential to coordinate... managed care efforts across systems...”

County agencies pool funds that they were spending on the targeted children and provide FCF Management with a set amount per child to purchase services. The Council and FCF Management, Inc.

are working together to track a range of outcomes for children served.

- In *Multnomah County, Oregon*, the Partners Project pools capitated

Medicaid funds, state and local child welfare funds, state and local mental health funds and local education funds. This pool is used to provide a flexible per child payment to a group of managed care coordinators. These coordinators deliver centralized, individualized case management services and arrange for direct service for the severely emotionally disturbed children served by the project. This “system of care” project is operated by the Multnomah County Division of Behavioral Health.

States and counties that have implemented managed care projects have found that a broad based, inclusive planning process is crucial to making the key design decisions illustrated in these examples: Who should initiate the managed care project? Who should the managed care “partner” be? What population should be targeted, and what group of services should be managed by the partner? How can agencies create fixed, flexible payments but also monitor performance on key outcomes?

Some examples of how states and counties are handling these key implementation issues are illustrated in “Practice Forum,” on page 5.

Practice Forum:

Making Managed Care Work for You

Implementing managed care means tackling a number of important practice issues. Here's a look at how several states are addressing some managed care implementation issues:

Sharing Roles

How does a public agency balance the need to allow another entity an active role in managing care with legal requirements for public agency involvement and the necessity of interacting with courts?

In Kansas, Massachusetts, and Tennessee, public agencies retain responsibility for conducting investigations and assessments.

In Kansas, public agency workers also maintain an ongoing role as case managers. They have final authority for case plan goals, but are expected to consider the contractor's recommendations. Public agency workers are also the single point of contact with courts.

In Tennessee and Massachusetts, ongoing case management is shared by treatment teams. These teams include public agency workers, the lead agency and provider partners. Contact with courts is also often shared—contractors often appear at courts with public workers.

In the Hamilton County partnership, the county is planning to have the contracted care management entities take over the assessment function. This role will complement their active role in ongoing

case management. The contract specifies, however, that care management workers must attend the semi-annual public agency case reviews and comply with court mandates.

Providing Funding

As public agencies try to create flexible funding for managed care contracts, many draw on the funding sources traditionally used for child welfare services. These include social service block grant funds, Title IV-B part 1 and 2 funds, state general revenue funds and local funds. Some states are also including IV-E funds and requiring partners to provide the necessary documentation to claim federal funds.

How are agencies establishing fixed rates for services? Massachusetts determined rates they offered to bidders based on a baseline study of actual expenditure data and service utilization data. Kansas provided data on child welfare expenditures to potential bidders, and asked that bidders propose rates at which they would be willing to provide the services.

States are also trying to determine to what extent fixed rates should be adjusted based on actual cost experience. In the Hamilton County, Ohio project, the contrac-

tor gathered cost data over the first year of operation, and the second contract includes capitated rates. It also calls for an end-of-the-year reconciliation and specifies a "risk corridor," where the contractor will pay for costs up to 5% over the amount of their contract and retain up to 5% of any savings.

Assuring Quality

Child welfare agencies need to establish and monitor standards for both services and outcomes. The definition of a range of service

standards that contracted providers must meet and the monitoring of those standards is part of quality assurance programs that child welfare agencies are recognizing need to be developed.

A key component of quality assurance is defining and holding the managed care partner accountable for outcomes. Kansas has defined and is reporting on a manageable number of meaningful, measurable outcomes in its privatization contracts. Under the foster/group care/reintegration effort, there are five key outcomes, each with one or two indicators.

Key outcomes are:

- children are safe from maltreatment,
- children experience a minimal number of placements
- children maintain family, community and cultural ties
- children are reunited with their families in a timely manner, and
- clients will be satisfied with services.

"A key component is...holding the managed care partner accountable for outcomes."

"...to what extent [should] fixed rates...be based on actual cost experience?"

Resources and More...

Here are some organizations and publications that can help you learn more about managed care issues and strategies.

About managed care principles...

Institute for Human Services Management—(301) 229-9455

“Managed Care and Child Welfare: Are they Compatible? Design Issues in Managed Care for Child Welfare,” January, 1996 (Reprinted in part in “Managed Care and Child Welfare: Will it Work?” in Public Welfare, Summer, 1996).

American Humane Association, Children's Division
—(303) 792-9900

“Ethical Standards for the Implementation of Managed Care in Child Welfare,” developed at the First National Roundtable on Managed Care in Child Welfare Services, June, 1996. Summary of proceedings (\$25).

Second National Roundtable on Managed Care in Child Welfare Services, held in February, 1997. Summary of proceedings (\$25).

Child Welfare League of America
—800-407-6273 or 908-225-1900

Managed Care: An Agency Guide to Surviving and Thriving, David Emenhiser, Robert Barker and Madelyn DeWoody, 1995 (\$18.95).

Making Managed Health Care Work for Kids in Foster Care, Ellen Sittenfeld Battistelli, 1996 (\$14.95).

The Child Welfare League also offers the Managed Care Institute

for Children's Services. Contact: (202) 638-2952.

Washington Business Group on Health—(202) 408-9320

Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and Their Families, Robert F. Cole with Stephanie L. Poe, 1993.

National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center
—(202) 687-5000

Health Care Reform Tracking Project: The 1995 State Survey, 1995.

On assuring quality...

