Managed Foster Care: Opportunity or Oxymoron?

Potential Benefits & Problems of Applying Managed Care Principles to the Foster Care System?

Managed care principles and practices appear to offer intriguing prospects and possibilities for strengthening the management of foster care services, particularly if the attendant risks can be adequately addressed. That this development is likely to happen is suggested by the following:

- The health care industry historically was, and the foster care industry currently is, reliant on ineffective fee-for-service reimbursement models.
- The difficulties experienced by providers and policymakers, both nationally and in individual states, in achieving either their fiscal or program policy goals.
- Rapidly increasing foster care expenditures and eligible populations across the country.
- Cost shifting by managed health care programs to foster care.

A number of provider organizations and managed care programs in the behavioral health field are considering diversification through modification or expansion of their service lines for other payers, such as child welfare/foster care, developmental disabilities, and corrections. Each organization must look at both opportunities for, and risks to, behavioral health organizations entering the foster care field.

There is great potential for positive change by importing managed care principles and practices into the foster care service industry. Some potential positive effects include:

- Removing the incentives under fee-for-service to provide the most expensive (i.e. highest fee) services and of more services than may be clearly needed.
- Expanding eligibility for and access to foster care services and to medical services for foster children.
- Increasing management flexibility and creativity by breaking down the often arbitrary categorical program funding restrictions (such as the separation of Title IV and Title XIX funds) which make it difficult to effectively manage service delivery.
- The opportunity for foster care service providers to participate more directly in the management of their environment.
- Increasing emphasis on quality of service outcomes measures (e.g., through performance-based contracts) in contrast to the current emphasis on compliance with "process"-based regulations which focus on how services are delivered.

Despite these advantages, there are pitfalls. Policymakers, service providers, managed care organizations (MCOs), and advocates for children and families in need of foster care services will need to be attentive to potential risks if they are to consider applying managed care principles to foster care service environments. Some of the risks include:

- Expanded eligibility for services in an era of budget balancing, could lead to "fewer services for more children and families", with providers of services having to "do more with less"
- The foster care industry on the provider and governmental levels has grown reliant over the last few decades on categorical funding and program regulations and, therefore, may need a significant period of transition in order to successfully function in essentially "deregulated" environments. Without appropriate adaptation periods, chaos could result.
- The juvenile/family courts could actively resist and even undermine the efforts of managed foster care services since court officials often regard these services as under their sole jurisdiction. "shared management" models with courts and MCOs must be developed in order to effectively serve children and families in foster care systems.
- Current foster care providers will have to develop new management skills in order for their organizations to be as "managed care ready" as possible. In addition, government agencies and other system managers will have to create a regulatory environment which is flexible enough to encourage planful programmatic experimentation, while maintaining outcome tracking and analysis, so that the results of experimentation can be thoroughly evaluated.
- Unfamiliar partnerships between private MCOs and government agencies at the state and local levels may occur, because private MCOs are not familiar with the foster care service delivery. Also, most government agencies do not have the necessary managed care skills and management capabilities (e.g., cost analysis, actuarial expertise, information systems, etc.).
- On the assumption that the consolidation trends experienced in health care will emigrate to foster care, over the next five to 10 years there will be fewer, but larger, child welfare provider organizations — and those that survive will do so, in part, by developing new and different alliances and foster care partnerships.

It is important, however, to maintain awareness of the potentially essential differences between foster care and health care. It appears at this time that it would be inadvisable to directly transport managed care principles and practices into the foster care service industry. Partnerships of foster care service provider organizations, managed care organizations, advocates, and governmental policymakers should be developed for pilot tests in order to develop a solid foundation for a new set of managed care practices specifically adapted and tailored for foster care.

Future issues of *OPEN MINDS* will continue to explore the expanding horizons in foster care with more indepth analyses of service utilization and expenditure data, as well as through discussions on pioneering initiatives across the country which are either already underway or are being planned. Readers who are either involved in, or are aware of, efforts which involve the development and testing of new program models, creative funding mechanisms, new management strategies, etc. related to foster care services and managed care principles are encouraged to contact the author at *OPEN MINDS*.

By Dave Doty, Ph.D.

Changes in the Child Welfare System and Role of the Public Sector Caseworker Under Child Welfare Managed Care

By Tracey Feild

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The topic of discussion or plan currently in many states and municipal jurisdictions is child welfare managed care. In a recent survey, the Child Welfare League of America found that 82 percent of states are considering applying managed care techniques to child welfare services. Among the reasons for this are: the use of managed care in other service systems affecting child welfare clients; pressure from private child welfare providers developing managed care models for other payers; a conservative trend in the role of government vs. the role of the private sector; and the general perception that the child welfare system is "broken" and in need of reform.

Many in the field believe that child welfare will inevitably be pushed toward managed care within the next five years. Yet, one of the biggest questions to arise is the delineation of roles and responsibilities between the public and private sectors.

DEFINING CHILD WELFARE MANAGED CARE

Child welfare administrators are defining managed care in a variety of ways. Some are attempting to narrowly define child welfare managed care in order to protect the current dominant role of the public agency and its staff. In so doing, they fulfill the mandate or "ground swell" for managed care without undertaking a total system reform. In other instances, administrators want to test the viability of child welfare managed care, phase it in over time, or minimize immediate change – perhaps hoping it is just a passing fad. This all has resulted in some interesting child welfare managed care initiatives undertaken within the public sector. The following are brief descriptions of these efforts:

Some recent initiatives are essentially **performance contracting** – linking payments for services to the contractor's performance in achieving predefined outcomes. The managed care techniques incorporated into this design link the payments to performance and base the unit of payment and rate on average costs for a particular category of clients. These contracts usually tie fiscal incentives to desired performance.

