TREND WATCH

By Gordon Sprenger and Mark Stutrud

Untraditional Partnerships, Sharing Risk to Deliver in the New Marketplace

Privatization of behavioral health services to public patients is growing at a tremendous pace. Most of these patients are served through managed behavioral health companies, HMOs or community mental health centers; in other words, through stand-alone entities that, for the most part, do not collaborate with a full range of healthcare providers in the community.

Behavioral healthcare, regardless of payer source, will evolve beyond this stand-alone, fragmented approach, and be delivered through integrated health systems – hospitals, physicians, mental health professionals and a broad range of other providers who work together to provide a full range of healthcare services. Such a system links providers together under an organizational umbrella that fosters easy provider communication and smooth transition for the patient when moving from one healthcare setting to another.

Delivering services through an integrated approach has very real benefits for behavioral health. For example, let's look at the record for diagnosis and treatment of depression. The literature tells us that between 2.3 percent and 3.2 percent of U.S. men and between 4.5 percent and 9.3 percent of women meet the diagnostic criteria for major depressive disorder.

Most clinical depression goes unrecognized and untreated, however. Of those individuals whose cases are recognized, only about 20 percent seek care from a mental health professional. At the same time, 75 percent of clinically depressed individuals do seek care from a physical healthcare provider. This may help explain why more than half of medical visits do not reveal an identifiable, treatable illness or injury.

Yet it is very difficult for physicians to recognize the mental health problems of patients in a 10- to 15-minute office visit. No wonder there are often errors reported in recognizing and treating behavioral disorders. Most physicians don't consult regularly with behavioral health providers, either to help sharpen their diagnostic skills or to foster on-going professional relationships. Not surprisingly, physicians report feeling disconnected from mental health colleagues.

Closer collaboration between physicians and mental health professionals would improve consultation and reaching the right diagnosis for behavioral health problems easier. It would enhance care for physical illness, as well. Research shows there are improved outcomes when behavioral services are added to the care of cardiac and cancer patients for example, and in managing chronic illnesses such as diabetes and asthma. Collaboration between primary medical/surgical and behavioral health providers allows the kind of coordinated clinical practice that leads to measurable improvement in overall patient health.

There's another reason to believe strongly in integrated delivery systems that is greater cost-effective. A range of providers working together under the same set of financial and clinical incentives is more efficient. This is true for privately insured patients, as well as for public patients.

Aligning diverse interests, concerns and needs builds accountability into the system for patients and communities, and those who pay for care – insurers and employers. This integrated approach makes good practical sense because as healthcare markets mature,

- Traditional, fragmented delivery systems won't stand the rigors of an organized buyer system. Instead, buyers will look for systems that are capable of managing the full range of care.

- Financial incentives aligned among hospitals, physicians and other providers will be required in order to effectively manage the full range of healthcare services. Providers will accept financial risk for physical and behavioral health under a range of contract methods.

- Most insured individuals, including those covered by government programs, will be enrolled in some form of managed care program. As managed care markets mature, they move from discounts to financial risk-sharing in delivering a package of healthcare benefits.

- Physicians will seek larger integrated healthcare organizations in which to practice because larger groups are better able to accept risk.

- Untraditional partnerships will form whether between hospitals and managed

care organizations between nonprofit and not-for-profit entities, or between hospitals and physicians, to name just a few. This will mean that cost shifting is eliminated.

As federal and state resources become more and more scarce, integrated systems will be best positioned to manage health benefits and services most effectively. Public/private partnerships can be one vehicle for delivering integrated services.

There are, however, no simple answers. It's not easy to form nontraditional partnerships. Working toward integrated delivery systems is nevertheless worth the effort because they lead to a future in which a full range of healthcare providers work together for healthier patients and healthier communities ▼

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Progress with Childhood OCD

Continued from page 21

Perhaps as much as 10 percent of children with OCD remain significantly impaired. Three areas in need of improvement are:

- Increase public awareness that OCD occurs in children and adolescents.
- Ensure that professionals are adequately trained to recognize and treat OCD.
- Counteract the misconceptions and stigma associated with the disorder.

Fortunately, we are moving in the right direction in all of these areas, and there is reason for optimism about the future ▼

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EMPOWERING *families*

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November 1996

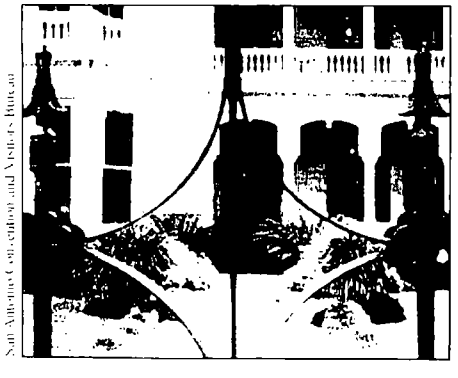
Make Plans Now

San Antonio Hosts NAFBS Conference December 11-14

by David Haapala

The NAFBS Conference Committee expects hundreds of family-based practitioners, policymakers, parents, administrators, educators, and researchers from across North America to converge on San Antonio, Texas, December 11-14, 1996, for the 10th Annual NAFBS Empowering Families Conference. Headquartered at the beautiful San Antonio Hyatt Regency Hotel on the River Walk, the conference site is perfectly situated with an extraordinary view of the river and within easy walk-

(See **CONFERENCE,** *p. 14)*



San Antonio Convention and Visitors Bureau

The King William Historic District is one of the many fascinating areas to visit in San Antonio. You can register for the NAFBS Conference using the Registration Form on page 15 of this issue!

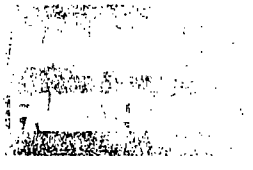
MANAGED CARE AND FAMILY-BASED SERVICES

Managing Managed Care for Families

by John Hutchins

Managed care — the philosophical and financing system that has transformed the private health care delivery system in the United States — is rapidly moving into social services systems and the publicly-financed health care sector. Within the next decade, 80 to 90 percent of Americans will receive their health care through managed care arrangements, according to industry expert Monica Oss, a keynote speaker at December's National Association for Family-Based Services (NAFBS) Annual Conference (see story at left). Medicare now offers incentives to seniors to move into managed health care, and, under federal waivers, states are turning to managed care contractors to help control the rising costs of Medicaid, which far outstrip the private health care inflation rate. NAFBS members working in mental health and substance abuse services have been dealing with the managed care wave for several years. Child welfare and other public social services are just beginning to feel its effects. However, no public or private health or social service agency will avoid the managed care revolution in the next decade.

The spectre of managed care creates consternation among many service providers used to open-ended entitlements and fee-for-service arrangements. However, as Langley and Preister



(1996) note in their new managed care guide for nonprofit social service providers (see Resources, p. 10), managed care is really only a technology — like research, computerization, and quality assurance — that can either enhance or hinder the mission of public sector agencies and other nonprofits.

(See **MANAGING,** *p. 6)*

MORE ON MANAGED CARE ...

(**MANAGING,** *from p. 1*)

What is Managed Care?

Managed care seeks to control the cost of delivering services by changing the financial incentives of delivery systems. By limiting services to those that are necessary and appropriate, by coordinating the delivery of services, and by rewarding preventive care, managed care strives to cut the wasteful overutilization and inefficiencies of traditional fee-for-service systems while still providing quality care. The principal financing mechanism of managed care is capitation — that is, the provider (whether a large company or an individual) agrees to provide services to a particular population for a per person per year fee. At its best, capitation encourages proactive, preventive, coordinated services to patients and clients in an effort to avoid more expensive remedial care later. In the early days of the managed health care industry, managed care organizations (MCOs) assumed the risk of capitation by enforcing strict utilization review over health care services. However, in recent years, MCOs have shifted the burden directly to health care professionals (whether individuals or groups) by requiring contracted providers to accept the risk of capitation themselves — eliminating the need for utilization review.

Managed Care and Social Services

In a recent survey of state child welfare services administrations, the Child Welfare League of America found that 41 of 49 states contacted are considering applying or planning to apply managed care principles to the financing and delivery of child welfare services. Twenty-two states are considering or planning to contract out all or part of their management functions, including seven states that would seek an outside vendor to deliver and monitor services. No state indicated that for-profit management organizations would be excluded from submitting a proposal. The top three services that states indicated might be included under managed care are: family foster care (59 percent), residential treatment (55 percent), and group care (52 percent).

The passage of federal welfare reform legislation, which ends the welfare entitlement and devolves administrative responsibility to the states, has freed states to transform their welfare systems. Many states are considering privatizing part or all of their welfare programs, which, in most cases, will mean some form of managed care. Several states — including Texas and Wisconsin — have already begun accepting bids. The huge sums of money being discussed — $563 million per year to run the entire Texas welfare operation, for instance — are attracting surprising new players to the table with little or no experience in social services administration, including Andersen Consulting, Electronic Data Systems, Inc., and Lockheed Martin. (In a clear demonstration of its interest in this new market, Lockheed Martin recently hired Michigan welfare commissioner Gerald Miller as a top advisor.) According to a recent *New York Times* article, state and county officials facing capped welfare budgets and strict work and time limit requirements find the idea of fixed-price contracts with corporations very appealing.

A Philosophical Fit with Family-Based Services?

At first blush, managed care, with its cost-conscious, bottom-line orientation, would seem to have little in common with the principles of the family-based services approach — comprehensive, coordinated, community-based, culturally-relevant services that empower families. However, *Claiming Children*, the newsletter of the Federation of Families for Children's Mental Health, suggests that managed care offers opportunities to create a comprehensive, community-based spectrum of services that is better integrated. A successful managed care approach to health social services would:

- control costs and monitor effectiveness,
- coordinate services into a network — that is, integrate disjointed service systems (child welfare, education, mental health) and separate funding sources (federal, state, and local), and
- integrate services to provide wrap-around care to children and their families at home (Adams, 1995).

At the same time, managed care appears to present greater risks for some populations. A recent study published in the *Journal of the American Medical Association* found that elderly people and poor people who are chronically ill tend to fare worse in health maintenance organizations (HMOs) than in conventional fee-for-service plans (Jeffrey, 1996). The managed care industry disagrees with the findings, and these researchers themselves also found that care for average patients was comparable between HMOs and fee-for-service arrangements.

For managed care to fulfill its potential as an agent for improved services for families, family advocates must play an important role. The Institute for Family-Centered Care, which promotes family-based services for children with special health care needs, warns that families and family-based professionals must make sure that managed care companies provide access to adequate preventive and support services, encourage collaborative relationships between families and providers, and ensure that families have a real voice in defining quality and shaping managed care systems.

Several national membership organizations, including the Federation of

(*See* **MANAGING,** *p. 7*)

(MANAGING, *from p. 6*)

Families for Children's Mental Health and the Child Welfare League of America, have recently published sets of principles to guide managed care companies and family advocates as they design new health and social service managed care systems.

"NAFBS is committed to helping family-based service providers and their clients deal with the changes that managed care will continue to bring to human services," says Steven Preister, NAFBS executive director. For instance, he noted that the 1996 NAFBS Annual Conference in December will highlight managed care issues (see p. 1) and the 1998 NAFBS Educators' Institute will focus on the role that professional schools have in preparing family-based providers for managed care (see p. 8). The NAFBS Board of Directors has also begun providing managed care training to state associations and has created a Managed Care Task Force to gather information about managed care penetration in human services and to develop a plan for further assisting NAFBS state associations and individual members (see box at right).

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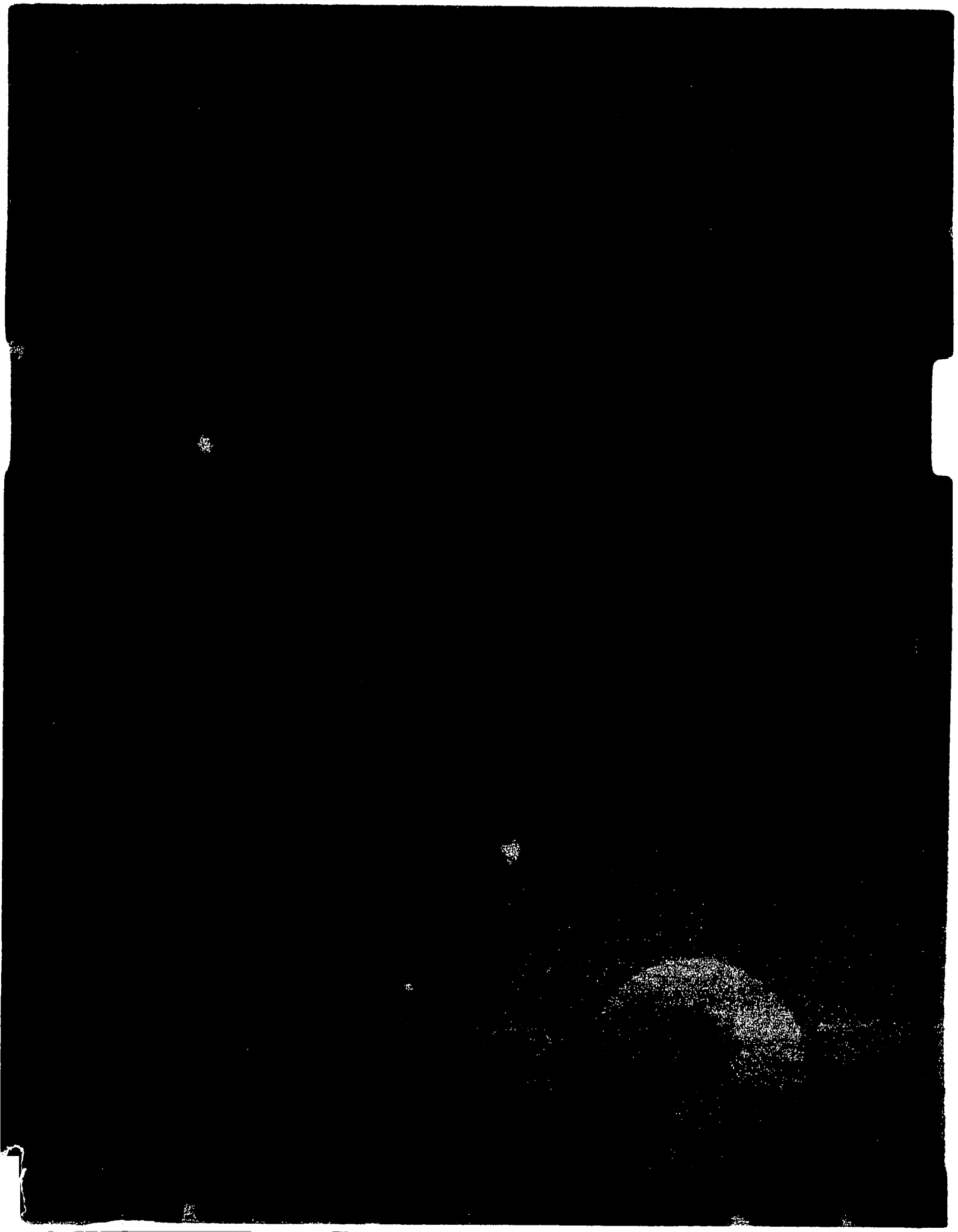
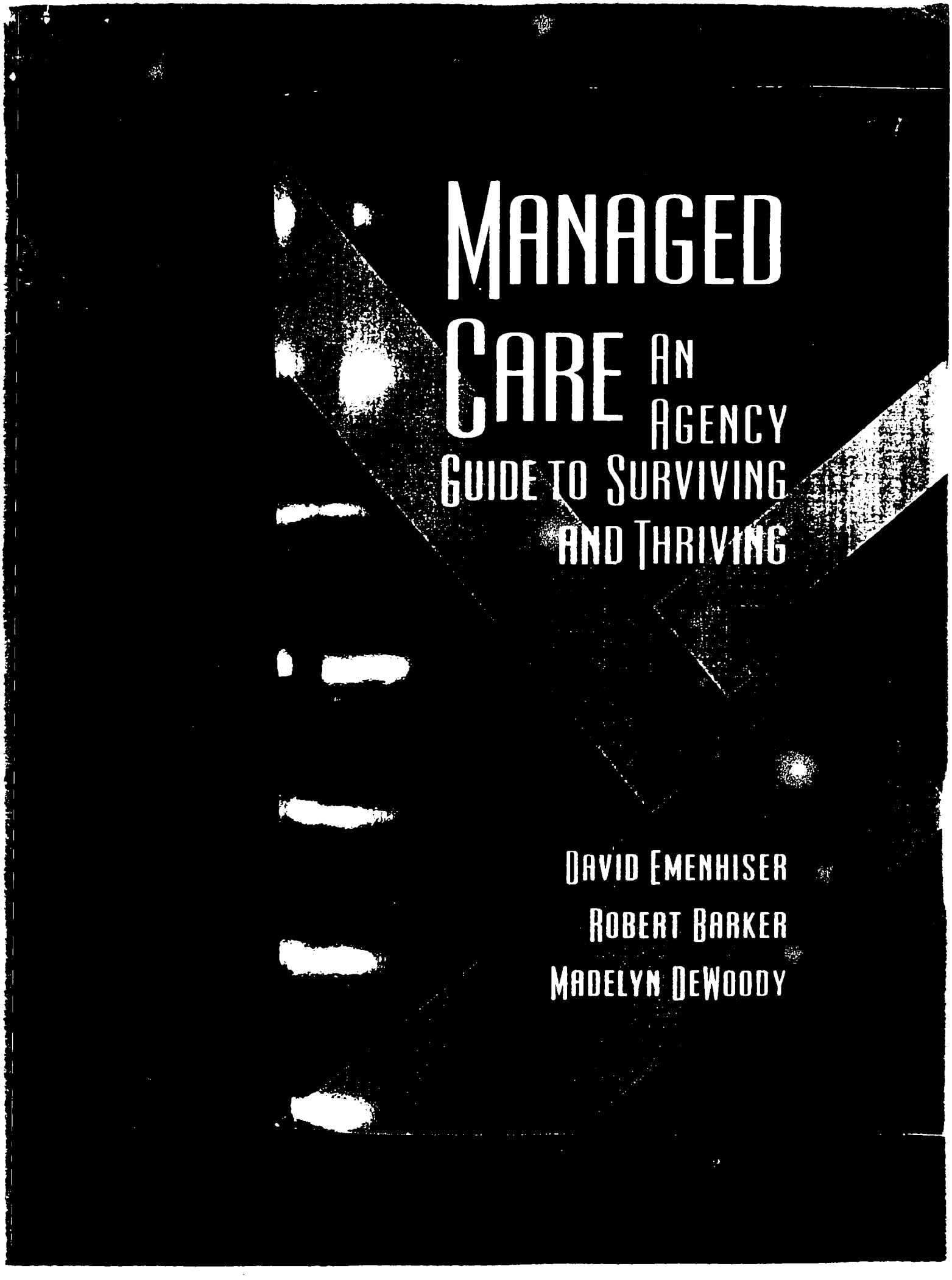
Call for Information on In-Home Services

The National Association for Family-Based Services (NAFBS) Managed Care Task Force is seeking information from NAFBS members providing in-home services about their relationships with insurance/managed care companies for use in preparing training materials for state associations. Please send your responses to the following questions, along with any contract formats, treatment plan formats, and outcome measures that you have found useful, to Steven Preister, NAFBS Executive Director, 6824 Fifth Street, NW, Washington, DC 20012.

1. Is the in-home program in which you are involved collaborating with any insurance companies for the provision of in-home services?
   - If yes, what kind of in-home services are insurance companies interested in? Mental health related? Correctional issues? Others?
   - What kind of contract was negotiated with insurance companies in order to balance the special needs of in-home services, such as travel, flexible hours, intensity, and irregular staffing patterns?
   - What kinds of treatment plans and prior authorization processes are being requested by these companies? How are you integrating individual diagnosis and family-centered services in these plans?
   - Are insurance companies demanding specific staff credentials?
2. Is the in-home program in which you are involved collaborating with local departments of human services for the provision of in-home services through managed care arrangements?
   - If yes, what in-home models are they interested in? Those that prevent foster care? Group care? Residential care? Other models?
   - What kind of contract, if any, was negotiated between your program and the human services department?
3. What kinds of outcome measures are you using in order to meet the requests of either insurance companies or human services departments?




MANAGED CARE
AN AGENCY GUIDE TO SURVIVING AND THRIVING
DAVID EMENHISER
ROBERT BARKER
MADELYN DEWOODY

CONTENTS

managed care environment—without minimizing the pitfalls and challenges that lie ahead.

Child welfare agency executives, management staff members, therapists, middle managers, and board members have much to gain from reading this book. Those in the ranks of public policy, state government, mental health, and other public and private human service agencies will also find this book useful.

One of the dangers inherent in writing a book about an emerging phenomenon is that future events will overtake the authors' current perspective on the topic. To counter this, we repeatedly emphasize the core issues of managed care, lend multiple perspectives to the future of child welfare, and encourage readers to take an active role in determining the future of their agencies. Whether or not managed care is ultimately viewed as a benefit to the children we serve or as a failure will in large part depend on the results of your advocacy efforts.

We hope that this book provides the tools needed for your journey into managed care.

David Emenhiser, Ed.D.
January, 1995

EXECUTIVE SUMMARY

> One must never lose time in vainly regretting the past, nor in complaining about the changes which cause us discomfort, for change is the very essence of life.
>
> —*Anatole France [1883]*

The introduction of managed care in the child welfare field is fundamentally revolutionizing relationships among clients, funders, and child welfare agencies. Relationships that have generally held constant over the past 20 years are about to change dramatically. While managed care is often viewed as the result of health care reform initiatives, more universal forces than that are at work. The implementation of managed care is being driven by the computer revolution, high-tech communication systems, the consolidation of capital, and issues of affordability and quality. These same forces are at work in other sectors of the economy: corporate downsizing, bank consolidation, and insurance company mergers. To assume that child welfare and children's mental health agencies will not be dramatically affected by these revolutionary changes is, at best, wishful thinking.

Currently, the implementation of managed care is a state-by-state phenomenon. Over time, however, it will likely become universal. Like the aftermath of any other revolution, some of what existed before will be swept away. Some child welfare agencies will not survive the transition; others will survive only as parts of other organizations. The managed care revolution differs from past innovations—deinstitutionalization, permanency planning, and family preservation—that largely resulted from internal efforts to reform the field. This revolution is being driven by external forces. In this sense, it is comparable to the

racial and religious integration that most agencies experienced in the 1960s. Few current child welfare agency executives have experienced this kind of climatic change.

The good news is that, like all revolutions, this one will create a number of opportunities for agencies. For those agencies that prepare for and decide to embrace the new reality, a host of possibilities will emerge, including the opportunity to implement new approaches to serving children, explore new funding sources, reorganize, and build new partnerships.

This executive summary is not a substitute for the entire text, especially considering the technical and in-depth nature of the topic, but a sampler to whet the appetite of those agencies preparing for managed care.

Chapter 1: The Basics

While managed care appears to be a new phenomenon, its roots can be traced back to 1929. In that year, teachers in Dallas, Texas, joined an organization (through Baylor College of Medicine) to cover the costs of hospitalization for the group. Over time, managed care has become the predominant form of private health care delivery and financing. On the public side, it is becoming a force in the provision of health care, mental health care, and social services as state officials seek to control Medicaid and other government expenditures.

What is Managed Care?

Three major activities characterize managed care systems: (1) arrangement for the delivery of services, (2) review of the quality and appropriateness of the services provided, and (3) reimbursement of providers who deliver services. These activities are tied to the two major goals of managed care: (1) reducing the overall costs of service delivery, and (2) ensuring the quality of services that are delivered. Costs are addressed by limiting reimbursements for service and by controlling inappropriate service use through reviews of the intensity of services and their duration. Managed care plans also focus on shifting reimbursement from a fee-for-service orientation to one where service

providers share the financial risk. To ensure quality, managed care organizations (MCOs) employ an array of local and national quality standards. MCOs achieve quality care by negotiating with their providers, assessing customer satisfaction, and establishing outcome measures and procedures for continuous quality improvement.

Elements of Managed Care

While managed care may take a variety of forms, all plans have certain common elements. Each consumer is "enrolled" in the plan and agrees to its terms. Managed care plans establish networks of service providers, who agree to the terms of a contract. These providers are selected based upon the quality, cost, and range of services they provide. Clients usually access the plan through a single point of entry—a primary care provider who serves as a gatekeeper and manages client access to specialists and other plan service providers.

In addition, managed care companies use a variety of reimbursement systems designed to shift the financial risk to service providers and to control the cost of services. One approach is a capitation contract, which prepays the service provider a set monthly amount for each individual enrolled in the plan, in return for the provider's agreement to provide a range of services for that set amount. Other payment methods include discounted rates, fee schedules, and the traditional (but relatively less popular) fee-for-service plan. As mentioned above, managed care places great emphasis on continuing quality assurance and improvement, and on utilization review programs.

Managed care plans encourage enrollees to use member service providers by allowing enrollees to obtain services with little or no copayment inside the managed care network, and by requiring significantly higher copayments from enrollees who use providers outside of the plan. While managed care often take the form of health maintenance organizations (HMOs), there are a number of other forms, which offer a range of services and provide services through different types of contractual arrangements. Appendix A provides a glossary of the most common managed care concepts.

Managed Care and Mental Health Care Services

Most managed care companies offer some form of mental health coverage for their enrollees. The costs of mental health care, however, have been more difficult to control than those of physical health care, due to the subjective nature of mental health care, the lack of a single standard of care and treatment, and the variety of practitioners and treatment modalities. Managed care systems tend to limit their clients' use of mental health services by requiring a physician's referral and out-of-pocket payments for a percentage of the costs, and by restricting the number of sessions or dollar amounts covered. The trends in behavioral health care include payer/MCO-driven decision making as to the effectiveness and efficiency of the service, outcome measurement, and consumer sensitivity.

Managed Care and Medicaid

With rising competition in the private insurance market, MCOs are becoming increasingly important in the realm of public insurance programs, especially Medicaid. Under current Medicaid law, five major types of managed care are permitted: (1) voluntary participation of Medicaid beneficiaries in HMOs; (2) use of targeted case-management services included in the state Medicaid plans as an optional service; (3) state plan exceptions that allow voluntary capitated service delivery programs; (4) freedom-of-choice waivers that permit states to require Medicaid-eligible individuals to receive services through a managed care, capitated program; and (5) waivers under §1115(a) of the Social Security Act that allow states to use managed care as a Medicaid "research and demonstration" program. The fifth option—§1115(a) waivers—has generated most of the attention recently as states have used it to reform their health care systems and contain costs. Section 1115(a) waivers provide states with considerable flexibility in establishing their own eligibility rules, service coverage, and provider arrangements. In those states that have received §1115(a) waivers, some themes are evident, such as eligibility expansion, the use of cost sharing with consumers and risk sharing with service providers, and increased managed care enrollment. A number of questions have been raised by such innovative application of waivers, including concerns that shifting financial risks to service providers may actually create a disincentive to serve, and that clinical decisions are being influenced by cost.