The American Humane Association and the National Association of Public Child Welfare Administrators co-sponsor a series of *Annual Roundtables on Outcome Measures in Child Welfare Services*. The Roundtables have produced Matrices of Indicators, which can provide a starting point for defining outcomes. Contact: Nancy McDaniel, American Humane Association, (303) 792-9900.

“Trading Outcome Accountability for Fund Flexibility,” Center for the Study of Social Policy, (202) 371-1565. This paper gives practical advice about the set of elements that need to be negotiated when a public agency wants to get positive results from devolving responsibility for services and flexible funds to another entity.

The Health Care Financing Administration's *Quality Assurance Reform Initiative* (QARI) guidelines, released in 1993, provide

guidance to state Medicaid agencies on designing and implementing quality assurance programs in their contracts with providers under Medicaid managed care plans. A description of QARI can be found in “HCFA's Quality Assurance Reform Initiative,” *Public Welfare*, Spring 1995.

From the National Child Welfare Resource Center for Organizational Improvement...

Research, technical assistance, training and referral services on:

- Planning, designing and implementing managed care systems
- Providing funding
- Assuring quality and evaluating programs

Financing Strategies to Support Comprehensive, Community-Based Services for Children and Families, Mary M. O'Brien, 1996 (\$12). Describes and analyzes four approaches and eight experiences with creating flexible funding for services for children and families.

Four teleconferences on *Exploring Managed Care for Child Welfare Managers and Administrators*, Spring, 1997 Available on audio-tape:

- Techniques for Planning and Designing Your System
- Continuum of Care Contracting In Tennessee
- Contracting with a Managed Care Provider Network in Hamilton County, Ohio
- Managed Care and Cultural Competence: A New Perspective

Call 1-800-HELP-KID for more information.

Child Welfare Waiver Demonstrations

As of September 1, 1997, the Department of Health and Human Services (DHHS) has given approval to eight states to operate child welfare waiver demonstration projects. The eight were selected from the initial group of fourteen state applications received by July 31, 1995. The Department expects to approve two more from that group this fall.

Section 1130 of the Social Security Act allows the Department to waive certain requirements of title IV-E or IV-B for up to ten demonstration projects. The Department does not expect to take additional applications unless given legislative authority. A bill authorizing additional demonstrations is being considered favorably on Capitol Hill.

DHHS explains that the approval process has been lengthy because it took longer than anticipated to resolve questions about how these projects will operate. Also, because of the limited number, DHHS has put a strong emphasis on developing evaluation plans that will provide maximally useful data comparable across similar waivers.

Three of the approved projects—*Illinois, Delaware and Maryland*—will use IV-E funds to support a sub-

dized guardianship option. Delaware will also use IV-E funds for multidisciplinary teams addressing parental substance abuse.

Three other projects—in *Ohio, Indiana and Oregon*—have approval to shift IV-E funds to pay for new, community-based services. The Ohio waiver specifically approves the use of a managed care approach. The state will implement models of managed care to provide 20 counties with fixed but flexible funds for child welfare services. Indiana will provide enhanced community-based services to 4000 children statewide. The Oregon waiver will allow the state to provide flexible IV-E funds for services to local systems of care, such as the one in Multnomah County.

Two additional states—*North Carolina and California*—have approval to implement both subsidized guardianships and other innovations. In North Carolina, participating counties will be given broad flexibility in the use of IV-E funds. They will be granted performance bonuses if they achieve system efficiencies and meet specified outcomes. California plans two additional programs—to fund intensive, innovative services and to allow extended voluntary placements.

Movers and Shakers...

Want to learn more about some of the projects discussed in this issue? Here are some people to contact and programs to watch:

Tennessee: Continuum of care contracts, Lisa Faehl, (615) 741-8905

Massachusetts: Commonworks, Bill Evans, MA Department of Social Services, (617) 727-0900 ext. 555

Kansas: Privatization projects, Marilyn Jacobson, KS Department of Social and Rehabilitation Services, (913) 296-3284

Florida: Privatization projects. Theresa Leslie, FL Department of Children and Families, (904) 488-9444

Iowa: Child welfare decategorization projects, Barry Bennett, IA Department of Human Services, (515) 281-8164

Hamilton County, Ohio: Families and Children First, Don Thomas, Hamilton County Department of Human Services, (513) 946-2205

Multnomah County, Oregon: Partners Project, Janice Gratton, Multnomah County Division of Behavioral Health, (503) 248-3999

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We'd Like to Hear From You!

This is our first issue of *Managing Care for Children and Families*—and we'd like to know what you think. Are there topics that you'd like us to address in future issues? Want to find out more about how agencies are tackling the challenges that you face? Let us know, and we'll do our best to help.

Just fill out the form below and mail it to:

Pat Nocera
National Child Welfare Resource Center for Organizational Improvement
PO Box 15010
Portland, ME 04112
or fax it to us at 207-780-5817. Thanks!

Name: _____ Phone: _____ Fax: _____
Agency: _____
Address: _____

In future issues of *Managing Care*, please address the following topic(s): _____

☐ I'd like more information about the National Child Welfare Resource Center for Organizational Improvement.

My particular area(s) of interest are:

- ☐ outcome measures
- ☐ strategic planning
- ☐ program evaluation
- ☐ human resource development

- ☐ licensing
- ☐ information systems
- ☐ interagency collaboration
- ☐ risk assessment

- ☐ kinship care
- ☐ court improvement
- ☐ other: _____