Privatization is another term often confused or used interchangeably with managed care. While privatization can include managed care techniques, it doesn't necessarily equate to managed care. Privatization may simply be contracting for services or functions previously undertaken within the public agency.

Applying **managed** care techniques to **contracted services** is another model being discussed by child welfare administrators. What this model does *not* include is any change in the role of the public agency case manager, who is still charged with a primary case management function. This model is often discussed for children who require residential treatment services. Generally the provider would be paid a flat amount or a flat monthly fee based on the average expected cost of out-of-home care. There is some level of financial incentive for serving the child in less costly care. Variations on payment systems reflect ➤

"How services are delivered under managed care fundamentally shifts from the risk of over-utilization to the risk of under-utilization."

"If public sector managed care does nothing more than shift the reporting requirements from detailed planning and expenditure data to a focus on outcomes for children and families served, it will have succeeded in advancing the administration of the child welfare system."

individual jurisdiction issues and values. The use of managed care techniques for contracted services allows state administrators to become comfortable with the concept of managed care without necessarily sacrificing staff or case control.

Public Child Welfare Managed Care: County-administered states and those with clearly defined regional or district offices are exploring the concept of establishing their local child welfare agencies as managed care entities, requiring the use of managed care techniques to guide resources. This model assumes the techniques can be applied effectively in the public sector. While it certainly could be argued that the current public child welfare system is a "mongrel" managed care system, it by no means embraces the rigor and structure typically imposed through managed care.

The current child welfare system already has a single intake procedure, attempts to coordinate care through a case manager, and has a utilization review process for children in out-of-home care (i.e., semi-annual administrative reviews).

Managed care techniques present, from the current system: utilization management, quality assurance, outcome measurement, practice protocols are elements that may be difficult to develop since it is likely that additional administrative funds would be necessary. Securing funding to enhance administrative systems has never been easily achieved in child welfare.

Despite the ability of the public agencies to implement all the elements of managed care, many county administered states currently place enormous service and financial reporting requirements on their local counterparts. Seldom do these requirements address quality of care issues. If public sector managed care does nothing more than shift the reporting requirements from detailed planning and expenditure data to a focus on outcomes for children and families served, it will have succeeded in advancing the administration of the child welfare system.

Child welfare managed care, in the

Managed Care Techniques

Child welfare managed care applies an array of techniques to manage the utilization of child welfare resources. Typically, the array of managed care techniques would include the following nine elements:

1. A single intake and assessment process is used to identify problems and needs.
2. Common protocols are used to match needs and problems with services which can be authorized for limited periods of time.
3. Establishment of a simultaneous and ongoing review of the consistent application of protocols, and a continuous review of the value of the authorized services in addressing the identified problems and needs (utilization management). The information obtained from this review is used to continuously adjust the services and authorized time limits.
4. All services are coordinated through a single point.
5. Expected or desired client outcomes, both systemic and individual, are defined and measured.
6. A formal quality assurance process is installed to assure:
   - that clients are receiving services that correspond to their needs;
   - that appropriate goals and expected outcomes are established and that the services are achieving them;
   - that services are provided only as long as necessary and at a level of intensity and restrictiveness only as high as required;
   - that clients are treated respectfully and are satisfied with the process, and understand their rights and grievance procedures.
7. Systematic review of provider performance is undertaken to assess the relationship between the types of problems and needs addressed, the mix of services provided, the cost of services, and the client outcomes in order to more effectively and efficiently assign clients to providers.
8. The unit defining the payment is a particular category of client, not the service provided, and the payment rate is based on average historical or expected utilization of the range of services across the category of clients.
9. Payments for clients can be used flexibly, encourage the use of preventive, low cost and least restrictive services, and are linked to predefined desired outcomes.

broadest sense, encompasses the range of managed care techniques and fundamentally changes the role of the public sector worker. In this model, the managed care entity (MCE) is paid based on flat rates or flat monthly fees that represent the average cost of the services provided to the particular category of clients included in the plan. The MCE is responsible for addressing a predefined range of client needs and is rewarded for achieving desired outcomes. The MCE also assumes an assessment process, service authorization based on practice protocols, provides case management services, and undertakes utilization management, quality assurance, and outcome measurement.

THE ROLE OF THE PUBLIC SECTOR CASEWORKER

Under this broadly defined child welfare managed care system, the role of the public sector worker is significantly different; no longer would the worker be providing case management services typically considered within the public domain. The MCE's case manager would assume responsibility for developing the case plan, arranging and monitoring the services, and establishing in-person contacts with the child and family. This transfer of case management responsibility does not mean the public sector worker is no longer needed. Their role will have to be redefined.

How services are delivered under managed care fundamentally shifts from the risk of over-utilization of resources to the risk of under-utilization. In the current system, there are unintended incentives to over-utilize services (payments based on unit of service provided). Shifting the incentives toward under-utilizing services, however, could result in children being at risk. Protecting children from harm is the fundamental purpose of the child welfare system. For this reason, the public oversight role is more significant and critical to the viability of child welfare managed care. That oversight role will be imperative in these four areas:

1. The investigation and risk assessment functions for high risk cases are likely to remain within the public sector. The distrust regarding the motivations of the private sector is too high to result in any immediate change. Furthermore, keeping investigative and risk assessment functions public while privatizing case planning and service delivery allows for a reasonable and responsible separation. The public agency is responsible for protecting the child; the private MCE is responsible for providing cost-effective and efficient services.