Implications for Child Welfare Agencies

Child welfare agencies in states that are moving toward adopting a managed care system must not hesitate to address a number of practical and strategic issues. The inclusion of special-needs populations in managed health care plans offers a number of advantages for clients and agencies, including expansions in early diagnosis and treatment, increased flexibility in treatment, and new sources of funding for community-based services such as wraparound. Managed care also poses risks, however, especially for children with the most intensive service needs, who require comprehensive, long-term, and often expensive treatment, and whose placements in care are often quite transient. Child welfare agencies must ready themselves by analyzing how the goals of managed care can be met within the framework of their agencies' mission, creating compatible services and pricing structures, and comprehending legal issues regarding contracts and liability. It is during this interim period that child welfare agencies have both an opportunity and an obligation to work with MCOs to insure that the special and complex needs of their agencies' clients are met through this new system of care and treatment.

Chapter 2: Preparation and Positioning

Chapter 2's topics are most relevant to executives, staff members, and board members of agencies that are nearing the point of transition from a fee-for-service to a managed care environment. During this transition, the very survival of the agency is at stake. Agencies must begin now to prepare their leadership, programs, finances, and marketing efforts for this new climate. Chapter 2 presents a number of offensive and defensive strategies to guide agencies through the dangers of the conversion period.

Leadership

The first and most important step in preparing for managed care is to ready the agency's leadership for change. During times of crisis, those who inhabit organizations tend to close ranks behind their leader and become more dependent than ever before upon that person's guidance.

At this initial stage, CEOs need to educate themselves about managed care and assess their level of comfort with change. Simultaneously, they need to educate their management team members and boards of directors about the concepts of managed care. With this preparation as a base, they can begin to strengthen their boards by selecting new members with the needed expertise, add managed care goals to their agencies' strategic plans, and intensify their advocacy efforts to guide their states' managed care plans and their implementation.

Furthermore, leaders must realize the power of self-fulfilling prophecies, and how contagious positive or negative attitudes about the future are with staff and board members. Leaders are entrusted with inordinate power to model and communicate their visions of the future to their organizations. The ability of an organization to survive and thrive in this new environment might well be decided by its leader's attitude and perspective.

Programs

Probably the most difficult aspect of an agency's conversion to a managed care environment will be changing its mix of programs. Managed care will emphasize prevention and early intervention, will erect barriers to placing children in expensive out-of-home care settings, and will limit lengths of stay. Therapists and middle managers will experience the greatest stress during the transition because they must fundamentally change their orientation to service provision, therapeutic independence, and relationships with their clients.

Agencies can adopt a number of offensive strategies to position themselves and their programs for managed care.

1. Agencies should consider expanding their continuum of care and treatment options to offer "one-stop shopping" for families and children in need of treatment services. MCOs will be attracted to agencies that have services available 24-hours a day, that respond quickly to a crisis, and that cover a wide geographic area, especially those that have a number of regional outpatient offices to enhance accessibility.

2. Agencies should emphasize programmatic unity and ease of client transfer to "step-down" services if they are to make a successful transition to managed care. While many agencies offer an impressive array of services, they lack programmatic and clinical unity.

3. Agencies should consider unifying and streamlining their admissions processes to speed response time, eliminate multiple points of entry, and create an agencywide admission criteria. In a behavioral care setting, agencies will not have the luxury of rejecting referrals.

4. MCOs seeking service providers will be emphasizing outcome indicators to measure the success of agency treatment programs and client surveys to assess satisfaction rates. Frankly, child welfare agencies should have been employing these methods for years, but have been slow to embrace quality assurance measures and procedures. Agencies that do not have such programs in place should implement them now if they hope to have data available during the critical phase of marketing themselves to MCOs.

Three other offensive strategies with broad implications for child welfare agencies are the implementation of computer networks, utilization review, and partnerships.

Much of the innovation demonstrated by MCOs is tied to the sophistication of their computer networks. Agencies that develop or expand their networks will be able to speed their billing processes and limit the staff time dedicated to client records, thus making themselves increasingly attractive to MCOs.

Managed care will probably lead to the demise of traditional

therapeutic independence due to the implementation of utilization review systems, best practice standards, and "brief therapy" modalities. With a generous amount of training and guidance, the majority of therapists will be able to make the transition. Some, however, will not. This latter group can create an internal challenge to an agency's transition to the new reality.

Finally, agencies and their boards should consider forming partnerships with other organizations and networks. Such endeavors can strengthen an agency by teaming it with others that provide the services it lacks (e.g., chemical dependency, adult mental health, inpatient hospitalization, etc.), and by spreading the financial risk of a capitated contract. Conversely, partner(s) with a questionable commitment to quality or a weak financial structure can be a detriment. Agencies should look for partners who share their values and have trustworthy management.

Finances

The ability of an agency to provide services that respond to a need, combined with the following defensive strategies, could set the stage for a successful move toward providing behavioral health care services in a managed care environment. Defensive financial strategies use an agency's assets to ride out the storm of the transitional period.

1. Internally, or with the help of an accounting firm, agencies should conduct a profit center study to discover the exact cost of each service, not just the rate charged. This knowledge is essential during negotiations with MCOs.

2. Agencies should work with their current bank (or find a new one, if necessary) to expand their line of credit. A line of credit equal to 10% to 15% of the agency's annual budget is probably adequate. Discussions with the bank about the line of credit should begin before the funds are needed.

3. In anticipation of a period of financial strain, agencies should prepare a reduction-in-force plan.

4. Agencies with endowments or real property assets will have a substantial advantage during the conversion period. Boards, however, should be prepared for the possibility of selling unused land or dipping into the corpus of endowments as a last resort.

5. Agencies should put into place a sophisticated financial management system that provides a timely accounting of billings, accounts receivable and aging, income and expenses per program, and so forth.

6. Agencies that raise over 10% of their operational budget from private sources and apply their grant writing capability to secure local, state, and federal funds will find these efforts pay great dividends during the conversion process.

Pursuing Competitive Advantage

In the competitive environment of managed care, nonprofit child welfare/children's mental health agencies have a number of advantages over for-profit and government-sponsored providers. Nonprofit agencies have learned to provide cost-effective services that generate income, whereas public agencies are often dependent on the size of the government allocation and the taxpayers' commitment to the population they serve. Nonprofit child welfare agencies have skills and flexibility that are more in keeping with the private sector than do public sector agencies such as mental health centers.

Nonprofit agencies are familiar with the Medicaid-eligible clientele, and have long histories of serving abused or neglected children, children with emotional handicaps, and their families. Furthermore, they have mission-directed staffs that are committed to the values of quality care and treatment. These values are imbedded in the fabric of the organizations, not dictated by government regulation or motivated by the pursuit of profits.

Nonprofit agencies have a substantial advantage in that their prices are usually lower than those of government-sponsored mental health centers, and substantially below those of for-profits agencies and hospitals. Many nonprofit agencies own their facilities and have financial reserves or endowments that

lower operating expenses and provide an important cushion. In addition, an important niche market in the new order will be the combination of therapeutic services and housing, a traditional strength of nonprofit agencies. While the use of out-of-home care may be limited, it will not be eliminated, as it provides a less expensive alternative to inpatient hospitalization.

Finally, nonprofit agencies have a long history of community service and visibility, resulting in a measure of credibility and legitimacy that will be attractive to MCOs and will provide an advantage over for-profit and government-sponsored service providers.

Marketing

All of an agency's preparation and positioning will be for naught unless it develops an aggressive and entrepreneurial marketing plan that establishes challenging goals, defines a geographic territory, and identifies the MCOs that it plans to approach. Agency executives and boards should use their contacts to identify prospective MCOs, then employ a market segmentation approach to identify the needs of these companies, determine how to gain access to their leadership, and devise a plan to present the agency as the solution to their needs.

Agencies can employ a number of techniques to give themselves the inside track over their competitors. These include using state agency contacts, obtaining professional advice to structure marketing plans, and exploiting the state's bidding process to identify prospects and obtain valuable market research data. Ultimately, however, the success of an agency's efforts to secure managed care contracts will hinge on the value, price, and quality of its services.

Chapter 3: Implementation

Chapter 3, the most technical section of this book, probably deserves two readings. Capitated contracts and services lie at the heart of managed care. Mastery of this topic can ease the transition of agencies to becoming behavioral health care providers under managed care.

Capitation payment models, in existence for more than a decade, were developed to give insurance companies and employers the ability to predict their health care costs for an entire year. Simply put, capitation means that an insurance company, MCO, or service provider sets a fee per member/client to deliver some or all of the services specified under a health care plan. Behavioral health care benefits are commonly provided separately from medical and surgical benefits. This separation is known as a carve-out.

In behavioral health care carve-outs, the payer (an MCO, insurance company, or employer) pays the service provider a fee per member, per month, in the range of $1.50–$5.00. Although there are almost as many payment and plan variations as there are plans, the payment rate is typically based on several factors: (1) the basic plan benefit, (2) whether the provider can collect any copayments, (3) service utilization history of plan members, and (4) the number of enrollees in the plan. Generally, the higher the number of enrollees, the lower the payment.

Sharing Risk/Sharing Gain

Many capitated contracts include quality and cost-control rewards. If the number of inpatient days of care remains below certain agreed-upon targets, but quality remains at expected levels, service providers may receive bonus payments or share in the profits of the insurance company or MCO. While at first glance lower inpatient utilization would not appear to matter to the payer (who pays a set monthly fee regardless of use), it can matter in the long run. If a service provider's inpatient utilization is too high, over time the provider will either need to ask the payer for a rate increase or will go out of business. The payer would then need to select another provider, disrupting continuity of care, especially for clients with chronic illnesses. Such disruptions are viewed negatively by MCOs.

To determine whether or not the payer's proposed capitated rate is realistic, agencies seeking to provide services should obtain utilization and cost histories of plan members. Armed with this information, service providers can then determine the number of clinical events per 1,000 enrollees (the standard

measurement unit in managed care), and the projected cost depending on the form of treatment. Providers should consider building in a profit margin of 5% to 10% and a utilization increase risk factor of 15% over the previous highest level of utilization. In most situations, capitation rates are increased only once each year.

To succeed under a capitation system, agencies must have an initial intake triage service. This should be backed up with a 24-hour on-call contact person and immediate access to service. Many hospital admissions occur not out of clinical necessity, but because a crisis occurs after hours or on weekends, when an adequate system is not in place to respond. An improved crisis response system engages families in appropriate services. Though those services may include brief hospitalizations, more often than not less restrictive services will meet the client needs.

Coordinating with Other Services

Most child welfare agencies do not operate psychiatric hospitals. In order to enter into capitated contracts, they must have an affiliation or fee-for-service contract with an organization or hospital that has a treatment philosophy compatible with theirs. The most common model is for a psychiatrist or group to become associated with the child welfare agency, and to take responsibility for hospitalizing children and managing their hospital treatment. This increases the probability of continuity of treatment and philosophy.

Some MCOs require that their service contractors manage or directly provide both adult and child/adolescent services. Child welfare agencies should focus on their specialty of child and adolescent services, and have the MCO purchase services for adults directly from another provider. Frequently, however, MCOs choose to deliver their behavioral health care services via a single capitated contract. One approach agencies can take is to develop partnerships with organizations providing adult services, and jointly seek the capitated contract. Under such arrangements, one of the organizations holds the contract and subcontracts with the other. The organization holding and

managing the contract receives compensation for taking the lead role, assuring contract compliance, and managing the risk.

Determining the Level of Risk

If the number of enrollees is low, capitation payment rates should be high. Capitation contracts are generally determined to be too risky if the total number of persons covered is less than 25,000. When the population to be served approaches 50,000, service providers are able to spread the risk effectively and have few peaks and valleys in service requests.

Agencies entering into contract negotiations should understand the probable negotiating positions of the MCO. It is safe to assume that MCOs are primarily interested in obtaining (1) reasonable capitation fees, (2) long-term contractual relationships, (3) service providers with sound reputations, and (4) service providers with sufficient resources to accept some financial risk. While nonprofit child welfare and children's mental health programs may have lower costs than other providers, they should not assume that they are the lowest cost provider in their market. Some for-profits with extensive outpatient capability can deliver services at a lower cost than nonprofits because they are not accredited or they pay their clinicians on a contract basis without benefits.

In their contract negotiations, agencies should consider presenting an initial capitated rate bid that is in the 75th percentile of the market, and that emphasizes their quality and capability. In some markets, competitive pricing may keep rates so low that quality services cannot be delivered. It may be in an agency's best interest to not participate in capitated contracts in such markets.

Changing the Organizational Culture

To convert successfully to a managed care environment, agency leaders and their staffs need to change their culture by providing increasingly timely and professional service. This is a prerequisite to meet the needs of insurance company staff, parents who are skilled at advocating for their children, and employers who

are paying for the services. Such relationships are more typical of partnerships than the usual clinician-client relationship. Flexibility in scheduling appointments (including providing weekend and evening hours), and candor about treatment information are approaches that are more typical of nonprofit managed care than public agency contracted services.

The agency's business office personnel need to be efficient and responsive to clients. Parents in private insurance plans who receive their services from a child welfare organization will compare its business offices with those of hospitals and physicians. Fee-setting and collection procedures should be of high quality, and should convey an organizational climate that reflects concern and compassion, combined with a strong sense of business acumen. The physical plant should be maintained at a level of quality that is competitive with that of for-profit clinics and hospitals. Repairs should be completed promptly, and inpatient units should be designed and maintained to convey the high value placed on the children served and the needs of all family members. Parking availability, distance, lighting, and safety should be addressed in a customer-friendly manner.

Changing the Treatment Focus

The expression "the meter is running" clearly applies in capitated contracts. Clinical staff must learn to focus on helping children and their families identify the specific problems that are most urgent. Timelines have to be agreed upon, and parents need to be informed at intake as to what is expected from them. Capitated contracts assume that interventions will be brief and problem oriented. The administration of an agency should not enter into a capitated contract if it is not willing to adopt a brief therapy and least restrictive treatment philosophy.

Clinical staff in most nonprofit child welfare/children's mental health organizations have to accept the reality that services will have to be denied or discontinued in some cases when the insurance contract does not provide adequate coverage, even though there is need. Provider organizations may choose to provide additional services to the client on a fee-for-service basis, including a sliding fee scale, if funds are available to subsidize that care and treatment. The utilization management staff should take the lead in helping clinicians identify alternative treatment options for difficult cases.

Summary

Capitation payment models are not appropriate for many organizations because of the inherent financial risk involved, but some large, multiservice/multisite organizations and other agencies able to partner with agencies that provide complementary services may find capitation service contracts advantageous. This is especially true for child welfare organizations that have invested significantly in community-based, brief treatment services.

Chapter 4: Case Studies

Chapter 4 contains brief descriptions of eight agencies in six states that have totally or partially made the transition to the managed care system. Each description highlights the history, size, and array of services these agencies provide, outlines the key events that led to each organization's pursuit of managed care; details the process of managed care implementation; and reveals how each executive addressed issues of staff and board involvement in the conversion. Perhaps of greater importance is each executive's advice to other CEOs facing the challenge of managed care and their predictions of the future of child welfare agencies in a managed care environment.

While not every agency fits one mold, some common themes among the eight agencies that were studied emerged that may help to explain their success thus far with managed care. The budget of these agencies ranges from $7 million to $70 million, with an average approaching $10 million, which may provide the resources and economies of scale needed in the new managed care environment. The eight agencies profiled also have long histories, ranging from 80 to 145 years of existence, with the majority nearing the centennial mark. An agency that has

survived the numerous revolutions in child welfare over the years might feel increased confidence in its ability to survive the next upheaval.

Without exception, these agencies offer a broad array of services, ranging from outpatient and community-based programs to residential and, in some cases, inpatient psychiatric services. Almost universally, the agencies described in Chapter 4 entered the world of managed care through a Medicaid provider contract. Most agencies experienced a gradual evolution toward providing managed care services. Almost without exception, each experienced some level of resistance from staff and trustees, with the greatest challenge coming from the ranks of therapists and residential staff. Each agency is struggling or has struggled with the customer service, utilization review, and seamless service aspects of managed care. Finally, and perhaps most importantly, all eight agencies benefited from activist leaders, who would rather create the future for their agencies than wait for the future to be dictated to them.

Those agencies that do not fit the profile outlined above can take heart, however. While there are many similarities among the eight agencies, there are also substantial differences. Each agency profile reveals a different course taken in response to the threats and opportunities of managed care. For some agencies, the initial pursuit of managed care resulted from a traumatic event, such as the potential closure of their residential program or their state's rapid implementation of managed care contracts. Some of the agencies were or have become affiliated with hospitals, while the majority independently pursued managed care. Some agencies took advantage of their board contacts to further their marketing and implementation efforts; others had less board involvement. Some of the profiled agencies negotiated capitated contracts; others pursued contract provider status with a number of MCOs.

One of the most interesting dichotomies among the agency executives is the range of opinions about the future impact of managed care on child welfare agencies. Those executives whose pursuit of managed care resulted from their own search for additional funding sources and new ways of enhancing quality

tend to be optimistic about the future of child welfare under managed care. Those executives who reside in states where government officials are initiating managed care to contain costs tend to question the state and MCO commitment to providing quality and are concerned about the future of child welfare agencies.

Agency executives tend to like control—when the locus of control is beyond their influence, they become concerned about the motives of those who have the power to dictate the new rules of survival. Despite their standing on the optimism/pessimism scale, all eight executives view a managed care environment as inevitable.

Chapter 5: The Future

Given that managed care is a rapidly approaching reality, what does the future hold for child welfare agencies in a managed care environment? What are some of the emerging issues that executives and boards must address?

One of the key issues is the survivability of child welfare agencies, given their current organizational structure and programmatic focus. While there is certainly a threat to the future viability of organizations, a number of opportunities also exist for agencies to make substantial and positive changes. For an analogy, agencies might look to the U.S. auto industry, which has radically altered how it conducts business in order to survive foreign competition and customer demands for quality. While MCOs will, in the near term, emphasize low-cost services and interventions, over time, the emphasis will shift to quality and customer satisfaction.

Two other key points are offered: the need to invest in prevention and intervention services, and the danger presented to the child welfare field by the lack of research to support claims of programmatic success.

The Impact on Child Welfare Agencies

As managed care continues to evolve and becomes the predominant service delivery model, child welfare agencies can anticipate a range of challenges as they plan for the future. These

challenges will include shifts in service delivery philosophies; increased emphasis on prevention and early intervention services; growing competition from for-profits; integration and collaboration of resources and services; changes in the accessibility, availability, and array of services; heightened accountability; emphasis on value; creation of sound management information systems; and creation of financial and cost analysis capabilities.

Opportunities to Redesign Organizations

Agency CEOs will have the opportunity to use the unique challenges of managed care to redesign the basic structure of their organizations. These opportunities include a new emphasis on data collection and outcome measures, and the communication of these findings to payers. Managed care will also lead to the reassessment of agency services, particularly those that are the most restrictive and expensive. In particular, the agency's system of judging therapeutic productivity and the conditions of employment for therapists may undergo substantial change. Usually, therapists are paid for their full-time availability, not their productivity. Suggestions are made in Chapter 5 on how to redeploy therapists by tying employment and reimbursement to agency income and therapeutic productivity.

Furthermore, agency executives are encouraged to use sophisticated management information systems (MIS) to replace the traditional one-on-one supervisory process. Such changes may have the added benefit of providing employees with an enhanced sense of personal mastery and commitment to the goals of the agency. Finally, agency executives and boards are encouraged to reassess their agency's physical assets, particularly real property not being used for programming. The suggestion is made that unused property should be sold and the proceeds used to further the organization's mission or to fund services to clients who lack other sources of funding.

Board Management Issues

In a managed care environment, increased pressure will also be felt by agency trustees. The relationship between CEOs and boards will change as both begin to address the issues of acceptable risk, the potential for financial loss, the need for quick decisions, and the consequences of partnership/independence decisions. Board members might do well to examine for-profit governance structures that provide CEOs with great flexibility and independence so that they might quickly respond to opportunities and crises. Boards and executives may also want to reexamine their contractual relationship to provide the latter with some protection for the career risks associated with the difficult judgements that will have to be made. Furthermore, board members' traditional role of securing private contributions will need to be reemphasized, given the importance of an endowment and an independent source of funding to the agency's mission and survival.

A Closing Thought

Child welfare agencies have traditionally emphasized client needs instead of results. To succeed in a managed care environment, agencies need to focus upon results that can be obtained by using the most cost-efficient therapeutic modalities. To proceed in any other manner is to threaten the agency's future.

References

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1 THE BASICS

> There is no good in arguing the inevitable. The only argument available with an East wind is to put on your overcoat.
>
> —*James Lowell [1884]*

Managed care is not a new idea. In 1929, it appeared in an early form when teachers in Dallas, Texas, joined an organization that, through Baylor College of Medicine, covered the costs of hospitalization services for the group. Over time, however, managed care has grown, taking on many forms through which a range of health care services—going well beyond hospitalization—are financed and delivered. Importantly, managed care now has expanded to new arenas of services, including mental health and social services.

Managed care will continue to expand as both the private and public health care delivery and financing sectors face rising costs and service delivery issues. In the private sector, managed care is becoming the predominant service delivery and financing arrangement. On the public side, growing numbers of states are moving toward efforts to control the use of public dollars for health care, mental health care, and social services through managed care approaches.

At the same time, managed care has become an integral component of the national and state focus on health care reform. Many questions are being raised about the form that health care financing and delivery will take in the future and the impact it will have on providers, clients, other service delivery systems, and the parties that pay for services.

Because managed care continues to gain ground as a financing and service delivery strategy, child welfare service providers must be knowledgeable about it, its terminology (see Appendix A), and the forms it takes in the private sector as well as within

the Medicaid program. Service providers must also consider the implications of managed care for the vulnerable children, young people, and families they serve, and for the child welfare field as a whole.

What is Managed Care?

Because managed care may take a variety of forms, it defies a concise definition or description. Common to all managed care systems, however, is the integration of the financing and delivery of services. In traditional fee-for-service systems, service providers and consumers make some or most of the decisions related to the organization and delivery of services, while payers simply pay some portion of the costs incurred. By contrast, in managed care systems, payers such as insurance companies play a substantial role not only in financing services, but also in decisions related to what services will be delivered, by whom, and for how long. Three major activities characterize managed care systems: (1) arrangement for the delivery of services, (2) review of the quality and appropriateness of the services provided to those enrolled in the managed care plan, and (3) reimbursement of providers who deliver services.

Critical to an understanding of managed care is a recognition of its two major objectives—reduction of the overall costs involved in delivering services and ensuring the quality of services that are delivered.

Cost Reduction

In large part, managed care has become so pervasive because it attempts to respond to the rising costs of health care. In 1960, health care costs represented 5.3% of the Gross National Product (GNP); by 1989, health care costs accounted for 11.5% of the GNP; and by 1993, they had reached almost 14% of the GNP [Abramowitz 1993]. By the year 2000, health care costs are expected to reach $2.3 trillion or 17.3% of the GNP [Abramowitz 1993]. The spiralling cost of health care appears to be the result of a number of factors—increasingly sophisticated and expensive technology, an aging population, excess capacity of overspecialized providers, medical malpractice and/or expanding liability for medical decisions, and inflated patient demand [Abramowitz 1993; Gaucher & Coffey 1993]. Proponents of managed care point to its ability to control some of the factors driving the escalation of costs. They focus on managed care's limits on reimbursement for services and its attempts to control inappropriate use of services through mechanisms designed to review and assess access to those services, their intensity, and the length of time over which they are provided.

Risk shifting is an important cost-containment strategy used by managed care. In traditional fee-for-service arrangements, payers (usually an insurance company) bear the financial risk associated with health care coverage. Under such arrangements, if the cost of services exceeds the amount of premiums collected, the payer loses money. In many managed care systems, some or most of the financial risk in providing services is shifted from the payers to those who provide services by prepaying those providers on a set-fee basis. If the service provider's actual costs exceed the prepaid fees, the provider—not the payer—loses money.

Despite the focus on cost containment in managed care, most observers point out that, to date, risk shifting has not appreciably contained aggregate health care spending. These observations have led many to conclude that, contrary to expectations, managed care is not the solution to rising health care costs. Despite this record, however, managed care continues to be the dominant force in the health care industry, and is gaining strength in other service delivery areas as well.

Ensuring Quality of Services.

In light of managed care's focus on cost containment and reduction of unnecessary service utilization, concern is often expressed about the quality of services provided, the potential for undertreatment, and possible limitations on access to essential care. Many managed care organizations have responded to these concerns with policies and procedures that define quality,

ensure that it is monitored, and direct its evaluation after services have been provided.

Most managed care systems establish or negotiate standards of care with their providers, and oversee the care that is delivered. Frequently, managed care plans incorporate standards of professional organizations, as well as those of the communities where the service providers are located.

To a growing extent, managed care plans are integrating systems that evaluate not only the process of providing services, but the outcome of services and the level of consumer satisfaction. Plans use such mechanisms as quality control (examination of the process to determine possible problems), quality assessment (identification of outliers on selected indicators, with more intensive review of the identified cases), quality assurance (feedback to low quality providers regarding deviation from good clinical practice), and quality improvement (translation of quality into administrative and work functions) [Boland 1993]. Typically, quality indicators are used to measure conformity with existing professional standards, the impact of services on the well-being of clients, the efficiency of the therapeutic setting, the intensity of service in relation to the type of client or case, and the extent to which clients are satisfied with services received [Boland 1993]. At the same time, treatment outcome (the effect of the service on client status) and treatment analysis (a determination of the cause of poor outcomes, i.e., the patient, the service provider, or the system) have become important dimensions of quality assurance and improvement.

Elements of Managed Care

Although managed care may take a variety of forms, certain elements are common to managed care arrangements as a whole:

- **Enrollment**. Individuals agree to participate in managed care plans and administratively "enroll" in a plan.
- **Single point of entry**. Individuals enrolled in managed care plans usually obtain all or most of their services through a primary care provider. This provider must approve referrals to other providers, including specialists. Unlike fee-for-service systems, in which the client/patient may obtain services from different providers without any prescreening, managed care limits choices.
- **Arrangements with selected providers to furnish a comprehensive set of services to individuals enrolled in the plan**. The group of providers selected by managed care companies is often referred to as the provider network. The goal of the managed care company is to form a network of high quality practitioners who cover a full range of primary and specialty care, and who engage in cost-effective practice. Managed care plans develop networks in a variety of ways. They may directly contract with providers, purchase other organizations with networks already in place, or rent access to an existing network.
- **Explicit standards for selection of service providers**. Increasingly, managed care companies are facing legal liability for selecting providers who render poor quality services to individuals enrolled in their plans. As a result, they are giving careful attention to selecting providers who provide quality services. Many managed care companies use specific standards to guide their selection of service providers, a process referred to as *credentialling*. These standards may be based on those developed by independent entities that set professional standards or on community practice standards.
- **Reimbursement mechanisms**. Managed care companies use a variety of payment strategies that tend to shift the financial risk to the service provider and/or control the costs of providing services. Common reimbursement mechanisms include the following:

  1. *Capitation*: a prepaid set monthly fee paid to the provider for each individual enrolled in the plan. The fee is paid in exchange for the provider's agreement to provide a range of services for individuals enrolled in the plan.

2. *Discounted UCR*: an amount that represents a reduction in the usual, customary, and reasonable (UCR) charge for the service.

3. *Fee schedules*: a listing of services with a predetermined payment for each service.

4. *Fee-for service*: payment for service as billed by the provider. Though not popular in managed care, fee-for-service has not totally disappeared, particularly as a method for paying specialists. When fee-for-service is allowed, however, it is often at a discounted rate.

A managed care company's choice of reimbursement method depends on a number of factors, including the organizational structure of the managed care plan, prevailing market characteristics, the utilization management techniques being used, and the plan's approach to risk sharing.

- **Formal programs for ongoing quality assurance and utilization review**. Managed care companies formally review quality and appropriateness of care, both to control costs and to improve quality. In some instances, they contract with utilization management firms that specialize in determining the necessity of service. Managed care companies also use gatekeeping activities (assessment and monitoring of service needs), precertification or prior approval (authorization before service is rendered), and concurrent review (assessment during service provision to monitor the need for and appropriate intensity of services). The utilization review process generally focuses on three questions:

  1. Is the care medically necessary and appropriate in terms of both frequency and length of service?

  2. Is effective care available at a lower cost?

  3. Do patients improve because of the service?

- **Financial incentives for individuals to use plan providers and procedures**. Individuals enrolled in managed care plans usually pay nothing or a small copayment when they receive covered services from plan providers. They generally must pay significant out-of-pocket costs when they go to providers who are not a part of their plan's network. In the case of many HMOs, use of out-of-plan providers—except in an emergency or with the approval of the HMO—is not covered at all.

Forms of Managed Care

Managed care appears in many forms. Perhaps the most frequently encountered is the health maintenance organization (HMO). HMOs themselves vary in form. For example, HMOs may be *closed panel* or *open ended*. Closed-panel HMOs require enrollees to obtain services only from the selected network providers. Services received from providers outside the network must be paid in full by the enrollee. Increasingly, however, HMOs are becoming open ended—allowing enrollees to receive some reimbursement for services obtained from nonnetwork providers. Staffing of HMOs also varies. In those HMOs referred to as *staff HMOs*, all providers are employees of the HMO. *Network HMOs*, in contrast, include providers who contract with the HMO to provide certain services.

Other forms of managed care include organized groups of providers under contract with a managed care organization to provide services to individuals enrolled in plans. These groups go by a variety of designations, including IPAs (independent practitioner associations), PPOs (preferred provider organizations), IPOs (independent practitioner organizations), and EPOs (exclusive provider organizations).

A major form of managed care that exists within the Medicaid program is the prepaid health plan (PHP). PHPs resemble HMOs, but do not provide the comprehensive range of services required of HMOs. One type of PHP is primary care case management (PCCM). In PCCM programs, a primary care provider renders primary services, and at the same time, acts as a case manager, identifying the additional service needs of the client, referring the client to other providers, and overseeing the care provided.

Managed Care and Mental Health Care Services

As with health care costs in general, the costs of mental health care services have continued to escalate. Many believe that the costs associated with mental health care are, in fact, more difficult to control than general health care costs. They point to several factors: the subjectivity of psychological health care in contrast to the clearer indicators of physical health care; the variety of psychological care in terms of types of practitioners (psychiatrists, psychologists, clinical social workers, marriage and family counselors, and many others); the many treatment approaches and clinical orientations used to identify problems and render care; and the lack of a single standard of care for psychological services.

To a growing extent, managed care systems are covering mental health care services. Many managed care plans offer a single-service psychiatric managed care product that exists separate and apart from the general health care portion of the plan. Alternatively, many multiservice HMOs include mental health care services within their benefit package. Mental health care services offered through managed care plans vary widely, but may include outpatient mental health services, home-based services, day treatment, therapeutic family foster care, residential treatment, community-based group home services, and psychiatric hospital care. A 1992 study of 59 HMOs revealed that most HMOs provide some level of mental health care services [Fox 1992]: 98% provided outpatient mental health services, 83% provided inpatient services, and 24% offered partial hospitalization or day treatment. More than half of the HMOs provided mental health care services within the HMO itself and approximately 20% offered mental health care services through providers with contractual relationships with the HMOs [Fox 1992].

Though managed care systems may include mental health care services, they tend to limit their availability through the use of several mechanisms.

- **Conditions for receipt**. A plan may require a physician's referral prior to the delivery of services, prior authorization by the plan, or a determination that the client will be responsive to short-term treatment.
- **Coverage limits**. A plan may limit the services that can be provided in terms of a designated number of visits/days per year, an annual dollar limit, or a lifetime coverage limit.
- **Copayment requirements**. A plan may require out-of-pocket payments per visit/day or as a percentage of the total charges for services.

A number of trends appear to be developing in the provision of mental health care services under managed care. These include:

- **Payer-driven decision-making**. Managed care companies are becoming increasingly proactive and sophisticated purchasers of mental health services, and are playing an active role in the design, selection, and evaluation of mental health care products and services. Payers increasingly expect providers to have information systems in place to address the effectiveness and efficiency of the services provided. The level at which mental health care services are provided depends largely on the payers' perceptions of the cost, benefits, and value of the services.
- **Outcome orientation**. Over the last several years, it has become apparent that processes focused on quality assurance alone will no longer be sufficient for managed care companies. Instead, managed care systems have begun to use specific indicators of the actual difference that treatment makes to consumers. Companies now require that providers measure and establish clinical effectiveness in terms of improved mental health functioning.
- **Consumer sensitivity**. Increasingly, consumers are involved with payers and service providers in the area of mental health care services. They are playing a greater role in deciding what, where, and how mental health care services are provided.

Managed Care and Medicaid

In addition to changing the face of the private insurance market, managed care has come to play an increasingly important role in the Medicaid program. Three types of contractors provide most managed care services under Medicaid: federally-qualified HMOs, state-licensed HMOs, and prepaid health plans (PHPs).

Federally-qualified HMOs must meet the requirements of the Health Maintenance Organization Act of 1973 and offer specified service benefits. A federally-qualified HMO must be included upon the HMOs' request in the employee benefit plans offered by many employers. State-licensed HMOs must meet state certification requirements, which usually include a defined benefit package, quality assurance procedures, and provider guidelines.

Finally, prepaid health plans (PHPs) provide services under contract with the state Medicaid agency. Service providers receive prepaid capitated fees. PHPs, however, do not qualify as HMOs because they do not offer a sufficiently broad range of services. One prevalent form of PHP in Medicaid is primary care case management (PCCM). In PCCM programs, a primary care physician directly provides health care services and is also credentialled to manage the overall care of the patient and to coordinate access to specialized services. Physicians are paid a fee-for-service for the direct care they provide, and an additional monthly fee for case management services. Primary care physicians act as gatekeepers for any and all additional services that the patient needs.

Managed care arrangements for the delivery of Medicaid services vary in a number of ways. The plans may cover different Medicaid-eligible groups. For example, in all states that currently have managed care arrangements, AFDC-eligible individuals are included within the managed care arrangement; states vary, however, as to whether they include individuals eligible for Supplemental Security Income (SSI). States also vary in the geographical area covered by managed care (statewide or in certain communities only), in the type of managed care enrollment (voluntary or mandatory), in the type of service provider used (nonprofit, for-profit, or both), in the services excluded from their managed care contracts, and in the optional services they include under their managed care contracts.

Current Medicaid law permits five types of managed care: voluntary participation of Medicaid beneficiaries in HMOs; state inclusion of targeted case management services in the state's Medicaid plan as an optional Medicaid service; state plan exceptions that allow the development of voluntary capitated service delivery programs; freedom-of-choice waivers under which the federal government permits states to require Medicaid-eligible individuals to receive their services through a managed care capitated program (usually an HMO or PHP); and waivers under §1115(a) of the Social Security Act that allow states to use managed care approaches under Medicaid for "research and demonstration."

HMOs under Medicaid

HMOs that serve Medicaid beneficiaries are classified as either partial service providers or as comprehensive service providers. In partial capitation situations, the state contracts with the HMO to provide a narrow range of services, such as diagnostic services or dental care. Comprehensive HMO service providers must offer one of the following:

1. inpatient hospital services and one of the following mandatory services under Medicaid: outpatient hospital services; rural health clinic services; physician services; skilled nursing facility (SNF) care; early and Periodic Screening, Diagnosis and Treatment (EPSDT); family planning services; home health care services; laboratory services; or x-ray services; or
2. any three of the foregoing list of mandatory Medicaid services.

HMOs also may choose to provide, either directly or through contracts with providers, any optional service in the state's Medicaid plan, including clinic services, rehabilitative services, and inpatient psychiatric services to individuals under age 21.

Targeted Case Management Services

Within their Medicaid programs, states may choose to include targeted case management services—an optional, federally allowable Medicaid service. When designing targeted case management services, states are free to define certain populations or certain geographical areas of the state that have a particular need for case management services. Upon approval by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services, states can implement targeted case management services and use them to coordinate Medicaid services received by the individuals within the defined class or geographical area.

State Plan Exceptions for Voluntary Capitated Service Delivery Programs

Though rarely used, §1915(a) of the Social Security Act allows states to design innovative managed care delivery systems, through which Medicaid beneficiaries voluntarily choose to enroll in capitated service delivery plans. Some states have explored the use of §1915(a) as a way of creating health care and social service HMOs that would provide a broad range of services to defined subgroups of Medicaid beneficiaries (such as children in state-supervised care), and would use capitation as a reimbursement mechanism. As of this writing, §1915(a) has not been used in this manner. As states turn increasingly to the use of §1115(a) (discussed below), it seems likely that §1915(a) will remain unused.

Freedom-of-Choice Waivers

Medicaid law requires, as a general rule, that beneficiaries have "freedom of choice" in their selection of service provider:

> Any individual eligible for medical assistance [under Medicaid]...may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required (including an organization which provides such service, or arranges for their availability, on a prepayment basis).

Freedom-of-choice requires that states give Medicaid recipients the same access to services as persons with private insurance, and prevents states from "locking in" or limiting access of Medicaid beneficiaries to health care providers.

Section 1915(b) of Medicaid law allows states to implement managed care programs by waiving the freedom-of-choice requirement. If a state obtains a waiver, that is, approval from HCFA to limit consumers' choice, Medicaid beneficiaries can be required to use those providers identified by the state. Freedom-of-choice waivers have been used in several states to require certain Medicaid beneficiaries to enroll in HMOs or PHPs.

Section 1115(a) Waivers

Increasingly, states are designing Medicaid managed care programs through §1115(a) waivers. Section 1115(a) of the Social Security Act permits states, with approval from HCFA, to conduct "research and demonstration" programs that depart from federal Medicaid rules. Under §1115(a), states may operate their Medicaid programs in ways that vary from federal statutory requirements, as long as the new program is "likely to assist in promoting the objectives" of the Medicaid program, and the fiscal impact for the federal government is budget neutral. Many states view §1115(a) waivers as an opportunity to use Medicaid funds to reform their health care systems, and, in particular, contain health care costs. In addition, §1115(a) waivers give states the flexibility to establish their own Medicaid eligibility rules, service coverage, and provider arrangements. Most importantly, these waivers permit states to restrict Medicaid beneficiaries' health care delivery options by requiring them to enroll in managed care plans on a statewide basis.

Three themes are evident in the programs developed by states that have received approval for §1115(a) waivers thus far:* (1) eligibility expansion, (2) cost sharing, and (3) managed care enrollment.

Eligibility generally has been extended in all waiver states to

* In 1993, six states were approved for §1115(a) waivers: Oregon, Rhode Island, Tennessee, Kentucky, Hawaii, and South Carolina.

a broad group of low-income individuals, including the working poor. Upper-income limits range from 100% of the federal poverty level in Oregon to 300% in Hawaii. Several of the programs, while extending eligibility, also require cost sharing—charging individuals and families a portion of the cost of premiums, deductibles, and/or copayments, based on a sliding income scale. The use by the states of managed care arrangements* allows the delivery of a comprehensive set of Medicaid services at a per capita cost. Managed care arrangements in the §1115(a) waiver states include mandated enrollment in one of several contracted HMOs, PPOs, capitated health plans, or primary care case management programs. Figure 1 outlines the managed care features of the §1115(a) waivers approved by HCFA and commencing in 1994.

Regardless of the form it takes, the implementation of managed care under Medicaid has raised a number of questions, primarily regarding access to care and quality of services. Concerns have been expressed that the shifting of financial risk to service providers may create an incentive to underserve, and an environment in which clinical decisions may be inappropriately influenced by the cost of implementing those decisions. Equally important are concerns about reductions in the quality of care provided, particularly given the poor health status of many Medicaid beneficiaries. As §1115(a) waivers are implemented on a statewide basis, prompting widespread enrollment in managed care plans, access and quality also may become issues for special populations and individuals in rural areas that primarily had not been enrolled in managed care plans.

Implications for Child Welfare Agencies

Child welfare agency executives must meet the growing use of managed care with a solid understanding of the issues that managed care raises for the children, young people, and families

* All states approved for a §1115(a) waiver in 1993 have managed care features with the exception of South Carolina.

Figure 1
Managed Care Features of §1115(a) Waiver Programs

State	Program	Start Date	Managed Care Features
Tennessee	TennCare	01/01/94	All beneficiaries must enroll in one of 12 contracted HMOs or PPOs.
Oregon	Oregon Health Plan	02/01/94	All beneficiaries must enroll in one of 16 capitated health care plans or with a primary care case manager.
Rhode Island	RIte Care	04/01/94	All beneficiaries must enroll in a capitated health care plan under contract with the state.
Hawaii	Health QUEST	07/01/94	All beneficiaries must enroll in a capitated health plan under contract with the state. There are separate plans for dental services and mental health.
Kentucky	Medicaid Access & Cost Containment Demonstration Project	07/01/94	All beneficiaries must enroll in a managed care program or be assigned to a case manager.

their agencies serve, and for the agency as service provider. With regard to children in the child welfare system, and particularly those in out-of-home care, a number of questions arise as states move to implement managed care plans for Medicaid-eligible children:

- Who will choose the health care plan for the child—the parent or the state?
- Which managed care plan will be the child's plan—the parent's, the foster parent's, the state's? What plan will apply upon reunification?
- How will care be provided for children whose placements are highly transient?
- How will the child's mental health and developmental needs be met?
- Will the fact that the juvenile/family court has custody and control of children in out-of-home care have a bearing on how services are delivered through managed care?

On the one hand, managed care strategies may bring certain benefits to vulnerable children, young people, and their families, including expanded eligibility for services among the children and families that child welfare agencies serve (particularly in those states obtaining §1115(a) waivers for their Medicaid programs); increased emphasis on prevention and early intervention, with funding available to support these services; heightened accountability with clear outcome indicators and ongoing quality assurance; and added flexibility in service design and delivery, particularly where managed care arrangements involve wraparound services, home- and community-based services, and family preservation services.

On the other hand, a number of concerns must be addressed as managed care approaches are implemented, including the effects of prepaid capitated rates on service access and comprehensiveness; the extent to which the use of "medical necessity" criteria by managed care plans limits access to expensive intensive services; the design of benefit packages that fail to take into account the complex and serious needs of many of the children and young people served by the child welfare system; and geographical restrictions on enrollment and services that fail to take into account the transient placements of children in care.

As managed care becomes a reality, child welfare agencies must also consider strategic issues that will affect them as service providers. These issues include:

- How will the agency's managed care strategy align with its mission?
- To what extent can the agency's services be provided on a managed care basis? What percentage of services can—or should—be paid with managed care dollars, and what percentage with other funds?
- Which MCOs will be doing business in the agency's market, and with whom does the agency want to do business? Are there companies with whom the agency can afford not to do business? Are there companies to be avoided?
- After taking into account the full cost of the service, depreciation costs, and the risk of not being paid for services rendered, what price will allow the agency to cover its costs yet remain competitive? Child welfare agencies should consider using consultation and market surveys; carefully reviewing the costs of contract compliance, billing, and collections; and accounting for other factors such as delay in the receipt of insurance payments.
- What package of services will the agency offer to the managed care company? Does the agency want to offer intake and/or screening services, residential treatment, day treatment, therapeutic or specialized family foster care, and/or home-based services?
- Which professionals will be certified providers under the managed care program? Will the providers include social workers, psychologists, and psychiatrists?

- How will appropriate limits on the services provided be determined?
- What outcome measures will the agency use? What are the expected treatment outcomes and expected number of visits or length of stay for certain problems or diagnosis?

In addition to the above concerns, agencies will need to develop quality assurance systems that permit a review for appropriateness of services and allow for a response to problem areas. They must also carefully scrutinize the legal issues surrounding managed care contracts. Does the managed care company seek to limit the agency's ability to contract with other managed care companies in the future? What are the provisions regarding cancellation and rate increases?

As states and the private sector move increasingly toward managed care, child welfare service providers should position themselves to work effectively with managed care companies and should develop positive, ongoing relationships with the MCOs. Child welfare service providers must help managed care companies to see their agencies as important components of provider networks. MCO benefit packages need to offer the skills and expertise that child welfare agencies bring, including the ability of the agencies to work with individuals, families, and groups; their experience in delivering community-based services; their crisis intervention expertise; and their skills in developing a client-empowered environment. Child welfare agencies must encourage managed care companies to use benefit designs that include a broad continuum of care, incorporating inpatient, intermediate (i.e., day treatment), and outpatient services. Agencies can also encourage certain trends that respond to the particular needs of children and families served by child welfare agencies, such as permitting an expanded number of outpatient visits, including V-Codes (psychosocial diagnostic categories) as reimbursable diagnoses, and providing reimbursement for group care and home-based services.

Child welfare agencies should also encourage managed care companies to build into their plans such factors as quality,

flexibility, client satisfaction, and case management. Effectiveness and efficiency, two managed care goals, are best served when systems are responsive to the needs of clients. Child welfare service providers are accustomed to designing and implementing such systems.

Finally, child welfare agencies should participate in the growing support for programs that promote wellness and early intervention. Increasingly, managed care organizations are emphasizing prevention and early intervention, particularly in order to limit serious health care costs in the future. Child welfare agencies can assist them in integrating such services into their benefit packages.

Participating in managed care may mean some fundamental changes for child welfare agencies. Child welfare and mental health agencies have traditionally been organized along department lines. Managed care forces organizations to integrate systems for managing the array of services — thereby requiring clinical services, administration, and plant and facility management to work together. Likewise, managed care requires that agencies view their clients as repeat customers whose satisfaction with service is paramount.

Child welfare agencies must monitor managed care developments in the private and public sectors, and, whenever possible, participate in the decision-making process regarding service design and delivery/financing approaches. Whether this process is one of working with, and marketing services to, managed care companies in the private insurance sector, or participating in Medicaid waiver decision making, child welfare agencies must be prepared and positioned to move forward.

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Managed Care and the Child Welfare System

from Child Protection Leader, American Humane Association, Children's Division

The child welfare system has been experiencing significant change through the introduction of managed care principles currently applied to health care and mental health systems. Traditional providers of child welfare services are seeing relationships with the children and families they serve, and the government agencies that purchase and depend upon their services, altered by this approach. These trends pose both challenges and opportunities for the child welfare community.

What is the impetus for implementation of managed care in child welfare? It is primarily an interest in cost containment. Furthermore, some believe that managed care is more efficient, resolving a fragmented delivery system by enabling the formation of continuums or networks. Another driving force in this scenario is the increasing demand for the reduction of government expenditures, waste, and duplication.

What effect will the forces driving the implementation of managed care have in the child welfare arena? In other systems where it has been implemented, its hallmarks are:

service delivery is organized through a selected grouping of providers; arrangements exist for the review of the appropriateness of the services provided; the managed care system exercises control over reimbursement methods for providers; and service intensity is planned in advance, based on an assumption about an appropriate quantity of intervention given certain presenting conditions.

Some of these factors may bring positive changes and efficiency to child welfare practice, but others may put children at risk, especially those who require intensive, comprehensive long-term treatment.

Most different for children and families in a managed care service delivery system is the tendency of insurance companies and government agencies; (1) to assume that a prescribed number of activities or visits will result in effective "treatment" of a family problem or condition that led to abuse or neglect, and (2) to limit access to behavioral health care services by requiring physician referrals and restricting the cost and quantity of treatment. (These changes are partly due to an admitted need for accountability and outcome data to justify treatment).

Child welfare agencies must, however, prioritize children, not claims reimbursement. A medical model that limits "treatment" is not appropriate in issues of child protection where additional diligence must be exercised to ensure that children remain safe. Moreover, a medical focus exclusively on a family's presenting problems flies in the face of social work models for strengths-based practice in working with troubled children and families.

To meet the challenge of continuing responsibility for child safety and adequate

service provision, private child welfare agencies will need to find new ways to measure and demonstrate the effectivness of the services they provide in achieving positive outcomes for children and families. An emphasis on cost efficiencies achieved through preventive care will serve these providers well in the changing environment in which they must now operate.

Public agency administrators must also respond to increasingly complex contract and legal issues, which pose the potential for new areas of liability. Even with pressure to shorten the duration of services, public agencies cannot compromise the safety of children in their care. Nor can they lose sight of their legal mandate to protect children. Administrators must also ensure that the contracting process continues to include smaller, diverse community-based providers in the delivering of child welfare services. The special challenges of bilingual and bicultural families must be acknowledged.

On the positive side, implementation of managed care presents both public and private child welfare agencies with a number of opportunities. Managed care organizations generally select provider groups based upon the quality, cost, and range of services they provide. Thus, smaller private providers can explore the possibility of joining with complementary providers in larger groups or networks. This gives the group maximum bargaining power with managed care companies and other third-party payers such as state child welfare service departments.

Just as private health care providers must now be more sensitive to the effectiveness, efficiency, and outcome of their services so, too, must child welfare providers now track these service quality indicators with increasing proficiency. Consumer satisfaction with services will also play an increasingly important role in a managed care environment; yet it is a factor which has not been sufficiently evaluated by child welfare agencies.

Because there is an ongoing need for reform and improvement in our child welfare system, implementing managed care can serve as a catalyst for public child welfare agencies, as they develop managed care contracts, to reward those providers who offer the best services to children and families at the most reasonable cost. Providers who join in a single network will also strengthen the depth and breadth of capabilities they can offer through the agencies who join the alliance.

In the final analysis, the transition to managed care in the child welfare environment can only be successful if it moves the system further toward its goal of improving the lives of troubled children and their families. If agencies use this opportunity to ready themselves to improve service quality, emphasize preventive care, and achieve efficiencies in cost and information management, then they will have used the change that is occurring to its greatest advantage. The focus must remain on the children and families that the system is designed to serve, however, or supposed improvement in efficiency of management will be bought at the cost of grave danger to the very people whom the system should protect - the children.

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Further information on implementing managed care in child welfare agencies and other challenges facing the child welfare field will be presented in a Roundtable by the Children's Division of American Humane Association, "Keeping the Focus on Kids: Outcomes, Ethics and Partnerships in a Managed Care Environment, scheduled for June 3-4, 1996 in Vail, Colorado. For information on this meeting, contact Michelle Shumaker at 1-800-227-4645 or FAX: 303-792-5333.

Posted by:

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

PRINCIPLES FOR SYSTEMS OF MANAGED CARE

The Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS) provides national leadership for improving the quality and availability of treatment and prevention services for mental illness, particularly with respect to adults with serious mental illness and children with serious emotional disturbances. As part of its mission, CMHS promotes policies for managed care systems by:

- promoting policies and standards for managed care systems that reflect equity and parity in the treatment and rehabilitation of persons with mental health care needs with other health care needs;
- fostering the development of linkages and partnerships among and between critical stakeholders such as consumers, family members, advocates, Federal agencies, States, counties and local communities, native American tribes, purchasers, managed care organizations, and providers working within managed care systems;
- providing training and technical assistance to all stakeholders in the mental health field in key policy areas for managed care systems;
- collaborating with managed care systems to encourage the provision of high quality and effective clinical and support services to promote a high quality of life for persons with mental health care needs; and
- promoting strategies for expanding health insurance coverage for individuals who are under/uninsured.

CMHS recognizes that changes in health care financing and organization make it imperative that all stakeholders work collaboratively in an effort to deliver accessible, appropriate, comprehensive, culturally competent, cost-effective services of the highest quality.

Policies and practices should address the concerns of all stakeholders in the system and ultimately be responsive to the rights and needs of the individual receiving the service.

Responsibility for the public health and well being of our citizens should be shared. To foster this goal, the following principles are offered to all stakeholders as public and private sector system integration occurs.

QUALITY OF CARE

Managed care systems should:

- treat all persons with respect and dignity;
- be based on "best practices," model programs, innovation, and continuous quality improvement;
- develop delivery and data collection systems to address the unique developmental needs of children and their families;
- ensure that services are tailored to individual needs and preferences, provided in the least restrictive and most natural setting possible and built on the strengths of the consumer and family;
- establish credential verification programs, assess critical provider skills and competencies, and provide necessary training to facilitate human resource development;
- provide mechanisms for resolution of provider disputes;
- ensure that services for adults directly include a continuum of care consisting of, but not limited to, a comprehensive array of flexible community living supports including prevention, treatment, rehabilitation, support, psychiatric rehabilitation, intensive case management, residential treatment, crisis, and self-help services and also provide effective linkages to other health and social services;
- ensure that services for children directly include a "wrap around" approach consisting of, but not limited to, flexible, individualized, strengths-based, family-driven services incorporating respite care, case management, day treatment, recreational support, and other non-traditional home and community-based services and also provide effective linkages to other health and social services; and

- incorporate targeted prevention activities, especially at key points of life transitions.