2. Once the risk level has been determined, the assessment process completed and the case plan developed, public agency staff may wish to approve the case plan. This approval assures the child is adequately protected, and that protection and permanency goals guide service delivery. The MCE may propose that the child remain at home with services provided in the home. The public agency staff will review the plan to assure that the proposed in-home service array is adequate to protect the child and address the family's needs. This involvement should protect against the potential for an MCE to under-serve client families.

It is possible that, after several years experience refining practice protocols, the case plan approval role can be reduced. But in the first few years of child welfare managed care, while protocols are still in their developmental stages, this role will be essential to the protection of children.

3. The third point at which public agency staff may wish to intervene is when there is a change in the case plan that results in a reduced level of care or service to be provided. The role of public agency staff is to assure the child is adequately protected and served, and proposed changes should reflect good case practice, as reflected in the protocols, rather than cost containment or avoidance. Again, it is possible that over time this role could be reduced, assuming practice protocols can be developed that can link needs and services to improved family functioning and child safety.

4. The fourth role involves creating a function not typically undertaken in the current system: a method of quality control similar to that used within the Aid to Families with Dependent Children (AFDC) program. This quality assurance process would entail case record reviews and interviews with direct care staff, case management staff, the child and child's family. It would provide a systematic, qualitative review of the interventions provided on behalf of children and families.

These newly-defined functions would serve to elevate the role of the public sector worker to one of oversight and monitoring as opposed to direct service provider. Separating the public and private sector roles would help the system deal with the uncomfortable and sometimes disturbing dichotomy between investigator vs. helper, and service provider vs. service monitor. The roles of helper and service provider would be lodged within the private sector, and the roles of investigator and service monitor would be lodged within the public sector.

These four functions may require fewer public sector workers than currently exist in many states. However, the workers needed would be the most skilled and experienced, and more likely to be at the supervisory level.

The shift to a broadly defined child welfare managed care system would benefit the child welfare system in many ways. First, it would make providers an integral part of the case planning process and allow for an independent monitoring mechanism. Second, it would add a healthy tension to the system that would result in more efficient and effective use of resources. Third, rather than continuing to be lost in the current quagmire of transporting clients, finding placement resources and achieving regulatory compliance, it would focus the public role on protection, permanency, and outcomes for children and families.

As states implement managed care tools in child welfare over the next several years, they will begin moving toward a broadly defined child welfare managed care system. Within 10 years, the child welfare system will have transformed into a system that is fundamentally different from that which exists today – a system that better serves the needs of children and families, while recognizing the limitations of the public dollar ★

ETHICAL OBLIGATIONS TO PROTECT CHILDREN: HOW MANAGED CARE CAN IMPACT SERVICES FOR CHILDREN AND FAMILIES

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"Keeping the Focus on Kids: Outcomes, Ethics and Partnerships in a Managed Care Environment

BY

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The American Humane Association is exploring the topic of our ethical obligations to protect children under Managed Care Special emphasis on issues of safety and permanence can help focus this challenge. to fully explore this topic in a limited time, it is necessary to perhaps overstate and generalize some of our concerns All concerns do not apply to all states, to all systems or to all agencies. Nonetheless, our concerns are based on actual work assisting child welfare and child protection systems as they adapt to the Managed Care environment

I. How Did We Get Here?

For decades, child welfare programs have been funded by various federal funding streams--IV-B, IV-E, Title XX--and others As we looked for additional resources to rehabilitate and to "fix what was broken" in our families, we turned to the uncapped Title XIX--Medicaid. States learned quite rapidly how to get reimbursement for behavioral health care services. **The term behavioral health is used to specify mental health and substance abuse treatment services. These behavioral services include impatient, outpatient, and residential care.**

In states like Massachusetts, new contracts for child welfare services were given preferentially to agencies with third party licensure because they were able to successfully shift the cost of rehabilitating or "fixing" the family from the more restricted Title XX to the seemingly more plentiful Medicaid. Such cost shifting initially relieved the burden on social service programs. Counseling and substance abuse treatment could be charged to health insurance, most often Medicaid when the poor were seen, instead of to the more limited social service funding streams.

At first, state governments approved of this "intertitle transfer" to Medicaid because it provided an uncapped reimbursement resource. However, the state dollars needed to match the federal Medicaid reimbursement began to escalate. While private businesses publicly decried escalating health insurance costs for employees, governments started to scrutinize the increase in Medicaid costs for the poor.

Increased spending for the elderly Medicare population was also growing substantially but containing Medicare was traditionally seen as politically "off limits." Although the growth of Medicaid behavioral health costs for poor children and families was minuscule when compared with the increases for the elderly, these costs were ones that state governments could more safely try to control without incurring political wrath.

The failure of the Clintons' health care reform was key turning point for policy makers and tax payers. There was already an appetite to control spending and the federal government was less likely to intervene to protect the poor A more conservative Congress was less prone to protect aspects of federal entitlements. Waivers of more restrictive health and welfare mandates were easily granted to states, supported by Democrats as well as Republicans.

Poor families on AFDC were urged and encouraged to sign up for HMO's Record numbers of families did sign up. It should be noted that for the poor, managed medical health care has much to offer. Poor people have traditionally obtained health care from emergency rooms and not from coordinated systems of care Thus, we can see very high rates of breast and prostate cancers among poor minorities. One does not get mammography in an emergency room.

If HMO's have been good for medical health, they have been seen as of questionable value for behavioral health Since they are designed to contain cost, there is little incentive to offer what we would thing of as "sufficient" mental health intervention for children and families. These constraints and limitations affect the poor and also the middle class families who get the same insufficient behavioral health care from HMO's. All insureds are getting less and paying more for it than they were five years ago

II. The Prevailing View

Child welfare and mental health professionals are skeptical about the changing environment Child welfare, mental health and service provider personnel grumble that Managed Care is really "Imagined Care" (see cartoon by Wasserman from the Boston GLOBE.) We hear that Managed CARE is really Managed COST. After all, the word "managed" is threatening to a public child welfare bureaucracies that have never been known for being particularly well managed.