Consumer Participation and Rights

Managed care systems should:

- meaningfully involve consumers and family members in the planning, development, delivery, evaluation, research and policy formation of managed care systems including the determination of "medically necessary" services;
- respect consumer choice of services, providers and treatment and assure consumer informed voluntary consent. Individual treatment plans should be based on the preferences and needs of consumers and families with children;
- ensure that consumers receive necessary legal and ethical protections and services;
- provide education to consumers and family members on their rights and responsibilities;
- establish grievance, mediation, arbitration, and appeals procedures to resolve consumer disputes in a timely manner. Ombudsman services should be provided. Necessary services should continue pending dispute resolution;
- support consumer rights and empowerment by providing education about, and access to, local self-help groups and protection and advocacy organizations; and
- ensure that confidentiality and privacy of consumer health care information is protected at all times, particularly as electronic information systems develop and expand. Release of specific information should occur only with a signed release from either the recipient of services or their legal guardian/representative.

Accessibility

Managed care systems should:

- ensure that services are culturally and linguistically appropriate, available, acceptable, and accessible (including geographically) to all individuals, with particular attention to vulnerable populations;
- provide education about mental health benefits and ways to access emergent, acute and routine care;
- provide services for individuals with pre-existing illness;
- work with provider networks that include community providers experienced in working with vulnerable populations;
- make available necessary specialized services required by participants that are not available through managed care system provider networks; and
- ensure continuity of care during transition from the current system to managed care environments and among different managed care systems as contracts change.

Affordability

Managed care systems should:

- provide affordable interventions at all levels of the continuum of care to reduce the prevalence and/or severity of mental illness and resulting disability through early prevention and identification of risk factors;
- ensure reasonableness of out-of-pocket costs and provide full access to critical services, especially for indigent populations; and
- provide appropriate mechanisms for consumers who want to seek care from providers who may be outside the established networks.

Linkages and Integration

Managed care systems should:

- coordinate with primary health care and substance abuse systems;
- utilize interagency collaborations with human services agencies such as public health, social service, child welfare, education, juvenile justice, criminal justice and long-term care systems; and
- assure linkage to critical services such as employment supports, housing, transportation, self-care and mutual support organizations, education and training opportunities, and rehabilitation service.

Accountability

Managed care systems should:

- engage stakeholders in developing and assessing quality assurance standards, and in incorporating performance, outcome (e.g., recovery and community integration) and consumer satisfaction measures to evaluate plan performance over the long-term, including measures of access, appropriateness, quality, outcome, and cost effectiveness;
- employ various evaluation methods including report cards and consumer satisfaction surveys and make the information available for further analysis;
- collect, analyze and publicly disseminate reliable information to foster system accountability and quality improvement; and
- develop information systems at the provider and managed care network levels collecting data on demographics, service utilization, revenues, costs, service outcomes, service provider performance, consumer satisfaction, and quality of life.

CMHS welcomes input and suggestions for subsequent updates of these principles

For more information, call the CMHS Knowledge Exchange Network at 1-800-789-CMHS(2647).

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MANAGED HEALTH CARE FOR CHILDREN IN FOSTER CARE: A GUIDE FOR PURCHASING SERVICES

All children are dependent on others for their care and well-being. But unlike most children, those in foster care have complex problems rooted in family, social, and environmental conditions. They need a range of physical and mental health services to overcome the effects of abuse and neglect. Yet many are placed at great distance from their families and may be moved suddenly and frequently in and out of care from one foster family home or facility to another, sometimes between counties and states.

To respond to these complex issues, CWLA has developed a guide on managed health care. It is hoped that this guide, along with its companion volume, A Guide to Managed Health Care for Foster Parents and Caregivers, will help to bridge the gap that currently exists between managed care as a service delivery and financing strategy and the broad and complex needs of children and young people in foster care.

The Guide has two major objectives:

- to help state and managed care organizations chart a course of action to increase the effectiveness of health care programs as they expand their Medicaid managed care programs to beneficiaries with more complicated needs; and

- to help child welfare agencies become more effective in negotiating for Medicaid managed care and overseeing the health of children.

To achieve these objectives, the Guide provides:

- An explanation of how the Medicaid, managed care and the foster care systems operate.

- An overview of the special needs of children in foster care.

(over)

- A checklist of health care and auxiliary services managed care organizations must provide to meet these needs appropriately.

- A list of questions for child welfare workers to ask about services available from the state's plan.

- An examination of a state's legal responsibilities for the health of children in foster care.

- An outline of steps that child welfare service providers and advocates must take to ensure that managed care approaches meet children's needs.

- Suggestions on how to expand eligibility for children's services (including greater access to prevention and early intervention services), create greater flexibility in service design and delivery, and ensure increased accountability and emphasis on outcomes.

- A look at potential barriers to services, such as "medical necessity" criteria.

FOR FURTHER INFORMATION OR TO DISCUSS THE GUIDE
PLEASE CALL ELLEN BATTISTELLI AT 202-942-0258

9/5/96

Building a Better Children's Service System Using Managed Care

by Carl Valentine*

Funding cuts at federal, state and local levels are eroding services for children and families at a time when the number of children at risk of abuse and neglect continues to rise. The runaway cost of out-of-home care for children continues to trouble state leadership. Creating a better service delivery system is possible by incorporating the best of child and family services with the technology of managed care.

More public child welfare programs, in partnership with private child care providers, are applying managed care strategies to child welfare services in order to measure outcomes, increase access, improve quality and reduce cost. Common features of these initiatives include: private sector service delivery monitored by the public sector; outcome-based payment; flexible funding; common initial child and family assessment/treatment planning process; integrated service provider network with a full array of services; common treatment protocols and creation of service profiles; internal utilization review and quality control; client-driven management information system and performance contract management.

Without a commitment to service quality, the result could be a system driven by short-term cost reduction. Services should respond to the needs of the whole child and take family strengths as well as family-child problems into account. Further, services should be neighborhood/community based and draw on kinship and other informal supports as well as best professional practice. Service interventions should be culturally compatible and structured for long-term success.

The Child and Adolescent Service System Program (CASSP), developed by the National Institute of Mental Health has incorporated these principles in offering services in the home and community. Applying the CASSP model to child welfare requires a paradigm shift just as it has in mental health. Children and their families would receive case management, crisis intervention and other support services from a neighborhood service center. Out-of-home care would be prevented whenever possible through Intensive Family Preservation Services. Any time away from home for a child would be as brief as possible and accomplished within the neighborhood to minimize disruption of the child's life. Collaboration with other service systems in the neighborhood would provide early intervention/prevention, mental health and substance abuse as well as basic health and education services to high risk children and their families.

Federal officials and some foundations are encouraging communities to build neighborhood-based child welfare systems. The resources of the child welfare system alone are not sufficient to meet demands on the system if it continues to stand alone investigating child abuse and neglect and relying on expensive foster care. The few outcome studies in the field depict a broken system that generates unacceptable results. A neighborhood-based child welfare service delivery model is most likely to promote longer-term safety and social, emotional, developmental well-being for children, because family support services are available at all times—not only when a child welfare case is current. People who know the family and see the child on a regular basis can initiate helpful interventions. This component is largely missing from the traditional child welfare system.

Health care, income supports, housing and general services such as day care, Head Start, parenting education and client advocacy all have their own rules and funding, but are essential to the success of the neighborhood-based system. Where the system is working well, bridges have been built among various systems so that they become mutually supportive.

Application of managed care can either enhance or destroy the model. Managed care provides flexible funding based on outcomes rather than units of service. It also provides early intervention, strategies for avoiding deep-end costly services and the mix of professional, para-professional and informal supports for maximum service at lowest cost. Managed care can provide outcome data that indicate what tax dollars achieve, which strategies work, satisfaction level of recipients and the areas requiring improvement.

Child welfare, with the most service resources, should be a major participant in the development of this service delivery system. However, child welfare resources are not used until abuse or neglect occurs and do not remain for the long term. Managed care can support, and even drive, the development of an improved service delivery system if the managed care system incorporates early intervention, prevention, mental health and other allied services and if funds can be used flexibly.

*Carl Valentine, Senior Consultant at the Institute for Human Services Management in Bethesda, Maryland, has consulted with many public and private children's service agencies on service delivery and funding issues.

Public Sector Managed Care for Children and Families

by Keith Schafer[1]

Almost everyone who delivers publicly funded human services believes managed care is on the horizon for their agencies. Most have a strong opinion about how good or bad that will be for them and the people they serve. Some time ago, I was asked by a coalition of providers to make a presentation on managed care that they had entitled, "The Wolf is at the Door"! Not well-known in their state, I suspected that they were talking about the topic, not me.

I once believed that managed care was either the "Luke Skywalker," or the "Darth Vader" of our public sector programs. I was as wrong as my colleagues were with their wolf analogy. *Giving managed care a personality as a force of good or evil creates a mythology that can immobilize the people who should ultimately determine its values and composition.*

Giving managed care a personality as a force of good or evil creates a mythology that can immobilize the people who should ultimately determine its values and composition.

Managed care is a set of tools and a service delivery framework. The tools are not unlike those previously used in publicly funded programs, just much more powerful. These tools, when combined and used in capitated, risk-based systems, are likely to have a profound impact on the culture and behaviors of publicly funded systems of care. The tools themselves are value neutral. *The values, goals and operating principles of a managed care system are determined by the people who design and control it.* If administrators, clinical staff, consumers, families or stakeholders are unhappy with how their managed care system works, it is probably because they designed and priced it poorly, or worse yet, were not involved in the design process at all.

Effective public sector managed care requires shared oversight among public administrators, consumers and their families, provider representatives, stakeholders who fund or refer consumers and the managed care organizations (MCOs) that control the day-to-day operations of the system.

I am skeptical that proper oversight can occur in public sector managed care systems solely through multi-year contracts written by state or county funding agents. Managed care systems are dynamic and, by definition, should be constantly changing and improving. Contracts must be supported by an oversight process that is capable of making the constant adjustments necessary in a managed care services system. Smart funding agents will create oversight bodies of MCO, provider, consumer and stakeholder partners, who will take the system far beyond the vision of the contract.

Continuing involvement of all the players in the oversight process promotes shared ownership and responsibility regarding the quality and efficiency of the system. This reduces the risk that people affected by the system will feel alienated from it. Many managed care companies still need to learn important lessons about the power of inclusion in the control process. A few already have and are its strongest advocates.

The Power of Managed Care

The summer before my senior year in college, I worked at a company that made wood products. On July 4, all the regular guys were off and we part-timers stayed to work. My job that day was to operate a pallet saw, a very powerful tool that could cut hundreds of boards to precise lengths in a day. Its function was fundamentally the same as my grandfather's hand saw. It was just more precise and infinitely faster. Somebody more experienced than I had set the controls that morning, so that when I laid a board against the saw's fence and pushed a button with my hip, a saw blade zipped out and cut the board exactly the right length. If those fences had been set improperly, I would have cut a lot of boards too short very quickly.

About noon that day, I placed my hand in the wrong spot and promptly lost a thumb. I learned how dangerous powerful tools can be in inexperienced hands. Not only can they be harmful to the user, they can cut a lot of boards short if those fences are not set properly.

Key Ingredients To Effective Public Sector Managed Care Systems

So how do you set the fences right when it comes to managed care? I believe that four key ingredients determine, in large part, the effectiveness of your managed care system:

1. Accurately estimating the costs of the system (pricing)
2. Meaningfully involving consumers and family members in the design, oversight, implementation and evaluation of the system
3. Blending funding streams into capitated payment mechanisms with incentives for MCO's, service providers, and perhaps even consumers, through clearly defined performance indicators

If a capitated managed care system is underpriced, it will inevitably be forced to deny access to eligible people and limit needed services if it is to survive financially.

4. Measuring the fundamental quality of the system by:
   - the ease of consumer access to services
   - a limited number of measurable, desired consumer outcomes, established by all involved in the system, particularly consumers and their families
   - degree of satisfaction of consumers, families, providers and stakeholders

Pricing a Managed Care System

No matter how skilled you are at manipulating the tools, if you don't have enough of the right materials, you can't build the house. If a capitated managed care system is underpriced, it will inevitably be forced to deny access to eligible people and limit needed services if it is to survive financially. This is the major criticism, often justified, of managed care today.

These are the basic steps that need to be completed to price a system:

1. Identify and describe the potential problems and needs of each population to be served (the typical state Medicaid program actually serves 7-11 discrete populations)
2. Establish the desired consumer outcomes the system will try to achieve for each population. For example, for first time pregnant teenagers, desired outcomes might be:
   - No second pregnancy until high school is completed
   - High school graduation or GED equivalency
   - Full term pregnancy and delivery of a healthy baby (not prenatal care, which is the service to achieve the outcomes)
   - Child and mother remain safe and healthy while served
3. Establish a specific services menu and protocols for each outcome, estimate service utilization for each population, and set unit rates (cost per service event).
4. Identify and estimate the cost of the administrative processes
   - System design and pricing costs
   - Provider network development and management
   - Utilization management and reporting processes
   - Quality improvement and systems evaluation processes
   - Appeals and grievance processes
   - Management Information Systems
   - Claims processing and financial management
5. Compare the desired budget with the funds available to operate the system.
6. If the desired budget exceeds available dollars, you must adjust in one of the following ways:
   - Reduce populations to be served
   - Reduce desired outcomes to be attained
   - Find more money for the system

If you cannot do one of the three, do not capitate your system!

Meaningful Consumer and Family Involvement

We all say we believe in it, but do we really?

- Are you and your MCO willing to have more than a token number of voting consumer and family representatives on your management oversight board?
- Will you ask consumer and family representatives to sit on standing advisory bodies to help set desired outcomes, design the system and monitor its performance?

- Do you have valid and representative ongoing satisfaction assessment processes?
- Do consumers and families know about your appeals and grievances processes, and are those processes timely and responsive?
- Do consumers have easy access to your system?
- Do you understand language and cultural characteristics that affect how consumers view your services?
- Do consumers and families help decide how annual budgets are spent, including reinvestment into the system?
- Do you pay experienced consumers and families to work with new consumers and families, and have other opportunities for consumer-operated services?

If you can answer "yes" to the above questions, you probably have meaningful consumer involvement. True consumer-friendly systems offer more than advisory opportunities by sharing governance and oversight responsibilities with consumer and family representatives.

Blending Funding Streams in Capitated Systems

Pooled or blended funding streams and the assumption of financial risk inevitably lead to managed care. If you are offered a flat amount annually for each individual eligible to receive services, on the condition that you must provide all necessary services to each person covered, you will be very interested in how well the system is priced as well as in what performance indicators you must meet to comply with contract requirements and be considered a high-quality system. You'll also want to know about less costly prevention and early intervention services, and in acquiring insightful data that indicate how you are doing. If you are financially rewarded for operating an efficient system that meets performance requirements and held accountable for any cost overruns, you will seek the most innovative ways of doing business.

Properly priced, performance-based managed care systems reward the brightest and most innovative providers.

Properly priced, performance-based managed care systems reward the brightest and most innovative providers. Sadly, our fee for services systems never did this. Often they perversely affected providers who tried to innovate, be cost efficient, and individualize their service approaches.

Measuring Performance in Capitated Environments

A managed care system should have measurable and realistic performance expectations that are given as much importance as cost in measuring its effectiveness. These performance indicators should include the following:

1. Were eligible individuals able to access the system easily and were they treated with dignity?
2. Were the prescribed services consistent with the assessment of problems, needs and desired outcomes identified for each family? Were they delivered? In a timely fashion?
3. What outcomes occurred for the people who were served? Many believe that outcomes are hard to define and harder to measure, wishing for national uniform outcomes and standards. It is more appropriate for each system to develop its own outcomes. Outcomes are our best value statements about what we think should happen for our consumers based on what we know now. The list we choose today would have looked much different 20 years ago, and hopefully will look a lot different 20 years from now. Consumers and families can tell you what outcomes should be measured. *Your problem will not be in defining outcomes, it will be in getting consensus about which of the many worthy outcomes you can afford to include in your system. Remember, each outcome has resulting services and measurement costs.*
4. What was the nature and disposition of appeals and grievances in the system and was resolution timely?
5. How satisfied with the system were consumers, families, providers and stakeholders?

No-one should create a capitated managed care system for publicly funded programs without clearly defined and measurable performance indicators to determine quality. Managed care is very simple in one regard. It gives you exactly what you ask of it. If you only ask for savings, that's what you are likely to get. Managed care systems driven only by cost cutting objectives are likely to cut a lot of boards short very fast.

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BUILDING A BETTER CHILDRENS SERVICE SYSTEM USING MANAGED CARE

Institute for Human Services Management

Funding cuts at federal, state and local levels are eroding services for children and families at a time when the numbers of children at risk of abuse and neglect continue to rise. True, federal entitlement funding,(Medicaid, AFDC, Food Stamps, IV-E Child Welfare), did not become block grants as we feared just a few weeks ago. But don't go to sleep, the public has not suddenly gained confidence in public child welfare. National leadership has not given up the idea of a balanced budget. The need to control run-a-way cost of out-of-home care for children continues to trouble state leadership. How can public funds be used more effectively to support at risk children and their families? How can the effects of these investments be reported to the public to create a willingness to maintain and perhaps even increase funding for child welfare? Difficult times call for new approaches. Lets use this lull in federal action, as attention turns to the presidential election, to build a service delivery model that incorporates the best of child and family services with the technology of managed care to create a better service delivery system for high risk children and their families.

Over the last several years increasing numbers of public child welfare programs in partnership with private child care providers are following in the footsteps of behavioral health by exploring the feasibility of applying managed care strategies to child welfare services for high risk children and their families. Objectives of such managed care systems are: increased access to care, improved quality of care, reduced cost of service delivery and measured outcomes. Common features of these managed care initiatives include:

- private sector service delivery monitored by public sector,
- outcome based payment,
- flexible funding,
- common initial child and family assessment/ treatment planning process,
- integrated service provider network that offers a full array of services,
- common treatment protocols and creation of service profiles,
- internal utilization review and quality control,
- client driven management information system, and
- performance contract management.

The application of these tools to child welfare without a commitment to service quality and a vision of how such a system should function could lead to a system driven by short term cost reduction. Best practice dictates services should respond to the needs of the whole child in the context of family where family strengths as well as family/ child problems are taken into account. Further, services should be neighborhood/ community based and draw on kinship and other informal supports as well as best professional practice. Service interventions

should be culturally compatible and structured for long term success. This simple service delivery model called CASSP, Child and Adolescent Service System Program, (see Diagram 1) was developed and promoted by NIMH for child and adolescent mental health services over the past ten years as a means of offering intensive treatment services in non-traditional settings of home and community. The compelling nature of this model is its simplicity, its incorporation of family in the treatment model and its use of individually tailored "wrap around" services packages making use of informal as well as formal professionally provided services.

The application of the CASSP model to child welfare services will require a significant paradigm shift just as it has in mental health. At risk children and their families would be provided case management services, crisis intervention services and other family support services like protective day care, parenting education from a neighborhood/ community based service center. Out-of-home care would be prevented when ever possible through intensive family preservation services, goal oriented time limited services lasting from 4 to 12 weeks. When out-of-home care becomes necessary for a child, the time away from home would be as brief as possible and accomplished within the neighborhood when ever possible to minimize disruption of other aspects of the child's life. Therapeutic family foster care would replace residential treatment for many children. Collaborative efforts, bridges, interagency agreements, among other service systems working in the neighborhood would enable early intervention/ prevention services, mental health and substance abuse services as well as basic health and educational services to be available for these high risk children and their families. (See Diagram 2 showing the array of services available at or through a neighborhood based service delivery system.)

Federal officials along with various foundations have been encouraging communities to build neighborhood based child welfare systems with high degrees of collaboration among the various service systems as the most effective way to address the needs of these high risk children and families. There are not sufficient resources within the child welfare system to meet the demands being made of that system if it continues to stand alone investigating child abuse and neglect and relying on expensive foster care as the service solution of choice. The few outcome studies in the field depict a broken system, generating unacceptable results. The general assumption driving the neighborhood based child welfare service delivery model is that such family focused, neighborhood based services are most likely to promote longer term child safety and child social, emotional, developmental well being, because family support services are available through the neighborhood service delivery system at all times whether or not a child welfare case is currently open. There are people who know the family, see the child on a regular basis in school, in the after school program, at church, on the playground, through a mentoring program, etc., that can initiate helpful interventions when necessary. It is this long term early intervention component that is largely missing from the traditional child welfare system..

For the CASSP model to function for child welfare, it must draw on resources of parallel and related service delivery systems. For example the public education system must be

working collaboratively with child welfare for the CASSP model to function effectively. The local school must be able to serve at risk children temporally placed in foster care or use of neighborhood based family foster care will not be successful and more expensive residential treatment with its on campus school may have to be used. For the schools to serve children experiencing family crisis and deal with the often related behavior problems, the teacher/ school principal may need support from a social worker provided by or through the family service center who supports/ assists the child's teachers, while working with the child, the foster family and the natural family, to provide a consistent treatment approach related to all sectors of the child's life.

Another example of a service system essential for the success of the CASSP model for child welfare is mental health/ substance abuse treatment. Often the crisis precipitating child welfare intervention is related to parental substance abuse. Child welfare funds are rarely available to pay for substance abuse treatment services for the parent, but without such treatment the child can not be returned home. Similarly, mental health counseling, crisis stabilization, may prevent the need for foster care placement for children in the family. And, mental health services can continue to support a family long after the child welfare case is closed.

Health care, income supports, housing, and general services like day care, Headstart, and parenting education, client advocacy all have their own rules and funding, but are essential to the overall success of the neighborhood based child welfare service delivery model. Where this neighborhood based collaborative system is working well bridges have been built between and among these systems so that they become mutually supportive of each other. (Diagram 3 depicts each of these service delivery systems and how they merge into an integrated service delivery system at the neighborhood service center.)

The application of managed care to this model can either enhance or destroy the model. Managed care does provide an opportunity for flexible funding based on outcomes rather than days or units of service, common service protocols, intake procedures, case planning and case management and services tailored to the particular needs of the child and his/ her family. It also can provide early intervention, maximum use of strategies for avoiding deep end costly services, and the blended mix of professional, para-professional and informal supports for maximum service impact at lowest cost. Furthermore, managed care could provide outcome data the would help the broader community better understand what their tax dollars were achieving, providers understand which service strategies were working in which situations, and key stakeholders an indication of client satisfaction and areas requiring improvement.

If the boundaries of the managed care program are sufficiently inclusive to bring most of the key child and family service programs inside the system the flexibility alluded to above can be achieved. But, should each service system develop its own managed care approach, fences will be built around each system making the kind of collaboration the community has become accustomed to almost impossible. Child welfare workers in states where foster

children have been brought under managed care for purposes of health care, are often experiencing increased difficulty accessing health care for custody children, as the child switches from the child's family health care provider to health care providers associated with each successive out-of-home care placement. Similar service difficulty can be expected if the boundaries of managed care are tightly drawn around mental health. Once the boundaries are set and the available funds fixed, mental health will try to limit access, and curtail service early before all factors including those relating to the family are in place for the child to return home. To obtain services, provided in the past without cost through open ended Medicaid reimbursement, child welfare will have to purchase the mental health services they require for their clients. Further, collaborative intake arrangements and early intervention mental health services provided in the schools would no longer be largely self-supporting through open ended Medicaid reimbursement, rather they would have to be supported from the limited managed care allotment, or purchased by the school or child welfare agency.

Thus, managed care can become a significant partner and stimulant for the development of a new child centered, family focused, community/neighborhood based service delivery system for children and family services. Child welfare should be a major participant and prime mover in the development of this service delivery system. Child welfare is the system with the most child and family service resources, but these resources enter to late, with the finding of child abuse or neglect, and do not remain for the long term. If these funds could be used more flexibly and the boundaries of the managed care system also incorporate early intervention, prevention, mental health and other allied service systems, managed care can support and in fact will drive the development of the neighborhood based service delivery system that can better address the challenges facing child welfare today.

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■ ON THE ECONOMY

BY SUSAN DENTZER

Shedding light on managed care

In health care, as with anything else, yesterday's solutions set the stage for today's problems. So it is with the boom in managed care – today's answer to yesteryear's unmanageable health costs and the excesses of unfettered "fee for service" medicine. Roughly 56 million Americans are now enrolled in one leading form of managed care – health maintenance organizations, or HMOs – up from a mere 6 million two decades ago. Megamergers and high CEO salaries of giant managed-care plans are now front-page news – and the industry complains, with some justification, that a raft of "HMO Killed My Baby" stories vastly outnumber those about HMOs helping women carry their pregnancies to term. All of this is a far cry from HMOs' humble beginnings, when their emphasis on preventive medicine at prepaid rates made them a counterculture movement within health care. As wags have joked, this may be the only U.S. industry to go from being considered a communist plot to a capitalist conspiracy in a little over a decade.

With that transformation has inevitably come growing oversight of managed care: The American Association of Health Plans, an industry trade group, reports that it is tracking roughly 2,000 pieces of managed-care legislation in various state legislatures. Many are thinly veiled efforts by threatened interests, such as physicians and other providers, to topple the entities that increasingly hold health care's financial reins. But at the same time, the huge economic and social shift inherent in managed care couldn't possibly take place without producing trends that genuinely warrant scrutiny – such as some questionable practices at Connecticut-based Oxford Health Plans that I wrote about in a recent column. We need to understand these trends if we're to succeed in improving managed care, rather than simply defeating it.

How to survive until the Golden Age, when health plans compete on quality

The role of risk. At the heart of many of today's managed-care arrangements is this question: Who assumes the risk, or the upside costs, of health care? In old-style "indemnity" insurance plans, the people who paid the bills did; providers treated patients as they saw fit and passed on the tab to insurers, employers and patients. In HMOs and many other managed-care plans, that risk has been shifted: now providers and insurers bear it in a way that gives them incentives to restrain costs. Health care buyers pay an HMO a fixed annual premium per patient; HMOs in turn may pass on a similarly fixed per-patient amount to doctors. If costs for treating that patient ultimately rise above these fixed sums, the HMO and its providers swallow the difference.

You don't need an M.B.A. to figure out that "the easiest way to make a buck now in the health insurance system is to avoid sick people," notes James Tallon Jr., president of the United Hospital Fund, a New York nonprofit group engaged in philanthropy and health services research. And indeed, the paramount tension in the industry is between that incentive – shunning high costs – and society's expectation that health insurance will cover necessary care. This tug of war manifests itself continually. For example, until recently health plans refused to pay for costly experimental bone-marrow transplants for breast cancer patients. Patients sued, courts ordered plans to cover the care – and now a forthcoming study by Congress's General Accounting Office shows that most HMOs in most states now pay for the procedures.

This pattern is likely to repeat itself over and over, as health plans engage in some practices that society – and even the plans themselves – ultimately reject in favor of something better. Consider physician compensation: Many plans have routinely paid doctors in ways that gave them big incentives to control costs – and thus ran the risk of encouraging them to avoid caring for high-cost patients. But successful managed-care companies – one is U.S. Healthcare, now set to merge with insurance giant Aetna – are moving to a payment system based far more on the quality of care that doctors deliver. Given the intense competition in the industry to enroll patients, such practices will undoubtedly spread. That may bring us closer to the nirvana that the industry describes: a day when health plans really are competing on the quality of care they deliver, rather than on squeezing costs.

Until that Golden Age arrives, what should we do? For starters, we may need more standardized regulation of HMOs across the states, which "vary dramatically in the degree to which they provide protections for HMO enrollees," notes a report by the Los Angeles-based Center for Health Care Rights. We also need common approaches on such issues as when HMOs should pay for costly experimental treatments, so that all health plans are playing by the same rules – and the rules are clear to patients. Fortunately, both the federal government and an association of state insurance commissioners are already at work in many of these areas in cooperation with industry groups. Their work will be slowgoing. But that's surely inevitable in the highly charged area of health care, to which we attach so many of our hopes – and our deepest fears. ■

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Managed Care for the Poor Tough to Manage, Va. Finds

Expansion of Medicaid Plan Beyond Tidewater Stalls

WASH. Post 4/29/96

By Spencer S. Hsu
Washington Post Staff Writer

NORFOLK—The first complaints surfaced a year ago. People had been promised hair-care products, free diapers, even chicken dinners if they'd sign up. Others had been solicited by door-to-door salespeople who, motivated by the prospect of cash bounties, often falsely promised that patients could stay with their longtime doctors.

In a scene recalling the land rush of a bygone era, five insurance companies raced to register Medicaid recipients in Virginia's Tidewater area in managed-care health plans. It was the first stage of a massive state undertaking to transform Medicaid—and save tens of millions of dollars annually—by putting private insurers in charge of poor and disabled Virginians' health care.

But hopes to expand the effort to Northern Virginia on July 1, and to make the program mandatory statewide by the summer of 1997, have been put on hold. It wasn't just the reported marketing abuses. Participants were confused over which physicians and hospitals they could use, and there was widespread concern that the sickest people might receive inadequate care.

Officials concede they moved too quickly without adequate safeguards for the people involved.

"We didn't have control of it," said Thomas G. McGraw, the Virginia Medicaid director heading up the project, who acknowledges that many abuses did occur. "We know there are problems, and we are willing to go back and address them."

Virginia's experience in overhauling health care for the poor is a vivid reminder of the pitfalls and possibilities as jurisdictions across the country, Maryland and the District among them, struggle to gain control of Medicaid costs by forcing participants into managed-care programs.

The endeavor, dubbed Medallion II in Virginia, dwarfs welfare revision in terms of total cases and overall spending. Yet officials here remain confident that they can make it work for as many as 400,000 Virginians, many of them disabled. The state already has barred direct marketing and tightened its oversight. When Medallion II is up and running properly, officials

See MEDICAID, D4, Col. 1

Confusion, Complaints Halt Expansion of Managed Care for Poor

MEDICAID, From D1

maintain, private insurers will provide more coordinated care while saving the state's $2.1 billion Medicaid budget an estimated $25 million a year.

"Medicaid managed care is still the trend of the future," said Alina N. Salganikoff, principal policy analyst for the Kaiser Commission on the Future of Health Care. "But states must regulate these areas much more tightly in a way that prevents consumers from being unfairly deceived."

Under Virginia's managed-care approach to Medicaid, doctors and other providers no longer are paid for each procedure performed or service rendered. Instead, the state gives chosen health insurers a predetermined fee per patient in advance and then lets them manage care through health maintenance organizations, which emphasize preventive care and control the use of hospitals and specialists through a primary physician.

In Virginia, where the state's Medicaid bill has increased fivefold over a decade, that preset fee is, on average, about $1,500 a person. Should care cost more than that during a year, the insurer absorbs the loss. Should it cost less, the company keeps the difference as profit.

"It is the ideal coordination of care," McGraw said. "The HMOs are put at a financial risk for the health of their clients."

Insurance companies have been offering managed-care programs to private employers for more than a decade. But they have less experience with the poor, who tend to be heavy users of the medical system and often come with complex social needs. Cases involving those who also are disabled, either physically or mentally, are particularly problematic.

"It's tough, and it's not just economic," Salganikoff said.

In Tidewater, five companies helped launch the mandatory pilot project in 1995. In just eight months, they enrolled 93,000 people and were awarded state contracts worth millions of dollars.

But in less than a year, 37 formal complaints about several insurers were filed with the state Medicaid agency. Some patients had been signed up for two competing HMOs. Others learned too late that they would be required to switch doctors or no longer could continue certain therapies, according to mental health advocates.

Their concerns focused on people such as a 32-year-old Virginia Beach man with schizophrenia, who said his therapy was disrupted when the HMO he chose unexpectedly made him switch the physician and medication he had used for a decade.

Because of loopholes in the state contracts, officials in Gov. George Allen's administration say they had

> *"We know there are problems, and we are willing to go back and address them."*
>
> —Thomas G. McGraw, Virginia Medicaid project director

little power to sanction insurers that acted improperly. One alleged violator was the Rockville-based Optimum Choice Inc., part of Mid Atlantic Medical Services Inc. Mid Atlantic Vice President Thomas P. Barbera said the company has fired and disciplined certain employees for abuses in recruiting and is reviewing its case with the state.

At this point, Medicaid managed care won't come to Northern Virginia, where 48,000 participants live, until at least next spring. Before leaving the Capitol last month, state legislators ordered that any expansion of the program be frozen immediately and called for a study of its effect on Tidewater patients.

"Northern Virginia is no more immune to these tactics than any place else," said Sen. Joseph V. Gartlan Jr. (D-Fairfax), a senior lawmaker. "This is an experiment that was showing a lot of signs of going wrong. We wanted to stop before going any place else."

Gartlan said legislators recognize that something must be done to control Medicaid costs. "But we don't want that to come at the expense of inappropriate denials or reductions of benefits," he said.

The insurance companies have not played down the difficulty of imposing managed care on Medicaid—nor their potential reward.

"This is a great opportunity. We have got a financial incentive to make health care for this population better than it has ever been," said Don L. Gilmore, who leads the Medicaid HMO for Sentara Health System.

The insurer, which is based in Hampton Roads, received an annual contract worth about $64 million by signing up 42,000 Medicaid recipients in Tidewater. It has since reduced their emergency room visits by as much as 30 percent at Norfolk General Hospital and 35 percent at Maryview Medical Center in Portsmouth, in part through a new overnight hot line staffed with registered nurses. It also started a transportation service to help patients get to regular doctor appointments.

Ted M. Wille, senior vice president, understands why some are dubious that private insurers will temper their actions with compassion. But, he added, "we've found ourselves in a situation where we have a lot of economic incentive to sit down with public health workers and learn from them. It's still early, but I think it's been a positive experience."

MEDICAID IN VIRGINIA

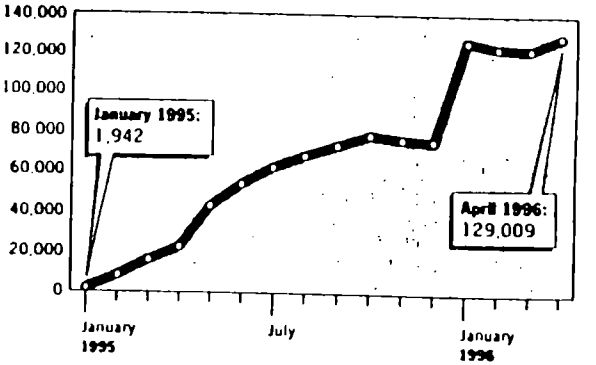
Medicaid is the nation's major health insurance program for the poor and disabled, and its cost is split between federal and state governments. In Virginia, it has been the fastest-growing part of the state budget, with a 1996 price tag of $2.1 billion.

Who Received Medicaid in Virginia, 1995

Recipient	Number	Avg. Annual Cost Per Person
Disabled	102,793	$6,903
Elderly (age 65 and older)	85,507	$6,615
Blind	1,110	$5,313
Adults on welfare	128,530	$1,738
Children	363,560	$927

Since Virginia began allowing Medicaid recipients to enroll in private health maintenance organizations in January 1995, the number of participants has skyrocketed. The state began mandatory enrollment in Tidewater four months ago but has indefinitely postponed a 1997 statewide expansion.

Number of Virginia Medicaid Recipients Enrolled in HMOs



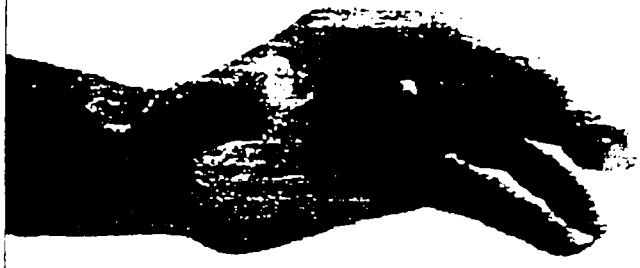
SOURCES: Virginia Senate Finance Committee, Virginia Department of Medical Assistance Services

THE WASHINGTON POST

N.Y. Times; 4-2-96

Managed Care Empires in the Making

Companies Build Networks to Stay a Step Ahead of a Hard-Charging Field



By MILT FREUDENHEIM

Leonard Abramson decided about a year ago that U.S. Healthcare Inc., his enormously successful health maintenance organization, needed a new strategy to keep its profits up. A flock of competing H.M.O.'s, led by Oxford Health Systems, was vying for customers on his home turf, in Philadelphia and New Jersey. Even more threatening, hospitals and doctors were melding into groups big enough to resist when the H.M.O.'s try to squeeze their fees.

Mr. Abramson, the founder and chief executive of U.S. Healthcare, turned over daily operations to his lieutenants and set out to find a strategic partner. He ended up selling his managed care company to the Aetna Life and Casualty Company, he said yesterday, to get the "mass we needed, the power to negotiate with the physicians, the hospitals, the drug companies" and force down their charges.

The deal is the biggest in a wave of consolidation as health care companies seek to become big enough to get the upper hand in negotiating prices with their medical suppliers so they can woo employers with low-cost health plans.

In many cases, the deals have involved mergers between managed care companies and between managed care companies and traditional insurers. But in the future competition may come from a different direction. Some analysts say that the most formidable competitors might be groups of hospitals and doctors that have united to deal directly with employers and skip the managed care middleman.

Aetna's deal to buy U.S. Healthcare for $8.8 billion in cash and stock will create a combined managed health care business that would cover 11 million people. Of those, 4.2 million would be in health maintenance organizations, the most tightly controlled system of delivering care. In addition, Aetna has 3.8 million people in traditional insurance plans.

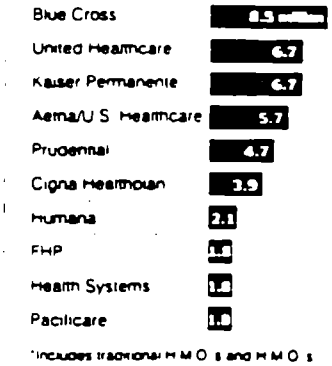
In a number of other recent deals, managed-care companies have acquired insurance companies that had big groups of customers in traditional lines of fee-for-service coverage. In these deals, the insurers also hope to broaden their appeal to employers by offering a variety of lines and eventually to convert their people to managed care, under which the payer's costs are lower and insurer's profits are higher.

Last year the United Healthcare Corporation, a big health maintenance organization based in Minneapolis, bought Metrahealth, a joint health

Cont'd on next page

Moving Up

The merger of U.S. Healthcare and Aetna creates the fourth largest H.M.O. based on the number of people enrolled at the end of 1995.*



*Includes traditional H.M.O.'s and H.M.O.'s that let members use out-of-network doctors

Source: Sanford C. Bernstein & Company

The Bigger They Are Becoming

The acquisition of U.S. Healthcare by the Aetna insurance company is but the latest example of the ongoing consolidation in the managed-care industry. Most of the mergers have been between H.M.O.'s, but, like the Aetna-U.S. Healthcare merger, there have also been combinations of H.M.O.'s and insurance companies with traditional health care plans. Here are some examples.

H.M.O. WITH TRADITIONAL HEALTH PLAN

1994 Healthsource buys the health care indemnity business of Provident Life and Accident Insurance Company for $310 million.

1995 United Healthcare buys MetraHealth for $1.65 billion. MetraHealth was created in 1994 by the merger of the managed care businesses of the Metropolitan Life Insurance Company and Travelers.

1996 Wellpoint Health Networks agrees to buy the life and insurance unit of Massachusetts Mutual Life Insurance Company for $380 million.

H.M.O. WITH ANOTHER H.M.O.

1994 Health Net merges with Qualmed Plans to form Health Systems International.

1994 FHP acquires Takecare for $1.1 billion.

1994 Physician Corporation of America buys Southeast Health Plan, a preferred provider organization.

A LEADER'S VISION

Health Care Empires in the Making

Cont'd from previous page

insurance venture of the Metropolitan Life Insurance Company and the Travelers Life Insurance Company, in a deal valued at $1.45 billion.

And there were at least three smaller acquisitions recently of insurance companies by H.M.O.'s: Last January, California-based Wellpoint Health Networks bought the Massachusetts Mutual Life Insurance Company. Last year, Humana Inc., based in Louisville, Ky., bought Emphesys Financial Group of Green Bay, Wis. And HealthSource, based in Concord, N.H., bought the Provident Life and Accident Insurance Company of Chattanooga, Tenn.

"There are probably going to be only three to five national players in five years or so," said Larry Feinberg, a general partner in New York with Oracle Partners, a health care investment firm. "The whole health care market is overbuilt. We are still pretty early in the ball game in terms of consolidation."

Doug Sherlock, an analyst in Philadelphia with the Sherlock Company, a health care investment banking firm, recalled that Wall Street analysts used to say that health maintenance organizations were a temporary fad that would be taken over by the insurance companies. "It looks like the little fish ate the big fish," he said.

Ellie Kerns, a securities analyst in Boston with Alex. Brown & Sons, said most managed care companies needed to expand into new markets, which could be a drain on earnings while taking years for them to establish a forceful presence.

U.S. Healthcare, which already has networks with 12,000 primary-care doctors in 13 states, could form combinations with Aetna in 21 states where the Hartford-based insurer has 20,000 primary-care doctors in its networks. These doctors — including internists, general practitioners and pediatricians — play a central role in restraining the costs of care.

Mr. Abramson, who would be Aetna's largest shareholder under the deal, said he expected the insurers to continue growing, while hospitals will be "downsizing and closing." He was skeptical about the prospects for a hospital company entering the health insurance business, as the Columbia-HCA Hospital Corporation says it will do in Cleveland and perhaps other markets. Columbia-HCA announced last Friday that it had agreed to buy most of the business of Cleveland-based Blue Cross and Blue Shield of Ohio for $299.5 million.

"Look what happened to Dave Jones, and he is a smart guy," Mr. Abramson said, referring to problems that arose when Mr. Jones's combination H.M.O. and hospital company, Humana, angered doctors and competing insurers, who boycotted the hospitals. Columbia eventually bought the Humana hospitals.

But Rick Scott, chief executive of Columbia-HCA, thinks things will work out differently in Cleveland, where Blue Cross is the biggest health insurer.

Indeed, Mr. Feinberg of Oracle thinks the balance of power may be shifting to hospitals and doctors at the expense of the insurers.

"The H.M.O.'s have had the greatest power over the last five years, relative to physicians and hospitals," he said. "They had the information, the demographic data about patients, and they were smart enough to understand what their costs would be."

Now, he said, "Hospitals and physicians are becoming empowered with better understanding of demographics and costs. For H.M.O.'s over the long term, this will have a negative impact on the balance of power."

J.D. Kleinke, an economist in Baltimore with HCIA, a health care information company, said the Aetna deal was "a classic consolidation play in an industry that is fragmented and ultimately will shake out." He added, "Unfortunately I think it will shake out a lot more drastically and thoroughly than Aetna realizes in the long term, say over 10 years."

Mr. Kleinke said "the Columbia-HCA purchase of an insurer was much more illustrative of where the entire industry is going in the long term." He said hospital groups in Minneapolis, Detroit, Portland, Ore., and Southern California were "already eliminating the middleman, the H.M.O.," and dealing directly with payers such as employers.

At at least one big customer, the Xerox Corporation, the amount of money involved in the Aetna purchase was worrisome. "As a purchaser I always get nervous when lots of money is shelled out by one organization that is acquiring another, say for $8 billion," said Helen Darling, manager of health care strategy at Xerox.

She added: "My worry is that the acquiring company will want to recoup their investment at a when we are trying to control co would watch them both like ha nervously worrying that thus fuel medical inflation, and that might make everyone, including isiators, more cynical about m aged care."

The Merger Partners at a Glance

Aetna Life and Casualty is buying U.S. Healthcare with money from the sale of its property and casualty business last year.

		Aetna	U.S. Healthcare
HEADQUARTERS		Hartford, Conn.	Blue Bell, Pa.
EMPLOYEES		29,143	4,980
CHAIRMAN		Ronald E. Compton	Leonard Abramson
REVENUE	1994	$12.2 billion	$2.9 billion
	1995	$13.0 billion	$3.6 billion
NET INCOME	1994	$410 million	$391 million
	1995	$474 million	$381 million
FIVE BIGGEST MARKETS, BASED ON NUMBER OF PEOPLE IN MANAGED CARE NETWORKS		New York, 1.6 million California, 1.2 million Texas, 1.2 million Ohio, 1.0 million Illinois, 663,000	Pennsylvania, 905,000 New Jersey, 662,000 New York, 554,000 Massachusetts, 79,000 Connecticut, 55,000

Source: Company reports, Bloomberg Financial Markets

The New York

THE PAYOFF

Once a Pharmacist, Now a Deal Maker

By BARRY MEIER

Leonard Abramson, a one-time cab driver, walked away yesterday with the biggest tip in his life — some $492 million in cash.

The 63-year-old Mr. Abramson, the founder and chairman of U.S. Healthcare, stands to be the biggest winner under the terms of the $8.9 billion offer by Aetna Life and Casualty Company to acquire U.S. Healthcare. If the takeover is completed, Mr. Abramson will not only gain the most cash from the deal but will also become the largest single holder of Aetna stock and a director of the company, which is based in Hartford.

Mr. Abramson, appearing trim and deeply tanned at a news conference yesterday at the Waldorf-Astoria Hotel in midtown Manhattan, is one of the pioneers of managed health care. Born and raised in West Philadelphia, he is a self-made millionaire many times over.

His business roots are in pharmaceuticals. He graduated in 1960 from the Philadelphia College of Pharmacy and Science, driving taxis to support himself while at school. Then, after a brief stint as a drug salesman, he worked for half a decade as a retail pharmacist.

> Medicare spelled opportunity to an H.M.O. founder.

The turning point for Mr. Abramson came in the mid-1960's with the creation of the Federal Medicare program. Sensing an explosion in medical spending, he saw the opportunity for prepaid medical plans like health maintenance organizations, an approach to health care that had previously attracted scant interest.

Mr. Abramson found his first backer in Dr. Bernard Rosta, founder of RH Medical, a small hospital-management company in Cheltenham, Pa. While at RH, Mr. Abramson created Family Medical Care, a prepaid medical plan that he subsequently purchased for $500,000. In the late 1970's, he changed the company's name to U.S. Healthcare.

Since then, U.S. Healthcare has been one of the fastest-growing managed-care companies, generat record that cheered Wall Street lysts but also antagonized some sicians and consumer advoc who accuse the company of str patient service and hospital lim

Mr. Abramson for his part, that H.M.O.'s like U.S. Healthc produce savings not so much restricting the length of hosp stays, but by avoiding excessive missions altogether through proved preventive care.

Mr. Abramson proudly describ himself as a bean counter and stic ler for detail. His favorite sayin "It doesn't count unless you c count it."

In recent years, he has emerg as a strong advocate for the ma aged care industry. He found fa with President Clinton's ill-fat proposal to overhaul health car once describing aspects of it as "pe verse socialism."

Even before yesterday's windfa however, the capitalist side of th health care industry had treated M Abramson very well. In Forbes mag azine's most recent listing of the 4 wealthiest Americans, his estimate worth was put at more than $50 million.

Network

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Winter 1995 **Volume 11, Number 4**

A Look Back, A Look Forward

by Donald C. Schmid, NAPCWA President

In looking back over 1995, I am impressed with how much the field of public child welfare has accomplished in a turbulent year. We began 1995 with a new Congress and a plan to reform welfare. This national initiative spurred public child welfare administrators to consider how we would make use of decategorized federal funds to develop a truly comprehensive service system for children and their families. We also have used this opportunity to build upon our efforts to implement the Family Preservation and Family Support Act of 1993 and continued to develop a flexible, comprehensive service system that both protects and supports children and families; to meet with consumers and other stakeholders to identify what outcomes they believe the child welfare system should produce; and to work with other human service partners to build an overarching and coordinated health and human service system.

In addition to helping our members prepare for sweeping national policy reforms, NAPCWA has sought to provide public child welfare administrators with the information we need to continue providing the right services and supports to vulnerable children and families in our changing local environments. Our forums have blended practice with policy in an attempt to provide public child welfare administrators with up-to-date information and tools to more effectively manage programs and services. For instance, we have highlighted initiatives by state and local public child welfare agencies to take advantage of the flexibility offered by federally proposed block grants. We have concentrated on best practices related to child protection, serving chemically affected families, and resolving the tension between family-centered and child-centered services. And most recently, we held a forum on managed care and its implications for public child welfare. Throughout, we have relied upon the wisdom and experience of our peers in the field who have grabbed hold of opportunities to implement their vision for an improved public child welfare system.

These forums also have built upon NAPCWA's four-point agenda, which provides a framework for implementing effective public child welfare services in the areas of best practices, collaboration, training, and results and accountability. The main focus of this agenda in 1995 and for the first portion of 1996 will be to update NAPCWA's *Guidelines for a Model System of Protective Services for Abused and Neglected Children and Their Families*. The *Guidelines*, first published in 1988, were directed toward clarifying the scope and nature of protective services to abused and neglected children within the broader, coordinated child welfare system. While keeping this initial mission in mind, NAPCWA will update the *Guidelines* to account for reform of child protective services in a number of states. CPS reform involves the development and implementation of a "multiple service track approach" that is supportive of differential responses to the families that come to the attention of the child welfare system. The common characteristics of these service tracks are to provide both assessment/service and investigative approaches to serving at-risk families.

An update of the *Guidelines* will be the first step in developing a continuum of best practice categories that correspond to the three-tier framework outlined in APWA's 1990 publication, *A Commitment to Change*. Each category of practices and services will be linked to specified outcomes for children. These two areas—best practices and outcomes—in turn will drive the association's training and collaborative efforts. For instance, we will continue to

(continued on page 2)

Upcoming NAPCWA Events

Spring 1996 NAPCWA Forum

Working Committees: March 30
Forum: March 31–April 1, 1996

Washington Court Hotel, Washington, DC
Reservations: (202) 628-2100

Fourth Annual Roundtable on Outcome Measures in Child Welfare
(cosponsored with the American Humane Association)

May 16–18, 1996

Menger Hotel, San Antonio, Texas
Reservations: (800) 345-9285

For more information, contact Betse Thielman, (202) 682-0100

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[illegible]

collaborate with our other human service partners to work toward positive outcomes for children and their families. And because our staff and systems partners will need to understand what results are intended to be achieved through the provision of outcome-driven best practices at both the administrative and direct service level, applied education and training will be critical.

1995 has proven that public child welfare administrators are vastly capable of orienting and directing their agencies in the midst of change. NAPCWA's agenda for 1996 seeks to provide public child welfare administrators with enhanced and new tools to take advantage of new opportunities for improving services and outcomes for the children and families we serve. We hope you will join us in breaking new ground.

Child Welfare Legislative Update

by Melissa Baker, APWA Policy Associate

On January 9, President Clinton vetoed the welfare reform conference committee bill, H.R. 4, the Personal Responsibility and Work Opportunity Act of 1995, passed by Congress just before Christmas. In his veto message, the president objected to the $60 billion in cuts to foster care and adoption assistance, SSI for disabled children, food stamps, assistance for legal immigrants, and the school lunch program.

On December 21, the House voted 245-178 to pass H.R. 4, with four Republicans, 173 Democrats, and one independent voting "no." On December 22, the Senate voted 52-47, with two Republicans, Mark Hatfield of Oregon and Ben Nighthorse Campbell of Colorado, voting "no," and one Democrat, Max Baucus of Montana, voting "yes." Given the insufficient number of votes necessary to override the veto, congressional Republicans indicated a willingness to consider another version of welfare reform using the Senate-passed version as a starting point. Republican leadership also may be looking at other alternatives such as revisiting the conference agreement or moving certain titles of the bill separately. At this writing, it is unclear whether House and Senate leadership intends to revisit the welfare reform debate before the 1996 elections.

The president pledged to work with Congress to enact a bipartisan welfare reform measure, but has indicated that welfare reform must be considered in the context of congressional efforts to reform Medicaid and the Earned Income Tax Credit, and must include sufficient funding for child care, health coverage for poor families, and state maintenance of effort. It is unclear what direction Congress intends to take with respect to child welfare, but with the Senate bill as a starting point, it would appear that Congress is at least considering maintaining current law in child welfare programs.

Meanwhile, at this writing, budget negotiations between the president and the Republicans are stalled, although the president signed several interim funding bills the week of January 12, funding a number of [illegible] critical to states and ending a three-week long federal furlough. The bill appropriates funding for foster care and adoption assistance through March 15 [illegible] FY 95 levels and provides funding for Title IV-B [illegible] welfare services through FY 96 at FY 95 levels. Congressional Republicans recently indicated that they may adopt a new strategy called *targeted appropriations* whereby they would continue to pass piecemeal measures appropriating funds only for their priority programs. Discussions around the budget and welfare reform are not mutually exclusive.

The following are highlights of the child protection provisions of H.R. 4, the vetoed welfare reform bill, some of which possibly may be included in future iterations of the welfare reform bill.