Managed Care is not so different from many other trends that have come our way. **Family Preservation was promoted to political leaders not only as a better service but as a way to reduce the escalating costs of substitute care.** Unlike Managed Care, Family Preservation had a wonderful, embracing and non threatening name Who, after all, could ever be against something as full of promise as "Family Preservation?"

III. Current Ethical Issues in Child Welfare

Before we look at ethical issues in Managed Care, we need to look at some of our current ethical problems and be careful not to blame new trends for old troubles. **How ethical, after all, is our current child welfare system?** Recent research completed by a federal grant in which I have participated shows that the public views child protective services personnel as "lazy, incompetent and indifferent." Why should they admire us? We do not share client information. We disagree with one another in public and help erode public confidence. We cannot explain what we do in plain English. What are "reasonable efforts?" Does the public know what they are? Not if they listen to us

We are the ones who took a fine concept and program called Family Preservation designed for a small number of specific families and turned it into the 'one size fits all'

service for all families. we have staffed public and private agencies with the untrained and the uncredentialed. **We have hidden our worst practices behind confidentiality statutes designed to protect client privacy.** Many public agencies, and some private ones, are run by political appointees and people without professional credentials. Would we tolerate this from our own health care provider?

Worst of all, we have not kept children safe Why did we ever say we could keep children safe? **We are not the only ones who are responsible for children.** Parents and the larger community have major roles to perform to keep children safe. Yet, our media often infers that Child Protection agencies are the only ones who have a role and a responsibility. Social workers who are isolated from the larger community cannot always protect children adequately.

Who are we to promise what we have never been able to deliver despite our best intentions? **We are seen as either removing children from parents too swiftly or failing to remove at all.** We promised an error free system by repeating to the public that "Every child deserves...." and "Every child will be protected from . . ." What doctor says "Every patient will get better?" or "Every sick person will be cured?" What hospital promises error free medicine? Why keep promising what we shall never be able to deliver?

We make these promises while children in our 'open' caseloads, children who are 'on our watch,' children residing in placements we have chosen for them to continue to suffer from abuse and neglect. Sometimes we fail to visit foster homes. Often we poorly monitor residential facilities. In some states, we have not even determined if our "approved" substitute caretakers have criminal backgrounds.

Our very definitions of safety and permanence vary. No two systems even use the same Risk Assessment tools. It was not until the American Humane Association began a professional study of Risk Assessment that the field began sharing Risk Assessment technology. In some states, a Risk Assessment tool is one or two pages. Some states have used different tools in different parts of the same state.

For all of our social and financial commitment to foster care, residential care, parent education, individual therapy and family counseling, **we have scant reliable outcome data** on the efficacy of any of them. We have scant outcome data to determine the advisability and effectiveness of the services in which we have invested billions of dollars. Where is the hard evidence that foster care, residential care, parent education, individual therapy and family counseling, build better children and stronger families? Until the American Humane Association began to explore the content and context of Outcome Measures, our field had made little effort to document the worthiness of its efforts.

Furthermore, child welfare has no uniform technology. There are no uniform standards or goals for child protection. We have no standards for who can provide child protection. There is no parallel to the Center for Disease Control for us There is no

national MIS system with a centralized data base. There is no New England Journal of Medicine or a JAMA (Journal of the American Medical Association) that practitioners read consistently. There is no federal help for us to solve our worst problems. There is no centralized academic commitment to our practice. The Schools of Social Work interested in child welfare have no unifying funding source compelling them to collaborate.

Our case practice confusion is pervasive. Every state and county must investigate child abuse and neglect one way or another. Yet, we have no uniform definition of an Investigation. How long should one take? Who should be interviewed? What are the contents? Where is the detailed protocol for doing a thorough one?

What is an Assessment? Why do so many workers confuse it with a Risk Assessment tool? What is Case Management? What is a Caseload? Do we keep our data by counting families? Children? Both? Even in the six New England states, we are unable to compare caseloads because no two states count the same way. Some count families, some count children and, to add to the confusion, states like Connecticut count both at the same time.

Unlike most other professions.--law and medicine come to mind--our staff do very little reading of literature in the professional journals. Many of our offices do not obtain and make available books or articles for routine review. **Continuing education is essential for intellectual and professional growth as well as for licensure but most state employees are exempt from professional licensure requirements. Since most CPS systems are public, we have, in effect, removed child abuse and neglect practitioners from the requirement of professional licensure.**

I suggest that the medical model holds promise to organize and systematize fragmented practice. For all of the disdain expressed about Managed Care, at least it is managed. The response to acute pancreatitis is the same no matter where a patient lives. Open heart surgery follows the same procedures and protocols in Boston as in Houston. Medicine has technology, protocols and standards. These should also be the foundation of child welfare.

Mental health practice may need some improvement but it offers some benefits. The DSM-IV that I use in Boston is the same one used by colleagues in Minnesota and Los Angeles. Child welfare has not even begun to organize and standardize itself. Yet, it is from child welfare professionals that we hear of enormous resentment to the medical model and to Managed Care. Inferences that Managed Care is "unethical" must be viewed in the context of our own poor ethical behavior. Our assumptions that we are the ethical people who promise to protect children and keep them [illegible] is open to dispute.