Child Protection Provisions of the Conference Report on H.R. 4, The Personal Responsibility and Work Opportunity Act of 1995

Like previous legislative drafts, the welfare reform conference agreement passed by Congress and vetoed by the president establishes two block grants for child protection programs and retains the open-ended entitlement for foster care maintenance and adoption assistance subsidy payments, replacing Title IV-B and repealing Title IV-E in its entirety. However, the conference agreement establishes a new effective date of October 1, 1996, and increases funding for the child protection block grant by $940 million above the funding in previous drafts for the period FY 97 through 2002. The two block grants have identical state plan requirements and data reporting requirements, enabling states to submit one state plan and one set of data reports.

Some highlights include:

Matching Payments for Foster Care and Adoption Assistance. Foster care maintenance payments and adoption assistance subsidy payments remain as open-ended entitlements, with eligibility linked to the Title IV-A rules in effect *before* enactment of H.R. 4.

Child Protection Block Grant. Other Title IV-B and IV-E programs—including administrative costs, training, independent living, and family preservation and support—are included in a block grant, with funding as an entitlement to states beginning at $2.047 billion in FY 97 and topping off at $2.766 billion in FY 2002. Funding for Title IV-B part 1, child welfare services, is included in the block grant, but remains as discretionary funding (authorized at $325 million), subject to annual appropriations.

State Share for the Child Protection Block Grant. The final agreement includes a change from previous drafts of the legislation with respect to the state share of the block grant. The formula is more specific and no longer uses 1995 as a factor. "State share" means the qualified child protection expenses of the state divided by the sum of the qualified child protection expenses of all of the

states. Under the revised legislative language, the term *qualified child protection expenses* means the greater of the total amount of the average federal grant amounts for 1992, 1993, and 1994 for Title IV-B subpart 1, child welfare services, Title IV-B subpart 2, family preservation and support services, and independent living; and the average federal share for 1992, 1993, and 1994 of expenditures (without regard to disputed expenditures) for administration, training, and statewide mechanized data collection and information systems as reported on ACF form IV-E-12, or the total amount for the programs listed above for 1994.

Medicaid Eligibility. Unlike previous drafts of the conference agreement, the final bill establishes Medicaid eligibility for individuals receiving foster care maintenance and adoption assistance payments. This language is part of Title I, the Block Grants to the States for Temporary Assistance to Needy Families. The bill is silent with respect to interstate cases.

Data Reporting and Information Systems. The conference agreement repeals the current data reporting requirements under the Adoption and Foster Care Analysis and Reporting System (AFCARS) and replaces them with new data reporting requirements. Furthermore, the bill repeals the open-ended federal match for child welfare information systems development and operations and includes funding for systems in the block grant. However, given the October 1, 1996, effective date, the 75 percent match for development authorized through FY 96 would remain in effect until that date as provided under current law.

Removal of Barriers to Interethnic Placement. The conference agreement maintains the House provision prohibiting delay or denial of placement on the basis of race, ethnicity, or national origin. Although the penalties have been modified from those of the House bill, a state would lose 10 percent of its child protection block grant funds for a violation.

The Child and Family Services Block Grant. This block grant is a modified version of the Child Abuse Prevention and Treatment Act (CAPTA) and has similar purposes. Programs included in the block grant are CAPTA state grants and research, demonstration, training and technical assistance activities; Community-Based Family Resource Grants; Adoption Opportunities; the Abandoned Infants Assistance Act; the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act; and the family support centers grants under the McKinney Homeless Assistance Act. The funding for this block grant is discretionary and is authorized at $230 million. A portion of the funding would be reserved for individual grants in research, demonstrations, training, and technical assistance.

Confidentiality. The conference agreement contains language not included in previous drafts loosening federal requirements for state certification of confidentiality and information disclosure, enabling states greater flexibility in releasing information to certain entities.

Court Improvement Program. Unlike previous drafts, the conference agreement reauthorizes the court improvement program established under OBRA 93 [illegible] repealed under the House bill and previous [illegible] agreement drafts.

For further information, contact Melissa [illegible] (202) 682-0100.

1995 NAPCWA Awards Recognize Two Leaders in Public Child Welfare

At its Winter 1995 meeting in New Orleans, NAPCWA recognized two leaders in public child welfare for their outstanding contributions to the field of public child welfare and on behalf of vulnerable children and families.

G. Peter Digre, director of the Los Angeles County Department of Children and Family Services, was presented with NAPCWA's 1995 Award for Excellence in Public Child Welfare Administration in recognition of his work in developing and supporting policies and programs that promote the well-being of children and their families. In introducing Dr. Digre, APWA Executive Director Sid Johnson commended his efforts as instrumental in helping to shape the national agenda for family preservation and support and cited his role in transforming the Los Angeles County Department of Children and Family Services into a model for the innovative delivery of services to children and their families. Dr. Digre serves as an at-large member of NAPCWA's Executive Committee.

Judith S. Rycus, program director for the Institute for Human Services, received NAPCWA's 1995 Award for Leadership in Public Child Welfare in recognition of her outstanding leadership and support of public child welfare agency efforts to support families and protect children. Larry Breitenstein, director of the Westmoreland County Children's Bureau in Pennsylvania and a member of NAPCWA's Executive Committee, cited Dr. Rycus' work in developing and establishing comprehensive, competency-based inservice training systems, which have laid the foundation for solid child welfare training practices across the nation.

NAPCWA presents these awards each year. The award for excellence in administration alternates annually between a state and a local administrator and will be awarded to a state administrator in 1996. Nomination forms for both awards are available from NAPCWA by calling (202) 682-0100.

Forum Summary

This issue of *Network* focuses on presentations made at NAPCWA's Winter 1995 forum, *Managed Care and Public Child Welfare*, held December 3–4 in New Orleans, La. The forum was dedicated to helping public child welfare administrators determine how they can use managed care to target services to meet the various needs of their clients, share risks with other service providers, establish and achieve outcomes, and manage costs.

Managed Care as We Know It—The View from Other Service Systems and Families

Managed care often is used as a "catch-all" phrase to describe widely varying approaches to restructuring health care and other service delivery systems for the purpose of containing costs and improving the quality and availability of services. NAPCWA's opening plenary featured a panel of representatives from the children's mental health system, health care system, and families who described a few models of managed health and behavioral health care for children and families. This session served as a foundation for the remainder of the meeting, which focused on managed care initiatives involving public child welfare services.

Lee Partridge, director of APWA's Health Policy Unit, which staffs the National Association of State Medicaid Directors, kicked off the plenary by discussing Medicaid managed care. Partridge, former director of the D.C. Medicaid program, noted that Medicaid managed care is being used to target resources; lower costs; and improve beneficiaries' access to care, providing them with a "medical home" for health services. She then outlined several elements of Medicaid managed care that have particular relevance for public child welfare administrators who are considering applying managed care principles to public child welfare services:

- Define whom the managed care program will cover; for example, Medicaid managed care programs generally exclude recipients who are eligible due to their need for long-term care.
- Decide which services the agency will exclude from the program (e.g., "carve-outs").
- Establish prices for services to the various populations served by public child welfare. Often there is insufficient actuarial data to predict costs for children's services. The lack of data is compounded by the various age ranges of the clients served by the public child welfare system; in general, services for younger children are more costly in managed health care programs, but in child welfare, older children may be the more expensive group if they need institutional care. Partridge suggested that in setting their goal for managed care outcomes, public child welfare administrators need to determine if and at what point the risk would be limited or shared with the child welfare agency. Another option would be to establish a capitated rate for a "family service package" only, and other services—like residential care—would be paid for by the agency in the traditional manner.
- Make sure that goals are defined in the Request for Proposals (RFP). For example, most state Medicaid agencies are explicit in that EPSDT requirements must be included under Medicaid services for children. Some states also build into their RFPs incentives for serving certain populations such as start-up money to develop a provider network in underserved neighborhoods.
- Plan to educate both providers and beneficiaries regarding managed care, including providing definitions of terms such as "MCO" (managed care organization) and "provider network;" identifying what changes and managed care will mean for all stakeholders; and observing beneficiary rights.
- The managed care program and the agency must establish consumer protections and evaluation opportunities, e.g., grievance processes, client satisfaction evaluations, where approval is needed for disenrollments for certain populations.
- The managed care program and the agency must establish a quality assurance mechanism, including defining what a plan is to accomplish and the agency's method of oversight.

Partridge concluded by identifying a few lessons that Medicaid directors have learned from implementing Medicaid managed care programs around the country. For instance, recent data shows improved client access to and outcomes for managed care programs (e.g., a study of birth outcomes in Michigan showed a higher rate of healthy births for mothers enrolled in managed care programs as compared with traditional fee-for-service programs). States with managed care programs have realized savings, sometimes quite large. Slow development and implementation of managed care is superior to fast growth so that administrators have a firm grasp on what managed care can and cannot do for their clients. Focus groups show that beneficiaries generally like managed care and its provision of a "medical home." Finally, public administrators need to share experiences and information on a regular basis because the managed care systems are developing so fast.

Colette Croze, health care reform project director for the National Association of State Mental Health Program Directors, noted that public child welfare administrators—like public mental health providers—are challenged to be both a purchaser and provider of managed care services. She then outlined some of the main changes that have occurred within the public mental health sector as the result of managed behavioral health care, including:

- The development of partnerships between the public mental health and Medicaid systems, public mental health and private providers, and the public and private sectors;
- The evolution of contracting methods to include competition, risk-sharing, and a focus on accountability;
- Experimentation with service system management, including the development of provider networks to offer economy-of-scale management;
- The enhancement of a provider base, with a focus on choice, access, and the creation of networks;
- Enhanced definitions of eligibility, with stricter clinical criteria defining eligibility standards,
- The development and utilization of evaluation criteria including outcomes and consumer opinion surveys

Croze also highlighted characteristics of effective managed mental health care. She began by addressing the role that the mental health system plays in developing a managed care service system.

- Mental health experts design the system to achieve *their* identified outcomes by defining what they want from managed care
- The mental health system purchases services through a purchasing cooperative or a single-procurement process;
- Purchasing specifications and financial objectives are clear to both the mental health system (as purchaser) and the managed care system (as provider);
- Bureaucratic requirements that have no relationship to quality or producing positive outcomes are eliminated;
- The mental health system simplifies and streamlines administration to maximize service dollars;
- The mental health system employs reasonable risk-sharing arrangements with incentives for performance and cost containment;
- Competitive procurement opportunities are offered to encourage innovation.

Likewise, the role of the managed care provider in offering effective managed care services:

- Uses *industry* expertise to define how those outcomes can best be achieved through managed care;
- Coordinates mental health, health, and substance abuse services, often offering a single access point through which consumers can access any and all services; and
- Enhances value-added functions throughout the system.

Trina Osher, director of the Family Leadership Initiative for the Federation of Families for Children's Mental Health, spoke about the importance of involving families in designing a managed care system that will address the needs of—and facilitate positive outcomes for—their members. The federation's interest in managed care began with discussions about how health care reform would have an impact on children with special needs. Although federal health care reform did not come to pass, family members continued to participate in a dialogue about managed behavioral health care, with specific regard to its potential effect on family-based systems of care for children with mental health needs. As a result of these discussions, the federation created *Principles of Family Involvement in the Development and Operation of Managed Health and Mental Health Care Systems for Children and Youth* that outlines the role of families in managed care. The principles fall under policy issues, service-related issues, and financial considerations. Some of the main principles include:

- Family members must be part of the decision-making team responsible for managed care system development.
- Families need to be involved in the evaluation and assessment of the managed care system.
- Managed care systems must be consistent with the principles of systems of care, which articulate the need for interagency collaboration and the creation of a continuum of care.
- Families must have a definitive role in the development of their child's care plan and service needs
- Managed care systems must support wraparound principles and cover nontraditional services designed and delivered through this approach
- The managed care organization should reinvest cost savings in children's mental health services
- Managed care systems need to ensure that families do not bear financial risk.

Osher emphasized that while families need public agencies to build an effective system of care, the agencies also need families to provide advice about their needs and to serve as a conduit regarding the impact of services on their members. She closed by urging public child welfare administrators to design managed care service systems as if they would be serving their own children. Copies of the complete *Principles* are available from the federation by calling (703) 684-7710.

Managing Managed Care— The Public Child Welfare Perspective

Charlotte McCullough, director of planning, managed care, and privatization for the Child Welfare League of America, addressed the function that managed care can play in public child welfare. She began by noting that managed care can affect child welfare either by managed care organizations securing funds to deliver primary and behavioral health services to children and families served by child welfare agencies, or child welfare agencies adopting managed care models for funding and delivering various child welfare services. In either case, due to the high percentage of states that have developed Medicaid managed health and behavioral health care, McCullough observed that the high incidence of serious health and behavioral health problems among the children in out-of-home care in the United States will mean that "current managed care plans will dramatically affect the primary and behavioral health of these children."

Indeed, a growing trend among public child welfare agencies is to render traditional child welfare services reimbursable through Medicaid. McCullough noted that a recent CWLA survey of public child welfare agencies found that in most jurisdictions some services for child welfare populations are now funded wholly or in part by Medicaid. Eighty-eight percent of survey respondents said that their states are exploring managed care options for child welfare services. And over 80 percent of survey respondents believed that managed care approaches to child welfare delivery systems will be more likely under a block grant.

McCullough outlined a few reasons that child welfare agencies are considering managed care. First, there have been historical incentives to provide as many units of services as will be reimbursed. In addition, reimburse-

ments for more expensive and restrictive services are higher, allowing for greater operating margins. Public child welfare agencies want to more clearly define outcomes of service delivery. They also want to compile or enhance evaluation and documentation data. And both federal and state governments are pushing for more accountable, cost-effective services. Managed care, therefore, is attractive because it is perceived as reducing costs, or at least the rate of cost increases, improving access to care in underserved areas, improving the quality of care through standardized oversight; and increasing the focus on preventive care and "wellness" rather than on crisis-driven treatment.

McCullough defined managed care as a "powerful set of tools that can dramatically and quickly impact a service delivery system." Managed care aims to improve access, quality, and outcomes for children and families. McCullough observed that these values are consistent with the core values of the child welfare system. The potential benefits of a managed care system are providing eligible persons with the services they need, when they need them, in the right amounts.

In contrast, the current fee-for-service system employed by public child welfare agencies with their service partners offers little incentive to change. A managed care environment, on the other hand, emphasizes continual improvements. For example, best practice standards can be spelled out in the contract for the managed care provider to operationalize. Risks are shared among stakeholders, so there is less likely to be disagreement on who is responsible for what costs or services. Services are accessed through a single point of entry, which allows for greater accountability and improved access to services.

McCullough outlined the essential features of effective managed care systems, including access and appropriateness, accountability and quality of providers, and positive client outcomes. The main principles for child welfare managed care—as defined by CWLA's National Advisory Committee on Managed Care—are to ensure access to high-quality services that achieve permanency for children in the most cost-effective manner.

McCullough identified key elements that need to be in place in order for a public child welfare agency to successfully convert services to a managed care model. The two primary elements include adequate funds that follow the clinical needs of individual children and families, and a full array of services and care. In addition, the system must be designed and priced with client outcomes and program goals in mind. The agency must establish consistent clinical and procedural protocols to ensure accurate initial assessments, gatekeeping, and better utilization management. The agency and providers must collaborate to build and maintain qualified provider networks. Quality-focused utilization management processes must be developed to assist providers in offering services and achieving optimal performance on behalf of the children and families they serve. Management information technologies must be developed and used to drive continuous quality improvement and track essential system and client information. Service outcomes and financial accountability must be linked. And consumers must participate in the ongoing design and evaluation of the system.

McCullough noted that CWLA continues to work with the Institute for Human Services Management, and to provide institutes and other training and technical assistance activities regarding managed care to public and private child welfare agencies. The offer specific information that addresses designing a managed care system, risk-sharing arrangements, utilization management and quality improvement systems, agency self-assessment, and management information systems. In addition, CWLA is working with other child welfare advocacy organizations to publish a newsletter on managed child welfare.

McCullough concluded by summarizing three main steps that public child welfare agencies need to take to develop their own managed care systems. First, they must collaborate with all other stakeholders to develop a reasonable plan of action based on a realistic assessment of the current delivery system. Next, they must determine the costs of shifting to a managed care system and ensure the availability of funds. Finally, public child welfare agencies must gradually implement change in order to ensure that the safety of children and families is maintained and protected; the provider community continues to be stable as changes to the service delivery system are introduced; lessons from other systems that have shifted to managed care are incorporated into the process; and both the public and private sectors have the knowledge, skills, and technologies to succeed.

Dorothy Webman, consulting director for Program Development at the National Resource Center for Permanency Planning, addressed national trends in the public child welfare sector that support the use of managed care as a strategic management tool. In establishing the context for using managed care in the public child welfare arena, Webman first noted that managed care is linked to systems reform, and public child welfare is uniquely situated—with both internal and external support for reform of its programs and services—to take advantage of managed care as a tool for managing systems change. Human service systems reform is driven, in part, by an attempt to manage the numerous environmental stresses that are impacting contemporary families and, indirectly, the child welfare system. Citing James Garbarino's "socially toxic environment," Webman noted that the public child welfare system is increasingly challenged to address larger social and political issues—ranging from poverty, poor access to health care, homelessness, HIV/AIDS, and domestic and other forms of violence—that result in multiple client needs. As a result, public child welfare is working to develop and use a comprehensive, multiple-service system to address the needs of vulnerable children and families.

The public child welfare system's efforts to address these needs are supported by federal- and state-initiated legislation designed to support reform of the child welfare

system implementation of the Family Preservation and Family Support Services Act, strong use of federal funding for automated child welfare information systems, a renewed interest in permanency planning for children, applications for Title IV-E and IV-B waivers, and planning for block grants are activities that support child welfare reform.

In this context, then, the main reasons that public child welfare administrators are looking to managed care are to increase client access to services, improve service quality, contain costs, and identify programs or service models that work. One of the main challenges to developing a managed care approach to managing public child welfare services, however, is anticipating the compound needs of the child welfare population and estimating the actuarial costs for addressing those needs.

In order to confront this challenge, public child welfare administrators must address some fundamental questions: Who are the main stakeholders in a managed public child welfare service system, and is the public child welfare agency willing and ready to work with them? Which of those stakeholders has the capital necessary to develop managed public child welfare services? Are those stakeholders willing to participate? What do they want in exchange for their investment? Webman especially encouraged public child welfare administrators to develop relationships with new, nontraditional partners such as the managed care industry, business, computer and software companies, consultants, researchers, lawyers, and accountants so that these entities can provide the public sector with needed data that it currently lacks. In so doing, however, the public child welfare administrator must be clear that her or his role is to establish the goals and outcomes for managed care services and to define the consumer of those services. This action in turn will drive the decisions of the other stakeholders, including how much risk they are willing to accept in providing services and the necessary financial base to support such programs. Webman ended by encouraging public child welfare administrators to identify existing actuarial information to help establish target populations and costs; NAPCWA might help by requesting aggregate data on children and families from managed care organizations already serving this population.

Block Grants, Blended Funding, and Managed Care for Children

Dr. Robert F. Cole, director of the National Resource Network for Children and Family Mental Health Services at the Washington Business Group on Health, addressed the need for human service agencies to work together in developing a comprehensive system of care for children with multiple service needs, with an emphasis on how managed care can be used by all service partners to identify and manage service provision for the benefit of all. To illustrate his point, Cole discussed the results of a few pilot Systems of Care initiatives—funded by the Robert Wood Johnson Foundation—that used managed care concepts in delivering comprehensive services to children with severe emotional disorders and their families.

In Oregon, the state developed a partnership with Multnomah County (where Portland is located) with an understanding that the locality would develop a delivery system involving all the agencies providing children's mental health services. For each of the five years in which the pilot took place, the county pooled close to $1,000,000 in public agency funds from child welfare, children's mental health, special education, and juvenile justice and leveraged it through the state Medicaid system to obtain federal matching funds. Then the state Medicaid agency used the funds to contract with the Partners Project, which provided a capitated rate of $1,600 per client per month, targeting children who were at-risk for placement in residential treatment services, inpatient care, or other specialized mental health services. The Partners Project operated out of the county children's mental health agency and was coordinated by caseworkers who each were responsible for 20 family cases. Based on family assessments performed by the caseworkers, a service plan was developed that authorized expenditures for a variety of services, including family support services that would not be deemed medically necessary according to traditional Medicaid rules. At its three-year audit, the Partners Project was operating under budget and dramatically reduced use of more expensive, intrusive services by the target population. Cole noted the Partners Project was considered to be a managed care pilot, and throughout the implementation of the program, the project began to more clearly define itself as such: the county agencies that provided the fund pool and the state Medicaid agency became the "governance authority" overseeing the system of care, and the children's mental health agency that developed the family case plan that also authorized services became the "care management entity."

In Dane County, Wisconsin, the county mental health system received a grant for a standard services contract to provide intensive, 24-hour crisis services, intensive case management, and a day treatment program. The county also had an agreement with the state Medicaid agency that any savings the program realized from diverting children into less costly hospitalizations could be reinvested into flexible, wraparound services for the target population. In the first year the program cut expenditures almost by half and eliminated almost all referrals to the state hospital. One challenge to the program came from provider agencies that provided standard per-diem services to children with severe emotional disorders. In order to address the providers' concerns and to provide an incentive to serve populations for whom there were limited resources, the county set aside some of the money it saved from hospitalizations and residential placement to develop a three-way contract between the county, state Medicaid agency, and a not-for-profit managed care entity. This contract

lowed for the development of a preferred provider option model where provider agencies could sign on to serve certain populations for a capitated rate of $3,500 per client per month. The providers also agreed to develop and manage a case plan for these clients that served as the authorizing document for expenditures. Cole also noted that the juvenile courts became proponents of this program because they had the opportunity to review and ensure that case plans were realistic. the courts also could disenroll children if they were not in agreement.

In Cambridge, Massachusetts, the state is planning a "carve-in" model with a risk adjustment to the health plan for children with high-level special needs. The mental health, child welfare, special education, and juvenile justice systems will identify the target population and pool the funds they would spend on them. This fund becomes the risk adjustment to the Medicaid premium. The integrated fund is monitored by a steering committee composed of representatives from each of the referring state agencies. The HMO receives the risk-adjusted capitated rate for each child it serves so that it has an incentive to serve even the most difficult cases, including children at risk of residential placement. The HMO develops a special system of care for these intensive care cases; it also provides a care coordinator who organizes a care team that develops individual case plans for each child and its family. The care plan authorizes flexible, individualized services and mobilizes the provider network. It also serves as the common plan of care for all agencies, lists goals and expected outcomes, and authorizes expenditures.

Through these pilot programs, the Washington Business Group on Health learned that approximately 2 percent of the entire eligible population will use 87 percent of the pooled resource money. Rather than dividing limited public funds among a number of agencies so that no one has enough to provide adequate services, decategorized funding provided through an integrated service system best organizes services for hardest-to-serve children, while still ensuring that flexible services exist for the remaining clients.

Cole observed that block grants, while threatening in many respects to some human service administrators, offer new opportunities for human service agencies that have begun applying managed care concepts to their own service delivery systems. The federal impetus to provide decategorized funds to states and localities will best be met with human service systems that have a strategy for targeting resources where they are most needed.

In order to help public child welfare administrators use managed care as a tool in preparing for block grants, Cole stressed the need to incorporate the following elements into the agency's own service delivery structure.

Accountability: The human service agency will do well to establish itself as a health and welfare authority that commissions an independent health care purchasing sponsor to oversee quality of care and the correct use of public funds. The purchasing sponsor probably would not be a governmental body and would operate as an active purchaser in the health care market along with other employer-purchasers. The purchasing sponsor would have a fiduciary responsibility to obtain value for the health care dollars it spends on behalf of public beneficiaries it represents. Cole noted that the corporate sector created the Foundation for Accountability to hold health plans accountable to their employees who use the plans. A purchasing sponsor representing public beneficiaries would naturally ally with their clients in creating a consumer organization to provide feedback on services they receive.

Outcomes: Public human service authorities should establish the outcomes that they expect managed care to achieve for their clients. Commission purchasing sponsors are responsible for buying these outcomes, and it is up to the managed care company to determine in a competitive market the best manner to achieve those outcomes.

Management: A sophisticated purchasing sponsor will make substantial demands on health provider organizations and plans in order to establish quality care and effective outcomes. Typically, employer purchasers and purchasing coalitions will demand that plans meet certain performance standards to qualify to be offered to employees. Over time, as provider organizations develop performance reporting capacity, quality standards are refined and improved. Managed care that is aggressively purchased has substantially improved health care.

Four States Discuss Managed Public Child Welfare Initiatives

Four public child welfare and human service administrators presented their state's experiences with managed care and child welfare at NAPCWA's December forum. A synopsis of each state's managed care program is provided below.

New York

Fred Wulczyn, director of the Office of Managed Care for the New York State Department of Social Services, described the HomeRebuilders program in New York State. HomeRebuilders is a public/private partnership involving the New York State Department of Social Services, local social service districts, and voluntary child care agencies. The state implemented legislation that allowed the department to offer a capitated rate to agencies under which they can offer flexible, noncategorical, wraparound services tailored to each family's needs. The capitated rate was established by determining the average number of days that identified groups of children required out-of-home services; the agencies are then paid a set rate based on that average. The focus of the services is on better care management through targeting treatment, therapeutic, and administrative resources to an identified group of children.

Currently six voluntary agencies under contract to the New York City Child Welfare Administration (CWA) offer the HomeRebuilders program. In addition to flexible funds, the agencies receive enhanced case management services from the Office of Case Management (OCM) and

Adoption Case Management (ACM). During weekly visits to the agencies, OCM and ACM staff work closely with both the families and agency staff to resolve issues more effectively and lead to a more timely response to agency requests for discharge.

Wulczyn urged public child welfare administrators to identify resources that currently exist in their agencies—as well as to cultivate an agency culture that allows for new innovations such as managed care—to prepare for effective, long-range reform of their agencies.

Ohio

Isaac Palmer, deputy director of the Office of Child Care and Family Services for the Ohio Department of Human Services, discussed Ohio's managed care pilots. In Ohio, six counties are experimenting with managed care in order to contain placement costs, increase placement options, establish good practice outcomes, and share responsibility for service delivery and outcomes. All public agencies that serve children—particularly those providing mental health, substance abuse, mental retardation, public health, education, and juvenile court services—are involved in planning each county's managed care contract. A county may choose to contract with a single private provider agency, a consortium of private agencies, a large behavioral health provider, or another county. In turn, managed care providers must offer a full array of placement resources, including regular foster care, residential, and day treatment options; an adequate number of foster care resources; a management information system; and access to other public clinical services provided by staff (with credentials issued by the state's mental health and drug and alcohol agencies) to provide the full range of interventions necessary per placement episode.