IV. Current Ethical Issues Purchasing Services for Children and Families

Private providers and voluntary agencies have a rich history of delivering services to children. Many private agencies, especially in the East, pre date governmental

involvement in human services. The term "privatization" is used to define the governments' purchase of private services to expand, supplement or replace public services. **Many ethical issues already exist in the way we purchase services from the private sector.**

We have contracted with a patchwork of agencies, most of them not-for-profits. For many private agencies, the expansion of Title XIX was financially beneficial. For approximately five years, it has delivered substantial reimbursement to providers of behavioral services. Many have been successful billing Medicaid for social service agency clients. However, some clients did not 'get well' until their benefits ran out. There have been very few limitations on these behavioral providers. **There has been little if any incentive to look at the cost effectiveness and the service effectiveness of government subsidized services delivered by private providers.**

The government has been a very financial good partner for many private agencies, sometimes better than is programmatically or fiscally advisable. Contracts with private providers got 'rolled over' year after year. Beds stayed full and providers thrived. Meanwhile, there was little evidence of outcome data or objective evaluations documenting the need or effectiveness of these contracted services. **If the state did not require data or outcomes, the providers did little to initiate good monitoring or evaluation.**

The emergence of Managed Care has cast a large shadow over many private agencies who perceive it as a threat. Managed Care and Managed Cost feel like a steel door closing on the livelihood of the providers. It is true that many providers will not survive in their current structures. some will be merged, some will be submerged and some will simply disappear.

Only those who can deliver services that are both cost effective and hopefully service effective will survive. Providers must advocate for quality even if the state does not insist upon it. While many providers complain that Managed Care is unethical, I ask why it is unethical that only those agencies who can deliver the best service at a low cost will be the ones to survive? That hardly sounds unethical to me.

Our current system of purchasing services for children and families is open to criticism. Public child welfare systems currently purchase millions of dollars' worth of services for families and children. Foster homes, residential care, psychological counseling and therapy, child care and caseworker training are among the major services that are purchased.

Most states and counties must follow bureaucratic purchase and contracting methods that can be archaic and inflexible. **In communities with few resources, clients often get what is available instead of what they really need.** When an agency considers purchasing services in a community, there are important cautions. Many of these

questions have important ethical implications. These are the same questions that must be asked when entering a Managed Care environment.

Is the client getting service that reflects an agency philosophy that is incompatible with what the client needs (or wants?) A good example has been the application, however well intended, of Family Preservation services for families that did not want them or were not ready to participate in the mutual agreements necessary for success. Did the family really need detoxification or drug treatment but get a parent aide instead? Did the family really need child care and get counseling? Such scenarios are typical of service availability gaps (and of poor case assessment practices) Is the agency offering, through its contracts cognitive therapy that requires client insight while not addressing more concrete behavioral issues like child safety?

Does the service that is purchased meet the needs of the client or of the provider? Many residential care facilities across the country have become powerful and effective lobbyist on their own behalf. They have a natural investment in keeping their beds occupied even when community based services may be better able to implement family reunification. The residential provider network is often successful in perpetuating its own survival through its prominence in the community, its citizen board members and its political visibility.
Can we really say that our public Requests for Proposal (RFPs) have been based on the clinical needs of the client and not on the perpetuation of an entrenched system? Have our contracted providers delivered quality and do we even have the systems in place to measure it? **Many contracts are 'rolled over' annually and providers rarely need to compete to keep their funding.**

Managed Care need not tolerate entrenched providers. For example, managed behavioral health care organizations have been very successful reducing the number of days of hospitalization for children. While it is true that some children may be discharged too soon, it is also evident that many remained in hospital settings longer than was therapeutically necessary when hospital budgets depended on extensive patient bed days. We note that when Managed Care demanded reduced impatient services, providers were able to quickly adapt by providing less costly day treatment and other services in less restrictive settings. It is doubtful they would have done so just because less intensive settings are better for children and families.

V. Ethical Concerns When We Compare the Principles of Purchase of Service with the Principles of Managed Care

Consider the answers to these questions before dismissing Managed Care as an opportunity for children and families. Consider the answers before asserting that Managed Care will be less ethically compatible than the current Purchase of Service system.

1. Does your Purchase of Service system require periodic and tightly controlled open and competitive bidding?

2. Is your Purchase of Service system independently monitored? For Cost Effectiveness? For Clinical Content?

3. Does your Purchase of Service system ensure the avoidance of duplication or does it simply add new providers while failing to delete existing ones who are no longer as relevant?

4. Does your Purchase of Service system insist upon well developed service plan outcomes? Are these outcomes measured?

5. Does your Purchase of Service system have a professionally designed data base that contributes information for improving practice? Are providers required to be self critical?

6. Does your Purchase of Service operate with a continuous Quality Assurance/Quality Improvement Plan?

7. Does your Purchase of Service system require frequent Client Satisfaction surveys? How are they used to improve services?

8. Are providers in your Purchase of Service system required to submit a detailed corrective action plan to resolve unacceptable service delivery?

9. Are there consequences in your Purchase of Service system for poor performance or is the contract usually 'rolled over' again.

If the answers to all of the above were "yes," Managed Care can be compatible in your community. If the answers were "no," there is work to be done.

VI. Can Managed Care Offer Potential for a Seamless, Multi Disciplinary Network of Services?

It is acknowledged both in the literature and in conversations with agency staff that families known to child protection agencies are too complex for any one agency or discipline. Too much of our service planning addresses fragments of family problems. Without accurate and comprehensive assessments, service plans are incomplete. Incomplete planning results in poor decisions that compromise the very safety of children. Child protection often looks at symptoms and misses larger concerns. It is as if a medical doctor treated a patient for fever and a skin rash and without further determining that the patient was HIV positive.