Each Ohio county undertaking managed child welfare services is responsible for defining outcomes and values to be included in its managed care contracts. Palmer provided some examples of values that should be guaranteed in such a contract, including assurance of neighborhood-based foster homes, group sibling placement, a single placement per child, family involvement in treatment services, and cultural responsiveness. In addition, the county retains the right to establish and maintain policies governing which clients are to be served and when they are returned home, monitoring the quality of programs, and providing opportunities for client participation in policymaking and quality monitoring. In addition, the basic elements in the counties' managed care contracts include utilization management controls, which discrete populations will be served, price management such as a per-case rate or capitation, single point of entry or referral, assumption of full or partial risk, statement of practice values, credentialled access to other public programs, and a demonstration of provider capacity. Palmer noted that the bottom line for managed public child welfare is to ensure that a child's safety and protection needs are met, compared to managed medical care, which seeks to maintain services until the client's medical condition is remedied.

Because Ohio is a county-administered state, the state public child welfare agency assists the counties by providing a full range of technical assistance, a boilerplate managed care contract for them to tailor to their own needs, assistance in evaluating contractor proposals, and feedback on what other counties and states are doing in managed care. Palmer noted that many of the counties that have undertaken managed care in Ohio have realized significant cost savings as well. He cautioned, however, that managed care works best for those counties experiencing increased placement costs, an inadequate number of foster homes, a high number of children inappropriately placed in the most restrictive settings, increasing foster care caseloads, and pressure from the judicial system. In contrast, managed care may not work as well for those counties where these demographic trends are not taking place.

Iowa

Charles M. Palmer, director of the Iowa Department of Human Services, outlined systems of managed care that have an impact on children in the Iowa child welfare system. Children served through the Iowa Department of Human Services may receive services through five different programs, all of which provide a review or authorization function.

- HMOs that provide a voluntary option for people who are Medicaid-eligible through the Family Investment Program (FIP), Iowa's welfare reform initiative. Implemented in October 1993, the FIP provides a needs assessment for clients who receive AFDC. Based on this needs assessment, individual clients enter into a contract with the state agency that specifies their plan for achieving self-sufficiency.
- MediPASS, the state's primary care physician case management program, which is an option for FIP and FIP-related Medicaid recipients who are not served by HMOs.
- Iowa Managed Substance Abuse Care Plan, through which substance abuse services are provided for almost all Medicaid recipients, including those enrolled in HMOs and MediPASS.
- Mental Health Access Plan, a managed care program that provides mental health services to almost all Medicaid recipients, except those enrolled in HMOs.
- Rehabilitation, Treatment, and Support Services—a clinical authorization process for the treatment component of services included within the child welfare system. Services are provided regardless of the child's Medicaid eligibility.

Responsibility to coordinate service delivery across systems rests with the child's caseworker as well as with those persons within each entity who review/authorize services.

Palmer noted that staff were resistant to managed care because they feared their new case management re-

responsibilities would prevent them from providing services. As a result, the state lost some of its clinicians. The state then filled those vacated positions with additional child protection staff and allowed the managed care providers to take on more clinical services.

Palmer encouraged human service administrators who were considering managed care to define the goals and the vision for a managed care system, the point at which the agency will turn over service delivery to managed care providers, where risk is to be shared (including specifying in the contract that the provider cannot "dump" harder cases), and to communicate and publicize the shift to managed care among staff and the public.

West Virginia

Sue Sergi, commissioner of the Bureau for Children and Families for the West Virginia Department of Health and Human Resources, discussed the state's efforts to implement managed child welfare. The department is responsible for meeting the health, safety, and treatment needs of eligible children and families who are involved in the child welfare, juvenile justice, and children's mental health systems. Currently the department directly provides child protective services, foster care, and adoption services for children and contracts with private providers for the delivery of behavioral health and rehabilitative services, including family preservation, treatment foster care, crisis shelters, group care, and residential treatment. The department is now seeking approval from the Health Care Financing Administration (HCFA) for a 1951(b) waiver, which would allow the state to contract with a single managed care organization (MCO) to assist in the administration, coordination, and delivery of all behavioral health and rehabilitative services statewide, as well as foster care, adoption, and juvenile services.

West Virginia's goal for the managed care process is to achieve significant improvement in at least the following four key areas: to better align the service delivery system and fiscal incentives with the state's guiding values; to improve access to a more balanced array of community-based, family-focused services designed to meet the individual behavioral health and rehabilitation needs of children and families statewide; to improve quality, outcomes, and consumer satisfaction for all behavioral health services provided through a balanced system of care; and to improve cost control, assuring that consumers receive the least costly and least restrictive services necessary to appropriately and sufficiently address their identified safety, behavioral health, and rehabilitation needs.

A variety of efforts have been initiated to facilitate the development and implementation of the managed behavioral health/health care welfare program: a steering committee was formed, consisting of key staff from the bureaus for Public Health, Children and Families, Community Support, and Medical Services (Medicaid); managed care and child welfare consultants were engaged to provide technical assistance; a 1915(b) waiver request was submitted to HCFA; numerous provider/consumer task teams were created to develop MCO system standards for medical necessity, utilization review, level of care criteria, provider qualifications, grievance procedures, MCO staff credentials, client outcome measures, and system performance indicators; an additional team was formed to examine and define new roles, responsibilities, and gate-keeping functions of department and MCO staff regarding child welfare services; and a broad-based managed care advisory council was established, consisting of 35 representatives from all consumer and provider groups statewide who offer recommendations and feedback to the department regarding all managed care issues and decisions.

Additional tasks are also being addressed in order for the managed care process to succeed: answers to implementation questions from HCFA are being prepared for submission in order to receive waiver approval; a request for proposal (RFP) is being finalized to distribute to bidding MCOs once waiver approval is achieved; as part of the waiver and RFP process, actuarial data and analysis are being prepared by contracted consultants, who also will assist the department in choosing a single MCO and in negotiating their contract. A phase-in schedule for managed care must also be developed and implemented, with concurrent reorganization of the department; and the performance of the MCO must be monitored, measured, and adjusted as necessary to improve the overall system of care. In addition, if Medicaid reimbursement is restructured into federal block grants, necessary adjustments in the state plan and the managed care program will have to be made.

Comings and Goings

Jan Cooper has left APWA to provide information management and consulting in New Hampshire. Cooper was a senior policy analyst in the Family and Child Welfare Division of APWA, where she concentrated on family preservation and family support services, information systems, and HIV/AIDS prevention among at-risk youth.

Ken Patterson has been appointed administrator of the Division of Children and Family Services for the Nevada Department of Human Resources. Patterson recently completed a year-long fellowship with the Annie E. Casey Foundation. Patterson is the former director of the Bureau of Children's Services for the Idaho Department of Health and Welfare.

Rose Alma Senatore has joined Network Six, Inc., a computer systems firm serving government human service agencies, as a special child welfare program consultant. Prior to joining Network Six, Senatore was commissioner for the Connecticut Department of Children and Families.

Managed Care Glossary

Administrative Costs

Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance programs, and risk management.

Adverse Selection

Among applicants for a given group or individual program, the tendency for those with an impaired health status, or who are prone to higher than average utilization of benefits, to be enrolled in disproportionate numbers and lower deductible plans.

Agency for Health Care Policy and Research (AHCPR)

The agency of the Public Health Service responsible for enhancing the quality, appropriateness and effectiveness of health care services.

Ambulatory Care

Health care services provided on an outpatient basis. No overnight stay in a hospital is required. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home health care services fall under this heading.

Beneficiary

Individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract.

Benefit Payment Schedule

List of amounts an insurance plan will pay for covered health care services.

Capitation

A payment system whereby managed care plans pay health care providers a fixed amount to care for a patient over a given period. Providers are not reimbursed for services that exceed the allotted amount. The rate may be fixed for all members or it can be adjusted for the age and gender of the member, based on actuarial projections of medical utilization.

Case Management

The process by which all health-related matters of a case are managed by a physician or nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referral to consultants, specialists, hospitals, ancillary providers and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

Claims Review

The method by which an enrollee's health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

Closed Panel

Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed, but legally separate, medical group that only serves the HMO. This term usually refers to a group or staff HMO models.

Coinsurance

A cost-sharing requirement under a health insurance policy which provides that the insured will assume a portion or percentage of the costs of covered services. After the deductible is paid, this provision forces the subscriber to pay for a certain percentage of any remaining medical bills, usually 20 percent.

Community Rating

Setting insurance rates based on the average cost of providing health services to all people in a geographic area, without adjusting for each individual's medical history or likelihood of using medical services.

Concurrent Review

Review of a procedure or hospital admission done by a health care professional (usually a nurse) other than the one providing the care.

Coordination of Benefits (COB)

Provisions and procedures used by third-party payers to determine the amount payable to each payer when a claimant is covered under two or more group health plans.

Co-payment

A type of cost-sharing which requires the insured or subscriber to pay a specified flat dollar amount, usually on a per unit of service basis, with the third party payer reimbursing some portion of remaining charges.

Cost Sharing

The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. Cost sharing can also occur when an insured pays a portion of the monthly premium for health care insurance.

Cost Shifting

Charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.

Credentialling

The process of reviewing a practitioners credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileging are met.

Deductible

The out-of-pocket expenses that must be borne by an insurance subscriber before the insurer will begin reimbursing the subscriber for additional expenses.

Diagnosis-related groups (DRG)

A system used by Medicare and other insurers to classify illnesses according to diagnosis and treatment. All Medicare inpatient hospital operating costs are determined in advance and paid on a per-case basis, according to fixed amount or weight established for each DRG.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

Employee Retirement Income Security Act (ERISA)

ERISA exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination and other state health reforms.

Exclusions

Clauses in an insurance contract that deny coverage for select individuals, groups, locations, properties or risks.

Exclusive Provider Organization (EPO)

A managed care organization that is organized similarly to PPOs in that physicians do not receive capitated payments, but that only allows patients to choose medical care from network providers. If a patient elects to seek care outside of the network, then he or she will not be reimbursed for the cost of the treatment.

Exclusivity Clause

A part of a contract which prohibits physicians from contracting with more than one managed care organization (HMO, PPO, IPA, etc.)

Experience Rating

A system where an insurance company evaluates the risk of an individual or group by looking at the applicant's health history.

Federally Qualified HMOs

HMOs that meet certain federally stipulated provisions aimed at protecting consumers, e.g., providing a broad range of basic health services, assuring financial solvency, and monitoring the quality of care. HMOs must apply to the federal government for qualification. The process is administered by the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS).

Fee Disclosure

Physicians and caregivers discussing their charges with patients prior to treatment.

Fee-for-service

The traditional payment method whereby patients pay doctors, hospitals, and other providers for services rendered and then bill private insurers or the government.

Fee Schedule

A comprehensive listing of fees used by either a health care plan or the government to reimburse physicians and/or other providers on a fee-for-service basis.

Fiscal Intermediary

The agent (e.g., Blue Cross) that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers' needs.

Formulary

A list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary.

Gatekeeper

A primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the gatekeeper must preauthorize the visit, unless there is an emergency.

Group Insurance

Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

Group Model HMO

An HMO that contracts with a multi-specialty medical group to provide care for HMO members; members are required to receive medical care from a physician within the group unless a referral is made outside the network.

Inpatient Services

Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including bed and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Health Maintenance Organization (HMO)

HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g, physicians, hospitals, and other health professionals, and members are required to use participating providers for all health services. Members are enrolled for a specified period of time. Model types include staff, group practice, network and IPA (for additional information, see staff, group, network and IPA model definitions)

Health Plan Employer Data and Information Set (HEDIS)

A set of performance measures designed to standardize the way health plans report data to employers. HEDIS currently measures five major areas of health plan performance: quality, access and patient satisfaction, membership and utilization, finance, and descriptive information on health plan management.

Hold Harmless Clause

A clause frequently found in managed care contracts whereby the HMO and the physician hold each other not liable for malpractice or corporate malfeasance if either of the parties is found to be liable. Many insurance carriers exclude this type of liability from coverage. It may also refer to language that prohibits the provider from billing patients if their managed care company becomes insolvent. State and federal regulations may require this language.

Indemnify

To make good a loss.

Independent Practice Association (IPA)

A health maintenance organization delivery model in which the HMO contracts with a physician organization, which, in turn, contracts with individual physicians. The IPA physicians practice in their own offices and continue to see fee-for-service patients. The HMO reimburses the IPA on a capitated basis; however, the IPA usually reimburses the physicians on a fee-for-service basis. This type of system combines prepayment with the traditional means of delivering health care.

Managed Care

A general term for organizing doctors, hospitals, and other providers into groups in order to enhance the quality and cost-effectiveness of health care. Managed Care Organizations include HMOs, PPOs, POSs, EPOs, etc.

Market Share

That part of the market potential that a managed care company has captured; usually market share is expressed as a percentage of the market potential.

Medical Group Practice

The American Group Practice Association, the American Medical Association, and the Medical Group Management Association define medical group practice as: "provision of health care services by a group of at least three licensed physicians engaged in a formally organized and legally recognized entity sharing equipment, facilities, common records and personnel involved in both patient care and business management."

Medically Necessary

Those covered services required to preserve and maintain the health status of a member or eligible person in accordance with the area standards of medical practice.

Multispecialty Group

A group of doctors who represent various medical specialties and who work together in a group practice.

National Committee for Quality Assurance (NCQA)

A non-profit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers, and the public sector.

Network Model HMO

An HMO that contracts with two or more independent group practices to provide health services. This type may include a few solo practices, but is primarily organized around groups.

Open Enrollment

A period of time which eligible subscribers may elect to enroll in, or transfer between, available programs providing health care coverage.

Outcomes Management

A clinical outcome is the result of medical or surgical intervention or nonintervention. It is thought that through a database of outcomes experience, caregivers will know better which treatment modalities result in consistently better outcomes for patients. Outcomes management may lead to the development of clinical protocols.

Outlier

One who does not fall within the norm; term typically used in utilization review. A provider who uses either too many or too few services (for example, anyone whose utilization differs 2 standard deviations from the mean on a bell curve is termed an "outlier.")

Out-of-area Benefits

The coverage allowed to HMO members for emergency situations outside of the prescribed geographic area of the emergency situations outside of the prescribed geographic area of the HMO.

Outpatient Services

Outpatient services are medical and other services provided by a hospital or other qualified facility, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests.

Participating Provider

A health care provider who participates through a contractual arrangement with a health care service contractor, HMO, PPO, IPA or other managed care organization.

Peer Review

A review by members of the profession "peers" regarding the quality of care provided a patient, including documentation of care (medical audit), diagnostic steps used, conclusions reached, therapy given, appropriateness of utilization (utilization review), and reasonableness of charges claims.

Performance Standards

Standards an individual provider is expected to meet, especially with respect to quality of care. The standards may define volume of care delivered per time period. Thus, performance standards for obstetrician/gynecologist may specify some or all of the following office hours and office visits per week or month, on-call days, deliveries per year, gynecological operations per year, etc.

Point-of-Service Plan (POS)

Also known as an open-ended HMO, POS plans encourage, but do not require, members to choose a primary care physician. As in traditional HMOs, the primary care physician acts as a "gatekeeper" when making referrals; plan members may, however, opt to visit non-network providers at their discretion. Subscribers choosing not to use the primary care physician must pay higher deductibles and copays than those using network physicians.

Practice Parameters

The American Medical Association defines practice parameters as strategies for patient management, developed to assist physicians in clinical decision making. Practice parameters may also be referred to as practice options, practice guidelines, practice policies, or practice standards.

Preadmission Review

The practice of reviewing claims for inpatient admission prior to the patient entering the hospital in order to assure that the admission is medically necessary.

Preferred Provider Organization (PPO)

A PPO is a health care arrangement between purchasers of care (e.g., employers, insurance companies) and providers that provides benefits at a reasonable cost by providing members incentives (such as lower deductibles and copays) to use providers within the network. Members who prefer to use nonpreferred physicians may do so, but only at a higher cost. Preferred providers must agree to specified fee schedules in exchange for a preferred status and are required to comply with certain utilization review guidelines.

Preauthorization

A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed.

Quality Assurance (QA)

Activities and programs intended to assure the quality of care in a defined medical setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against preestablished standards.

Risk

The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed upon thresholds. The sharing of risk is often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Pool

A pool of money that is to be used for defined expenses. Commonly, if the money that is put at risk is not expended by the end of the year, some or all of it is returned to those managing the risk.

Staff Model HMO

An HMO that delivers health services through a physician group that is controlled by the HMO unit; most physicians are salaried employees who deal exclusively with HMO members.

Self-Insurance

The practice of an employer or organization assuming responsibility for health care losses of its employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization.

Stop Loss

That point at which a third party has reinsurance to protect against the overly large single claim or the excessively high aggregate claim during a given period of time. Large employers, who are self-insured, may also purchase "reinsurance" for stop-loss purposes.

Tertiary Care

Subspecialty care usually requiring the facilities of a university affiliated or teaching hospital that has extensive diagnostic and treatment capabilities.

Third-Party

Administrat or Individual or company that contracts with employers who want to self-insure the health of their employees. They develop and coordinate self-insurance programs, process and pay the claim and may help locate stop-loss insurance for the employer. They also can analyze the effectiveness of the program and trace the patterns of those using the benefits.

Usual, Customary and Reasonable (UCR)

Health insurance plans that pay a physician's full charge if it is reasonable and does not exceed his or her usual charges and the amount customarily charged for the service by other physicians in the area.

Utilization Review (UR)

Also known as utilization management or utilization control, utilization review is a systematic means for reviewing and controlling patients' use of medical care services as well as the appropriateness and quality of that care. Usually involves data collection, review and/or authorization, especially for services such as specialist referrals, emergency room use, and hospitalization.

Utilization

The patterns of use of a service or type of service within a specified time. Utilization is usually expressed in rate per unit of population-at-risk for a given period (e.g., the number of hospital admissions per year per 1,000 persons enrolled in an HMO)

Withhold

That portion of the monthly capitation payment to physicians withheld by an HMO to create an incentive for efficient care. A physician who exceeds utilization norms does not receive the withheld amount. This system serves as a financial incentive for lower utilization. The withhold can cover all services or be specific to hospital care, laboratory usage, or specialty referrals.

States Eye Managed Care for Child Welfare Reform

Forty-one States Are Considering Managed Care for the Financing and Delivery of Child Welfare Services

Nearly all 50 states are undergoing some type of reform in child protection and child welfare services -- whether in an attempt to respond to or circumvent legislative changes, as a reaction to litigation, threat of litigation, budgetary concerns, or public criticism; or in a legitimate quest for more cost-efficient and effective child and family services. Increasingly, states are considering principles, practices, and techniques which, if planned, designed, and funded correctly, ensure value for child welfare service expenditures by balancing costs, quality, and access to care. In effect, they would employ some combination of the managed care principles currently used in the delivery of physical and behavioral health services.

In February and March 1996, the Child Welfare League of America (CWLA) Managed Care Institute conducted a survey of state child welfare services administrations. To gather information for this survey, telephone interviews were conducted in February and March with at least one representative of the public child welfare services divisions in each state administration. This article contains information from 49 states. (Information from Nebraska was unavailable.) The purpose was to establish a baseline from which to monitor the implementation and use of the principles and technologies associated with managed care in the delivery of child welfare services.

Preliminary results indicate:

- Forty-one states out of 49 (82%) are considering applying or planning to apply managed care principles to the financing and delivery of child welfare services.
- Of those 41 states, 19 are considering sharing or planning to share risk with providers using models such as capitated rates, case rates, incentivized fee-for-service, or performance-based contracts.

  Few states have chosen which risk-sharing model they will use, and nearly all will implement plans incrementally, starting with limited services, specific geographic regions, and/or particular populations.

In addition to or apart from any plans to use managed care techniques, 34 of the 49 states plan to restructure, or are currently restructuring the administration of child welfare services. Thirty-six state legislatures have considered measures that would significantly change the delivery of child welfare services. In 24 states, the governor signed into law at least one provision that would significantly change the delivery of child welfare services in that state

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Without question, states are motivated to change and they are planning and implementing change. (In at least 19 states, the move to a managed care approach originated in the state or county child welfare office.)

It is important to note the many limitations of this survey. Interviewers were aware of differences in the level of certainty of the respondent and ambiguity and variance in the definitions of several terms (including managed care). Also significant is the fact that each state is at a different stage of implementation. Reported information regarding the specifics of state plans includes changes states are considering. The level of consideration ranges from very early stage plans to new systems already underway.

Management and Administration of Child Welfare Services

Of four states considering applying managed care principles to child welfare service delivery:

Eight states are considering plans in which the state would be entirely responsible for managing, delivering, and monitoring the services covered under a managed care plan.

Fifteen states are considering plans in which the state would manage the system, but would contract out for certain management functions.

Seven states would seek an outside organization, agency, or vendor to contract for, deliver, and monitor the services covered under the plan.

Of the 22 states considering contracting out or planning to contract out for all or part of management functions:

Eleven states would not place any restrictions on the type of agencies or organizations eligible to submit a proposal.

Eight states didn't yet know if there would be any restrictions on which entities could submit proposals

No state indicated that for-profit management organizations would be excluded from submitting a proposal.

Targeted Populations, Geographic Regions, and Services

Most current plans to implement managed care techniques and principles will affect only a portion of the child welfare population and involve limited service areas.

- Seventeen states would implement their managed care plan across the state.
- Four states would implement their plan in a specific geographic area.
- Six would limit their plan to a specific number of children.
- Twenty-four states indicated that they would include one or more of the following populations: children in kinship care, family foster care, residential or group care; and children in multiple systems (child welfare, juvenile justice, and/or mental health).
- Six respondents indicated that their state was considering or planning to include children and families who were at risk of abuse and neglect, but did not have incidents of substantiated abuse or neglect and or an open CPS case.

The top three service areas included or under consideration for inclusion in a managed care plan are:

- Family Foster Care (59%)
- Residential Treatment (55%)
- Group Care (52%)

Managed Care Tools and Principles

Most states considering using managed care for child welfare services intend to employ a broad array of managed care tools, such as utilization management (80%), continuous quality improvement (70%), and expanded, integrated MIS (67%).

When specifically asked, respondents expressed uncertainty whether the state or county government or a managed care entity would be responsible for the development and implementation of specific elements associated with these tools. These elements include: best practice protocols, social necessity criteria, provider profiling, credentialing, and MIS capabilities such as improving client tracking ability, comparing outcomes information across services and programs, and linking expenditures to outcomes.

Twenty-three states of the thirty responding to this question indicated that the state plan or RFP-identified specific outcomes. Of those 23, only 12 have identified indicators or other outcome measures. Twenty-eight of 49 states reported currently using performance-based contracts for at least one area of child welfare service delivery. Six states currently contract with private agencies using a rate structure that allows the provider to share potential financial risk and retain potential savings.

State Goals

Of states considering using managed care techniques, 29 states identified specific goals they hope to achieve. The top three identified goals were:

- Better Quality (80%)
- Cost Efficiency (73%)
- Increased Customer Satisfaction (55%).

The top three service areas included or under consideration for inclusion in a managed care plan are:

- **Family Foster Care (59%)**
- **Residential Treatment (55%)**
- **Group Care (52%)**

Linkage with Medicaid Managed Care

Survey results demonstrate a need for linkage and information sharing from child welfare managed care plans and Medicaid managed care plans within states, and from national studies on children's managed health care, behavioral care, and child welfare services.

Respondents -- representatives of child welfare agencies in states in which children in the foster care system are enrolled in a Medicaid managed care plan for behavioral and/or physical health -- hold the following views on the access and quality of care available to foster care children in their state compared with previous fee-for-service systems:

- Access: 37% better, 7% worse 11% same and 44% don't know
- Quality: 22% better, 3% worse 15% same and 59% don't know

Preliminary Conclusions

While it is clear that applying managed care to child welfare is under discussion in a large majority of states, the survey highlights enormous variation among the states -- from different definitions of managed care to a range of plans, targeted populations, and timetables for the application and implementation of managed care principles. Of states considering soliciting outside proposals for management functions very few have chosen to eliminate or prohibit a potential management role for either provider networks or private for-profit managed care organizations. Nearly every state considering using managed care reports involving providers in the planning process.

The evidence of such wide diversity among state plans is significant. There is no single, universally applicable model that is managed care. The plans in each state are shaped by unique political, geographic, demographic, and systemic characteristics, as well as differing levels of available resources.

Improved understanding of the application of managed care tools to child welfare services is increasingly important for those concerned with maintaining or improving the quality and efficacy of child welfare services. While few plans have reached the point where an evaluation is possible or useful, this survey is the first step toward monitoring the development and implementation of state managed care plans.

by Charlotte Mc Cullough and Susan Wright

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Speaking with a Common Language: The Past, Present, and Future of Data Standards for Managed Behavioral Healthcare

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Change is obvious at every level of the mental health and substance abuse enterprise. Currently, more than 107 million persons are covered by some form of managed behavioral healthcare, and 17 States have received waivers for Medicaid managed care that include mental health and chemical dependency. This dramatic change demands a new look at the state of information development, particularly data standards.

In a managed care environment, consumers, providers, payers, and management services entities will all be concerned with and affected by the quality, appropriateness, and coverage of the data standards that are employed. For example, consumers will want informative report cards with which to choose behavioral healthcare plans; providers will be concerned with the instruments used to measure the outcomes they achieve, with their relationships to the volume and type of clinical encounters, and with capitation rates paid for care; payers will seek accurate information on costs and the effectiveness of expenditures; and management services entities will need to understand how well capitation systems are working. Thus, for different reasons, all participants in the mental health and substance abuse enterprise will be concerned with data standards.

Within each of the examples cited above, statistical information systems need to be based upon data sources that employ common data standards if they are to be successful. In other words, summary information is only meaningful if based upon a common metric and common definitions. Hence, data standards form the basis for the mental health and substance abuse information enterprise.

The purpose of this chapter is to examine the degree to which current mental health and substance abuse data standards must be updated to be responsive to the dramatic evolution of mental health and substance abuse services under managed care financial arrangements. This will be accomplished by reviewing

previous efforts at development of data standards and examining these from the perspective of managed care information requirements. The chapter will conclude by discussing potential partnerships to facilitate needed changes and by presenting recommendations for specific courses of action.

EARLY EFFORTS AT STANDARDIZATION

More than a century ago, the U.S. Census Office worked collaboratively with the New England Psychological Association to define seven distinct forms of mental illness (mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsia) to be used in the 1880 census of the population. This collaborative undertaking set the tone for subsequent work that was to ensue in national census activities.