In child protection, we may have a service for one of the family's symptoms and miss the larger concerns. For example, social workers often exhaust themselves searching for housing when Mom and her kids get evicted for non payment of rent. While the problem may look like homelessness, Mom was actually evicted for non payment of rent because her money went to buy drugs. Mom needs drug treatment services even more than she needs housing. Most of all, looking for housing and services for Mom may ignore the threats to the safety of the kids

CPS alone cannot evaluate substance abuse, domestic violence, mental illness, failure to thrive and cognitive functioning. However, with the arrival of Managed Care, there is potential for access to more expertise and clinical competence via collaborative assessments and services. **The medical model has something to offer the multiple problem family.**

VII. The Positive Goals and Principles of Managed Care?

If we generalize the principles of Managed Care, it should be noted that

Managed Care encourages:

- Interagency collaboration
- Efficient record keeping
- Clear service planning
- Defined outcomes that are continuously measured through Quality Assurance/Quality Improvement
- A potential for multi disciplinary assessment and service delivery
- A potential for a seamless continuum of care
- A single point of entry
- Competition that keeps providers "on their toes"
- Client satisfaction surveys
- Qualified/certified/experienced staff (required for reimbursement from insurance)
- A for profit goal that can resist the pressures of cronyism and 'old boy' contracting.

VIII. Areas Needing Close Attention: Ethical Concerns for Children and Families in a Managed Care System

After we look at the potential for Managed Care, we must nonetheless be vigilant to ensure that there are **Protections** for our families and children. Serious concerns exist and must be addressed in Managed Care is to be an enhancement and not another layer of bureaucracy.

To ensure Protections for children and families in a Managed Care environment, child welfare professionals must address the following concerns:

- Is the treatment chosen for a client selected because it is brief and less costly or because it is **effective**? Is this why, for example, a child is on medication and not in a more costly form of treatment?

- Are the Managed Care company's service outcomes evaluated **independently**?

- Is the Managed Care company aware that certain **special populations** are likely to be high end users? Is the company willing and able to provide service **extensions** for them? (Traumatized children, disrupted adoptions, etc.)

- Does the service include family members? In health care, families members are rarely part of a formal medical treatment plan. With behavioral services to children, family members must be included. Who funds services for uninsured parents? The absence of comprehensive health insurance can only be resolved in the public policy arena and is not the responsibility of Managed Care. **Nevertheless, Managed Care organizations may be better and more successful lobbyists for more inclusion than are current human service advocates.**

- Is the family on AFDC and being directed to an HMO? HMO's are good at delivering health care for poor families because of the benefits of the primary care physician for clients who usually receive health care in an Emergency Room. However, HMO's have a poor record of delivering behavioral health services.

- Does the Managed Care company understand **cultural differences** and the needs of linguistic minorities?

- Is there a mechanism for the Managed Care company to communicate effectively with the state/county agency responsible for child protection?

- Does the Managed Care organization staff understand their responsibilities as **mandated reporters**?

- Does the Managed Care company understand **client satisfaction** and have in place **grievance procedures** for clients?

- Does the Managed Care system understand the need for **smooth transitions** as clients move from service to service? A seamless system cannot have tears in it.

- Are your private provider agencies on board for change? Or are you allowing them to compete and fight for business at the expense of clients? Service must be connected without disruption.

- Is the hospital's **discharge planning** adequate for clients? Do not accept a vague and inconclusive hospital recommendation such as "residential care is recommended." Such a recommendation is inadequate. Demand more specific planning that can be implemented in practice

- Do you know how to negotiate for **additional services** for clients? When ten visits will not do, be certain that there are mechanisms in your Managed Care organization to provide additional services. The method should be in writing and known to agencies and clients.

- Do you know how to **appeal a decision** with which you disagree? You must never 'set up' the client to advocate for more services. It is unethical and 'bad business' to tell the client to complain. A private clinician who tells the client to call the Managed Care company to get more services is unfairly involving the client in matters that should be between the agency/provider/clinician and the Managed Care organization

- No child (or for that matter, adult) should be discharged from a setting (hospital, residential care facility) on a Friday.

- Is the **discharge plan** (hospital, residential) shared with and understood by a responsible adult? By the CPS caseworker? If not, why not? Who fills the void?

- Is there special attention for the **"high end users?"** The seriously disturbed? The dully diagnosed? The mentally retarded? The developmentally disabled? The severely traumatized? If not, how are you planning to educate the Managed Care organization on their behalf?

- If you have **capitated models**, are they closely monitored for clinical outcomes? Is the service sized smaller to fit the dollars available or are the dollars stretched adjusted and expanded to fit the services needed?

- Are there proper structures in place for **medication**? Are there alternatives to medication? Is there a responsible adult trained on the supervision and distribution of medication when a child is discharged from a hospital or residential treatment facility? Is the responsible adult sufficiently proficient in English to understand how to get help and whom to call for adverse reactions or overdoses? If medication is contrary to a family's culture, has sufficient attention been paid to education?

IX. Concluding Recommendations for Child Welfare Managers

- Stop complaining
- Start learning
- Build alliances with compatible disciplines and compatible agencies
- Educate Boards of Directors and other concerned advocates
- Be 'at the table'

Look for opportunity to learn from Managed Care how to improve your

intake

service planning

monitoring and evaluation

quality assurance/quality improvement

measurable outcomes

The goal of Managed Care must be to smoothly transfer the responsibility for a client so that service is not interrupted. Service cannot be disrupted when a client moves from one service to another. **When we hand off the baton of care, we cannot allow it to fall in the road as it makes its way across the therapeutic road map.** We must see that any gaps that exist are filled.

We ought not judge an organization by its status as a non-profit or a for-profit. Judge it by its work product! I do not expect people to do the right thing automatically. Child welfare professionals must always advocate for children and families. Remember, as Will Rogers said, "Even when you are on the right track, if you stand still, you will still get run over."