Later, these efforts were expanded to mental health providers. Starting with the 1923 Census of Patients in Mental Institutions, conducted by the then U.S. Bureau of the Census, diagnosis was used as one of the descriptive variables in state mental hospitals. This resulted from the joint efforts of the National Committee for Mental Hygiene and the American Psychiatric Association to introduce a standard classification of mental diseases into most of the state mental hospitals in the country. Subsequently, this classification was adopted by the Surgeon General of the Army, the U.S. Public Health Service, and by almost all public and private mental hospitals.

In 1949, Federal mental health statistical operations were moved to the newly-created National Institute of Mental Health (NIMH). Almost immediately, NIMH set up the Model Reporting Area for Mental Hospital Statistics, a joint endeavor with the state mental health agencies. The first step involved a study of the 11 states with central mental health statistical offices to determine definitions used, types and frequency of data collections, types of reports generated, etc. A major finding was that only 2 of the 11 states used

the same definition of first admission, and that wide variation existed in the definitions of discharge and resident patient.

To remedy the situation, NIMH invited the 11 states to a meeting in 1951 (the first National Conference on Mental Health Statistics) to agree on a course of action and to begin the process of developing and implementing comparable data standards. By 1965, 34 states were participating in this voluntary, collaborative project. In 1966, NIMH expanded the project to include ambulatory mental health care and designated the annual National Conference on Mental Health Statistics as the principal vehicle for consensus building and standards development. Generally, this endeavor was very successful and set the stage for subsequent progress. Dr. Morton Kramer, currently Professor Emeritus at Johns Hopkins University in Baltimore, was largely responsible for these developments and the progress achieved.

Mental Health Statistics Improvement Program (MHSIP)

By 1976, NIMH had effected a reorientation from data standards for state mental hospitals toward one focused on mental health statistical standards for all mental health organizations. A new program was initiated at this time--the Mental Health Statistics Improvement Program (MHSIP)--to continue and expand the collaborative relationship with the states and to evolve data standards that reflected current developments in mental health services.

For the first decade of the MHSIP, all work involved contributions in-kind by participating states since federal grants were not available. To the present, the states continue to contribute in-kind by encouraging staff to participate in MHSIP committees and by participating in national, voluntary data collections operated by the Center for Mental Health Services (CMHS) National Reporting Program (NRP) for Mental Health Statistics.

The initial set of data standards evolved by the MHSIP were published in 1983. These standards were based on the mental health organization as the principal reporting unit. Separate minimum data sets were proposed for organizations, for the clients they served, and for the human resources available to provide care. By the middle of the decade, these data standards had been widely adopted by the states. The approach employed was viewed by the World Health Organization (WHO) as a model for emulation by other countries.

INSERT FIGURE 1 ABOUT HERE

The 1983 MHSIP data standards were quickly accepted by the mental health field. However, the environment was changing rapidly--block grants were being introduced; a new focus was emerging on the population with serious mental illness; and state mental health planning was mandated under federal legislation. Managed care was also beginning to emerge in the early part of the decade, but was not a major force until 1990.

As experience developed with the MHSIP data standards and as changes occurred in the environment, the MHSIP community recognized the need to update the standards. In 1989, two new minimum data sets were added--one for financial information, the other for events. The original minimum data sets--organizations, human resources, and clients--were updated. In addition, a conceptual framework was developed for the MHSIP, based upon hierarchical, relational concepts. The clinical event was viewed as the basic unit of the system, to which one could link client, provider, and financial information, within an organizational frame. The revised and expanded set of standards was published in 1989.

INSERT FIGURE 2 ABOUT HERE

These standards were subsequently expanded with specific recommendations for

performance measures and for data standards for child mental health programs. The Ad Hoc Advisory Group to the MHSIP, a set of state, local, and consumer representatives, has played a particularly important role in developing the data standards and providing leadership to the field. Dr. John Hornick, Director of Planning for the New York Office of Mental Health, is the Chairperson for 1994-95.

In this same period, the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) worked with the states and local providers to define a minimum data set for a Client Data System (CDS) to be reported on every substance abuse client who received care from a public provider. Items included in the minimum data set were designed to be compatible with the MHSIP, and MHSIP representatives were invited to participate in the standards development process. The CDS is still in operation at present.

NIMH awarded the first grants to states to implement the MHSIP data standards in 1989. The original grants (type 1) were for $100,000 per year, for up to 3 years of support. By 1994, virtually all states and territories had received one of these grants. Throughout this early period of MHSIP development, two persons were instrumental in its success, Mr. Cecil Wurster, formerly Chief of the Branch with responsibility for the MHSIP program, and Dr. Walter Leginski, currently Chief of CMHS programs for persons with mental illness who are homeless.

In 1992, the NIMH grant announcement was expanded to include a second phase of implementation grants (type 2) and decision application grants (type 3) for the states. The second phase grants were intended to facilitate more complete implementation of the MHSIP standards; the decision application grants were for the purpose of developing and demonstrating the capacity to apply actual data to administrative, policy, or research problems. Both types carried

stipends of $125,000 per year, for up to 3 years of support. As of 1995, when the grant announcement was revised by CMHS, the current organizational location of federal mental health data collection activities, about three-fifths of the states and territories had received second phase implementation grants; about one-fifth, decision application grants.

CURRENT EFFORTS AT STANDARDIZATION

In 1995, CMHS adapted the grant announcement to the dramatic changes that were occurring in the environment. The new announcement focused attention on use of information for problem resolution; capacity development received less attention. The 1995 announcement was directed toward the facilitation of comprehensive state mental health planning and adaption of the state mental health agency to health care reform initiatives being planned or implemented by the state. These topics are described immediately below.

Historically, most state mental health agencies have employed statistical information to plan only for state-operated or funded programs. This planning typically has not included mental health organizations or practitioners from other not-for-profit or private sector entities. Similarly, mental health services delivered through primary care organizations or practitioners, social service organizations, or self help groups have not been encompassed in this planning.

As the states move toward managed care, it is essential that their planning be expanded to encompass the entire population with mental illness, as well as high risk groups. This will permit each state to understand the dynamics of clients who move from private sector plans to public sector managed care programs or other safety net programs operated by the state. The new MHSIP grant announcement encourages the acquisition and analysis of quantitative data for such planning.

State health care reform initiatives are proceeding at a rapid pace. In most states, these initiatives center on application for a federal waiver to transform the state Medicaid program into a managed care plan operated by a private-sector management services organization. Frequently, these waivers are designed to develop separate managed care plans for populations with mental illness or substance abuse problems, i.e., a "carve out" program.

To plan for managed care programs, the state needs to design a benefit package, develop homogeneous risk pools of consumers who will use different types and intensities of services, estimate the per client per year cost for each of the risk pools, develop a plan for how essential ancillary services will be provided and reimbursed, and prepare baseline service information prior to implementation of the managed care program so that performance can be assessed.

In the implementation phase for privatized managed care programs, state activities will change from planning to monitoring the performance of programs. In this phase, additional data are needed on population health status, enrollment, encounters, outcomes, and system performance indicators, the latter of which need to be synopsized in report cards for payers or consumers. The new MHSIP grant announcement is designed to encourage states to use statistical information for these planning and implementation activities.

Key Consumer Input

Since 1990, NIMH and, more recently, CMHS have provided support for a Mental Health Consumer/Survivor Research and Policy Work Group comprised of consumer leaders from the field. The purpose of the group has been to provide advice to the government and to the MHSIP on the development and implementation of data standards for mental health. The Work Group has helped to define person-centered data systems that reflect a major shift in philosophy toward persons

and use services. This has heightened awareness of consumer perspectives on service delivery, outcome, and recovery processes.

As a second major endeavor, the Consumer/Survivor Work Group has engaged in research through focus groups to define the cognitive maps that consumers use to think about service outcome. Currently, the Work Group is participating with CMHS and MHSIP in the development of a managed care report card for mental health and substance abuse. Development of this report card will create a method of providing feedback to consumers on plan performance. The final product will be made available to the states for use in their contracts with managed care organizations.

DATA STANDARDS FOR BEHAVIORAL HEALTHCARE

The MHSIP data standards provide an excellent foundation for the information systems required by managed behavioral healthcare. However, the current system of standards requires expansion and modification to meet the full range of information needs in the future. Essential developments in content, recording, and transmission standards are identified below.

Content Standards

Essential components of a good information system for managed care include, at the person level, data on the health status of the covered population, enrollment and encounter data for each covered person, and outcome data. In addition, the system will include information on disorder rates in the general population, descriptive information on the organization and operation of managed care entities and the providers that contract with them, and performance information on individual managed care plans.

INSERT FIGURE 3 ABOUT HERE

Health status data should be collected at the individual level in order to assess the individual's need for treatment. This would include information on the nature of the mental health or substance abuse problem being experienced and the impact of that problem on the functioning of the person. The essential concept is to identify problem and functioning measures that are predictive of the need for mental health or substance abuse services and that can be used in the development and assessment of clinical treatment plans.

Some work has been completed in this area. The National Comorbidity Survey is based on the Composite International Diagnostic Instrument (CIDI). The CIDI is an instrument through which lay interviewers can assess psychiatric and substance abuse diagnoses. Dr. Ron Kessler has completed methodological work on the CIDI to identify stem questions that are highly predictive of diagnosis. At present, the "CIDI stems" need to be codified into data standards, and a parallel set of items on functioning needs to be added to these standards (see discussion of outcome measures below).

Enrollment and encounter data are required to monitor managed care plans. Enrollment data should be collected at the individual rather than aggregate group level; they can provide an overview of the sociodemographic characteristics of an enrolled population. Together with health status data, enrollment information permits the construction of different risk pools when coupled with service use information. By contrast, encounter data are needed to provide a running account of services received AND their costs for each client. Such information can be used by providers to determine whether they are exceeding agreed upon capitation rates; it can also be used by states and other payers to monitor what types of persons are receiving what types of care and how this compares with the health status. MHSIP provides an excellent foundation for encounter data through the event data set developed as part of the 1989 standards.

Currently, the Subcommittee on Mental Health Statistics of the U.S. Department of Health and Human Services National Committee on Vital and Health Statistics is debating what should be recommended for enrollment and encounter minimum data sets. The Subcommittee will pay particular attention to what would differ in enrollment and encounter data standards for populations with mental health and substance abuse problems, compared with other populations. The overall National Committee is preparing to issue proposed enrollment and encounter minimum data sets to the entire health field; the work of the Subcommittee will be incorporated into this product. In anticipation of this product, the Ad Hoc Advisory Group to the MHSIP is preparing a report on enrollment and encounter data to submit to the Subcommittee.

Outcome data are a necessary component of an integrated, managed care management information system. Yet, a major deficit of the mental health and substance abuse fields is the lack of agreement among consumers, family members, clinicians, rehabilitation specialists, administrators, and researchers about how to measure the outcome of services. This deficit has hampered the development of improved clinical protocols, as well as the standing of these fields in the broader clinical community.

In recognition of the need for rapid developments in the area of outcome assessment, the National Alliance for the Mentally Ill (NAMI) has entered into a collaborative project with CMHS, NIMH, NIDA, NIAAA, and the Eli Lilly Co., to engage in three tasks: the development of a set of principles for outcome measures and systems; the implementation of a longitudinal demonstration to document an improved outcome measurement system; and the evolution of a communication strategy that can highlight the progress being made in this area. Broad-based input will be sought from the mental health and substance abuse fields on the products from this project.

Other projects are evolving to examine how current instruments, such as the

Behavior and Symptom Identification Scale (BASIS-32), the Medical Outcomes Study Short Form (SF36), and the Global Assessment of Functioning (GAF) can be abbreviated and adapted for a managed care environment. Clearly, a need exists for the evolution of data standards for outcome measures.

Disorder rates in the population data should be collected on a sample basis to allow for assessment of the overall health status of the general community population. These data comprise a necessary component for adequate services planning at the system level. The collection of these data over time, can be used to provide information on overall system performance with respect to its effect on the general population.

The ability to obtain this type of data hinges on the efforts underway to develop and test good predictive health status measures that cam be used within general population samples. The "CIDI stems", described earlier, have already been incorporated into the 1994 National Household Survey of Drug Abuse, an annual household survey conducted by the Office of Applied Studies within SAMHSA. It is anticipated that they will also be included in the triennial periodic modules of the redesigned National Health Interview Survey, scheduled for initiation in 1996 by the National Center for Health Statistics.

Descriptive information is required on managed care entities and on the mental health organizations and providers that contract with them. Characteristics, such as organizational structure and linkages, types of plans and services, types of payers and enrollees, types of organizational and individual providers, and sources of revenues and expenditures, are relevant. This information is similar to that collected through the Inventory of Mental Health Organizations and General Hospital Mental Health Services (IMHO), currently conducted by CMHS.

The 1994 IMHO had already been modified to collect information on the participation of mental health organizations in managed care plans. In addition, a checklist was developed to collect information on the range of services available through these organizations. The evolution of the IMHO will continue in the future to reflect the changes being made in managed care practices.

Plans are developed to collect information from managed care entities that operate or contract for networks of providers, as well as for health maintenance organizations (HMOs) that provide directly or contract for mental health services. Initial work in this area will be undertaken in late 1995 through a CMHS meeting with managed care entities. Clearly, organizational data standards will require revision to accommodate to these new requirements.

Performance information is required to evaluate managed care plans. Report cards are one specific form of performance information that will spark dialogue among key groups as they are developed. As noted above, CMHS is currently collaborating with the MHSIP and representatives of the consumer community to develop a mental health and substance abuse report card, primarily from the consumer perspective. This report card will encompass the key dimensions of access, appropriateness, outcome, prevention, and satisfaction. It is anticipated that this report card will be available in prototype form for critical review by early fall 1995.

Simultaneously, CMHS is working with other key groups developing behavioral healthcare report cards to facilitate coordination among them. One meeting has already been held among these groups, and additional meetings are planned. These groups are the National Committee on Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Managed Behavioral Healthcare Association (AMBHA), the Institute for Behavioral Healthcare (IBH), and NAMI. A collaborative endeavor among these

entities can provide the framework for data standards in this area

Recording and Transmission Standards

Equally of concern to the mental health and substance abuse fields are the recording standards for clinical data and the transmission standards for sharing electronic versions of clinical and financial information. Recording standards are needed for the mental health and substance abuse components of an electronic patient record, which is currently being developed. Transmission standards are concerned with the form in which information is sent and received electronically, as well as the format that is employed for such information. Both areas are intimately linked with privacy and confidentiality concerns.

Recording standards are very important at present because they will ultimately define the clinical information that is captured about clients and the services they receive. In most instances, derivative statistical information will be limited by the nature and scope of this electronic information. CMHS is currently supporting an Ad Hoc Work Group for the Computerization of Behavioral Health and Human Service Records that will prepare recommendations for recording standards.

At present, most work on transmission standards is outside the fields of mental health and substance abuse. The National Institute on Standards and Technology (NIST) of the U.S. Department of Commerce is currently working in this area, and the European Common Union (ECU) has set up a project to identify appropriate transmission standards. At minimum, information representatives of the mental health and substance abuse fields need to stay abreast of this work.

PARTNERSHIPS FOR THE FUTURE

As we prepare for the 21st century, we need to envision now we will develop data standards for the future and the new partnerships and joint ventures that will be needed to make this possible. Clearly, task focus and partnership linkage are interdependent and synergistic. Suggested below are several major partnerships that could be very productive at the present time, together with a brief comment on the partners who are needed in order to make these endeavors successful.

Partnerships to revise current MHSIP data standards must be a high priority in the short-term future. The areas that should be incorporated or revised have already been described above--health status, enrollment and encounter, outcome, and system description and performance. The key to future work in this area is to add new partners, such as managed care entities and HMOs, while continuing the excellent collaboration of CMHS with consumers, providers, and states initiated in the past. This work should be undertaken as soon as possible in order to maintain consistency of information collected on managed behavioral healthcare, as this field evolves rapidly.

Partnerships to develop a mental health and substance abuse report card for managed care is another high priority. Previous work has been described above. The critical issue at present is to achieve an appropriate level of consistency in report cards across public and private plans and different service settings. For example, report cards for private plans may not require the same range of information as those for public plans because the clients are vastly different and their service needs are not as extensive. However, when the same topic is covered on different report cards, then it is reasonable to expect that it be measured in comparable ways. All major entities developing report cards for managed behavioral healthcare--CMHS/MHSIP, the National Committee on Quality Assurance, the Institute for Behavioral Healthcare, the Joint Commission on Accreditation of Healthcare Organizations, the American Managed Behavioral Healthcare Association, and the

National Alliance for the Mentally Ill need to be partners in this endeavor. Private sector managed behavioral healthcare entities that already have report cards should also be consulted.

Joint activities with WHO hold promise for helping us learn from projects already carried out in other countries, as well as for developing a data base for comparative inter-country analyses. WHO also frequently serves as a conduit for the sharing of informal knowledge about regional projects being conducted in Europe, the Far East, etc. Within this context, joint projects with WHO on data standards can facilitate more rapid development of appropriate standards in the United States.

High priority needs to be given to the development of joint projects with WHO around data standards for health status and outcome, as well as data standards for a more discrete and operational array of mental health and substance abuse services. WHO already has projects underway on the former topic, e.g, revision of the International Classification of Impairment, Disability, and Handicap (ICIDH), and has held several preliminary meetings with the United States and other countries on the latter topic.

Collaboration with AMBHA and the Group Health Association of America (GHAA) is very important for establishing appropriate data standards for managed behavioral healthcare entities. AMBHA represents and understands managed behavioral healthcare entities that operate in a network environment; GHAA represents and understands HMOs and their mental health and substance abuse components. An opportunity exists to work with AMBHA and GHAA in the development of future information projects within their organizations, as well as to elicit their participation in broader projects. CMHS needs to employ the federal leadership role to convene these entities with others in common data pursuits.

Recommendations for the Future

Listed below are several general recommendations for the future that ensue from the review outlined above. Each reflects a different facet of the data standards enterprise for the mental health and substance abuse fields. Some will be relatively easy to achieve; others, relatively difficult.

In the future, joint endeavors between government--federal, state, and local--and the private sector mental health and substance abuse industry will be the only feasible way to assure essential consistency in data standards. As all levels of government assume a smaller direct mental health and substance abuse service provision role with the growth of contracted managed behavioral healthcare, the focus of standards development will also need to shift to the private sector. Government will be able to make this shift and maintain accountability to the Congress and state legislatures through the types of partnerships and joint ventures described above. Such partnerships should be initiated in the short-term future.

Data standards development activities must reflect the views of all participants. Partnerships between government and the private sector reflect part of the picture. Consumers, family members, and providers are essential to complete it. Although the MHSIP has done an excellent job in bringing these groups to key partnerships, more needs to be done to bring their points of view on data and information to the managed behavioral healthcare industry. Clearly, each of those groups is directly affected by any decisions reached by the industry; hence, they should have a voice in these decisions.

Adaptation to unanticipated future changes will be a necessary part of the data enterprise over the next decade. Managed behavioral healthcare is now established. However, the future course is uncertain with respect to which

structures and methods will predominate: separate managed behavioral healthcare plans, integrated general healthcare networks, HMOs that include behavioral healthcare, or other forms. Likewise, the development and adoption of computer technology is proceeding at a fast pace, but the future course is not completely clear. The data standards enterprise needs to anticipate and adapt to new developments when if not before they arise, rather than to lag behind those changes by several years. This can only occur if careful attention is given to developments in services and technologies as they occur, with reflection upon their data implications.

Data standards should adequately reflect "virtuality" in service delivery systems. The most efficient, cost-effective way to achieve comprehensive, seamless service systems in the future is not likely to be through the development of a single service cafeteria in which all services are available, but rather through contractual and computer linkages among these services so that they are seamless from the perspective of consumers and providers. This approach represents a "virtual" organization. Such "virtual" organizations are likely to become very common as mental health and substance abuse services are linked with general healthcare services, and social services, housing, and other services are brought under the managed care umbrella. Data standards should reflect these "virtual" organizations and be capable of permitting interface among their service components.

The future holds considerable promise. We must be prepared to meet the challenges that it presents. Clearly, our past and present have positioned us to do this in an excellent manner.

NOTES

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FIGURE 1

1983 MHSIP MINIMUM DATA SET ELEMENTS

ORGANIZATION

Name
Address
Location
Service Area
Telephone Number
Director's Name
Ownership/Control
University/College Connection
Type of Organization
Operating Expenditures
Income by Source
Accounting Year
Staff:
  Discipline/Training by
    Employment/Contract Status
  Vacancies
Clinical Consultants by
  Discipline by FT/PT
Reporting Year
No. Discontinuations
No. Client/Patients on Rolls
Program Element (PE) Data:
  PE's within Organization
  PE's Provided by Affiliation
    by No. of Clients
  Affiliates Name/Address
  Discontinuations by Primary
    Diagnostic Groups
  Census by Diagnostic Groups
  Primary Age Groups
  Inpatient/Residential PE's:
    Beds
    Patient Days
  Outpatient/Partial Care PE's:
    Additions by Diagnosis
    On Rolls End of Year
  Partial Care PE:
    Half-Day Sessions/Week
    Visits (Year)
  Outpatient PE:
    Operating Hours/Week
    Visits by Type (Year)

HUMAN RESOURCES

Organization ID
Date of Report
Record Identifier
Employment Status
Job Title
Discipline/Training
Education
License/Certification
Participation in Private Practice
Principle Place of Employment
Date of Birth
Sex
Race/Ethnicity
Activity Hours/Sample Week:
  by Program Element
  by Major Activity/Service
  Consultation/Prevention Hours
    by Recipient Group

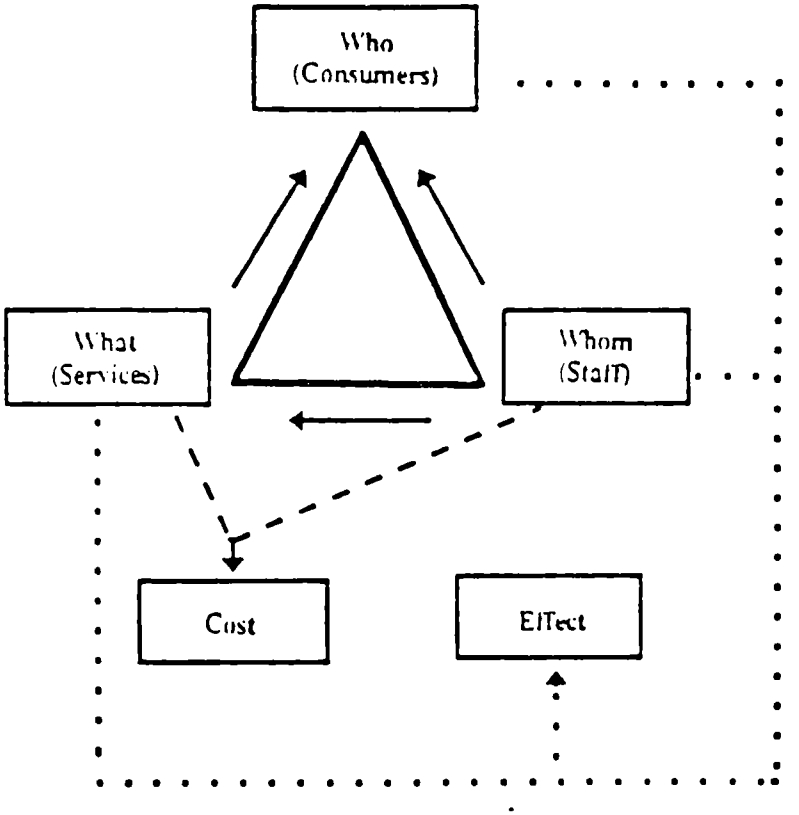
CLIENT

Organization ID
Type of Report:
  Census/Discontinuation
Date of Addition
Date of Last Service
Census:
  Active Program Elements
Sex
Date of Birth
Race/Ethnicity
Marital Status at Addition
Residence Location at
Addition
Presenting Problem
Handicaps/Impairments
Diagnosis
Referral Source
History of MH Services
Expected Payment Source
Living Arrangement:
  at Addition
  at Discontinuation
Discontinuations:
  Volume of Program Contact
  Circumstances at Discontinuation
  Discontinuation Referral
Date of Report

Adapted from Pelton and Lagnado (1983)

FIGURE 2

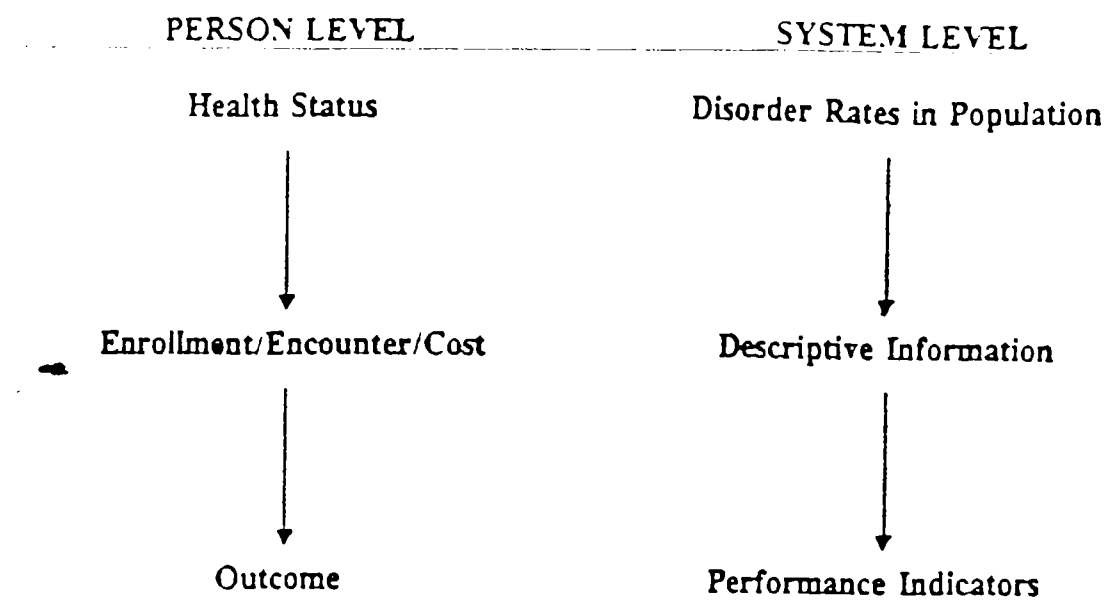
CORE INFORMATION REQUIRED FOR DECISION SUPPORT SYSTEMS IN MENTAL HEALTH ORGANIZATIONS



Adapted from Leginski, et al. (1989)

FIGURE 3

MODEL OF DATA FOR MANAGED CARE



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