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MANAGED CARE AND CHILD WELFARE: ARE THEY COMPATIBLE?

Design Issues in Managed Care
for Child Welfare

January 18, 1996

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MANAGED CARE AND CHILD WELFARE: ARE THEY COMPATIBLE?

Design Issues in Managed Care for Child Welfare

Institute for Human Services Management

Over the next several years, the child welfare system is likely to move toward managed care. This movement raises two questions: 1) Will managed child welfare subsume all of the flaws and weaknesses of managed care as it currently exists? and 2) Will managed care benefit the field of child welfare in any way? This paper examines the forces behind the movement toward managed care in child welfare, attempts to identify the unique elements of child welfare that must be considered in planning managed care, hypothesizes on how managed care can benefit child welfare, and raises important design issues for child welfare managed care. Part II of this paper examines operational issues in designing child welfare managed care.[1]

Why Managed Care in Child Welfare?

There is an undeniable surge of support for managed care, which is viewed as the "quick fix" solution to a range of public human service problems. Child welfare is one area of human services that has been perplexed by its share of problems. It is these problems, that seem to overwhelm the system, that help put child welfare in a position to become "managed." Managed care is inevitably moving toward child welfare due to several factors:

- The child welfare system is seen as "broken," and in need of fixing;
- Federal funding changes/ reductions will force more discipline on the system in order to better manage cuts;
- Managed care is becoming widespread for Medicaid clients;
- Managed care is perceived as the solution to "out of control" human service budgets; and
- Private child welfare providers are already developing managed care systems for other payers.

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[1] Part II of this paper, entitled *Managed Care and Child Welfare: Issues in System Design* is due to be completed in February 1996.

The child welfare system is seen as "broken," and in need of fixing. The myriad of class action lawsuits and services integration/ system reform initiatives in the past ten years attest to the "broken" state of child welfare. Lawsuits in both child welfare and juvenile corrections assert a range of problems throughout the system, focusing considerable attention on the quality of care provided to and the length of stay for children placed in out-of-home care settings. Remarkably, while most of these lawsuits have resulted in significantly increased resources for the system, most of the systems are still plagued with problems, in some instances problems that have plaintiff attorneys threatening contempt actions at any given moment.

Services integration and reform initiatives have attempted to address many of the problems identified in lawsuits. These initiatives have been developed across systems within local jurisdictions and entire states, or have focused on a single system attempting to address the continuum of care. Some have been supported financially and technically with generous foundation grants. While some of these initiatives have produced interesting and promising service delivery alternatives, to date there is no consensus on the overall value of any of these reform initiatives. None has resulted in general consensus that the child welfare system is "fixed," or can be fixed through implementation of a particular approach. The fact that *Time Magazine* recently devoted three articles to child welfare, one documenting a recent child death, a second succinctly capturing some of the problems with the system, and the third documenting one county's efforts to address some of the problems, shows remarkably more interest in and understanding of the child welfare system and its perceived problems than has generally been shown by the mass media.[2]

Federal funding changes/ reductions will force more discipline on the system in order to better manage cuts. It seems inevitable that federal funding used for child welfare will be changed in the next couple of years, through the capping or blocking of one of three entitlement programs (i.e., Medicaid, Title IV-A emergency assistance, or Title IV-E). When an entitlement is eliminated in favor of a block grant, the impact is a cost shift from the federal government to the state/ local government. As states begin to absorb the cuts, child welfare will not be the only area affected. The impact on the states of block grants in income maintenance or Medicaid will be devastating. The pressure to eliminate program benefits, increase eligibility standards, or find alternative financing methods will each affect the child welfare system. Cuts in program benefits or changes in eligibility standards are likely to increase the number of families relying on the child welfare system as their final "safety net." Any efforts to offset federal cuts through state/ local revenues will affect funding available for child welfare.

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[2] "Abandoned to Her Fate," "Making the Tough Calls, and "Fixing the System," *Time Magazine*, (December 11, 1995): 32-45.

As cuts in funding occur, managers will be forced to develop ways of rationing services while still protecting children. In the past, cuts have been leveled against family preservation programs in favor of foster and residential care. In spite of the recent backlash against family preservation, cuts in these programs are not only short sighted, but the services being cut are relatively inexpensive, so little is saved. In lieu of gutting family preservation programs, taking percentage cuts across all providers, or cutting investigative or foster care staff, good managers will attempt to find areas that can be cut without seriously impairing the program. Over-utilization in residential care is likely to be an obvious target in most jurisdictions. One of the best ways to control over-utilization is through managed care.

Managed care is becoming widespread for Medicaid clients. Most states are developing primary care managed care systems for Medicaid clients; many states also include behavioral health care as well. Valid or not, managed care is generally perceived as successful in curtailing the rate of growth in Medicaid expenditures. In many states, managed care has been imposed on child welfare clients through other service systems, mostly primary care or behavioral health services.

Under managed care for both primary health and behavioral health care, the child welfare worker's role is analogous to the worker's role in getting appropriate educational services for clients. That is, the worker is responsible for making sure the client gets what he/she needs, but has little power in the decision making process against a monolithic bureaucracy – the managed care organization. No longer can the worker simply take the client to the appropriate provider and authorize treatment. The worker serves primarily as an advocate for services, rather than as the authorizing agent. Most would agree that advocating for services takes considerably more time and energy than authorizing services.

Under Medicaid managed care for primary care or behavioral health services, one solution to the dilemma of control over service authorization is for the child welfare system itself to pay for the services, then no managed care gatekeeper approvals would be required. This alternative, however, requires that the child welfare system forgo Medicaid reimbursement on the services purchased. While the importance of this decision may change under a Medicaid block grant, it is a costly decision under an entitlement program.

Like it or not, where managed care under Medicaid is being implemented on a large scale basis, there is tremendous commitment to its success. Good news about its success will fill press releases, thus assuring continued and growing support. Child welfare is likely to be pulled onto the managed care bandwagon as legislators and governors ask: If managed care works in Medicaid, why can't it work in child welfare?

Managed care is perceived as the solution to "out of control" human service budgets. While managed care has become popular, if not mandatory, under Medicaid, it is becoming the "solution of choice" for all seemingly "out of control" human service budgets. Absent Medicaid, child welfare is now in the forefront of "out of control" budgets. After some gains in controlling the foster care population in the mid-80s (as a result of P.L. 96-272), the costs of out-of-home care for children and youth with special needs have soared. Often, the only other human service program with similar levels of expenditure growth is juvenile corrections. In corrections, however, there is still support for removing delinquents from the community, so less attention is paid, at least for the present, to cost control for juvenile corrections.[3]

Private child welfare providers are developing managed care systems for other payers. While responsibility for children's mental health, child welfare and juvenile corrections is often located in separate state or local public agencies, the private agencies serving children, youth and families often serve all three groups of clients and are paid by all three systems. Many private child welfare providers have already begun planning for or implementing managed care through the mental health system. Since it makes sense for them to design a system of care that serves all clientele, many private providers are beginning to approach child welfare agencies with proposals for managed care. Through provider associations and professional organizations, information, technical assistance, and actual experience on how to undertake managed care is becoming increasingly available. There will be tremendous pressure from private providers over the next several years to privatize segments of the child welfare system.

How Does Child Welfare Differ from Other Systems that Have Implemented Managed Care?

Child welfare as a field differs from other fields that have implemented managed care. Because it is different, managed care models developed for child welfare will have to be different as well. In this section, differences in the child welfare field that are fundamental to how services are delivered will be discussed. These differences include:

- Services are involuntary;
- The goals of the system are child safety and permanency;

[3] Eventually and inevitably, in states where youth are placed in private treatment facilities at high costs, the managed care movement will encompass juvenile corrections as well.

- The state's role as parent demands consideration of ethical issues; and
- The system has limited control over conditions and interventions.

Services are involuntary. The primary and most significant difference between child welfare and other systems that have implemented managed care is its involuntary nature. Clients do not usually come to the child welfare system looking for help, unlike the mental health and the primary health care systems. In those systems, people looking for help want it badly enough to advocate on their own behalf: If they are sick, they go to the doctor, they take prescribed medicine; if they don't get well, they go back to the doctor. The patient's interest in his own well being motivates him to advocate on his own behalf. This is not the case with the typical child welfare client. *Clients do not usually come to the system looking for help, and once in the system, are often resistant, if not hostile, to the "help" that is offered.* Furthermore, they are not given the opportunity to determine when they are "well," and no longer in need of system interventions. In fact, child welfare interventions may be imposed on unwilling families by the courts or police.

Youth involved in the juvenile corrections system are there involuntarily as well. They are the youth who "got caught" in a status offense or delinquent act. The services provided to these youth are not always viewed as "services," but at punishments (e.g., boot camps, day treatment, etc.).

The goals of the system are protection and permanency. Another significant difference between the child welfare system and other systems that have implemented managed care is the overriding goals of protection and permanency, and how these goals affect the treatment process. Child welfare cases are opened because the system assesses a threat to the child's well being. The factors that contribute to this assessment include family, household and community considerations. The interventions needed to reduce the risk of harm to the child may be remarkably minor or incredibly complex. Unlike other systems, the goal of the intervention involves more than stabilization or improvement in the *child's* individual level of functioning. The child welfare system concerns itself with the entire family environment in which the child will grow and develop. The impact of this mandate is that the family is critical to the child's intervention. Furthermore, *the interventions provided to the parents* may be critical to, or may be the *only* intervention provided on behalf of the child. In some instances, the intervention provided to the child cannot be undertaken apart from the intervention provided to the parent.

While in the child welfare system, a primary goal is protection of the child, in the juvenile corrections system, a primary goal of the intervention may be protection of the community. This goal has a different and significant set of implications for managed care. A judge may order the placement of a youth into a residential setting for the purpose of protecting the community from the behavior of that youth. Managed care systems developed for the juvenile population will have to develop services mechanisms that can adequately protect the community from the possible behavior of delinquent youth. Moreover, these mechanisms will have to be "sold" to the judge and the general public as adequately protecting their interests from delinquent youth.

The goal of permanency, which is fundamental to the child welfare system, results in case decisions that might be foreign to the mental health system. The child welfare worker will place value on leaving the child in the home for treatment (to assure parental involvement and "connectedness" with the child) versus removing the child to an alternative setting (even when that alternative may be an easier treatment setting for the child) if it is perceived that the parents' involvement would otherwise wane. This decision results from the overriding goal of permanency for the child. The child welfare worker must look at the long range relationship between the parent and child, and decide how best to maintain or strengthen that relationship until the age of majority.

Conversely, the child may have to be removed from his home if the risk of harm to the child is deemed to be too high. Furthermore, the child may not return home until the risk factors within the family/ household are reduced. Under these circumstances, the child's primary needs may be interventions provided to the parents. Recalcitrant, hostile or uncooperative parents may prolong the intervention required for a seemingly simple problem.

When parents are not available to the child, the goal of the system is to find parents for the child, or find a suitable and permanent living arrangement, which will offer appropriate interventions, supervision and guidance until the child reaches adulthood. This responsibility is far broader than any role defined in other systems where managed care has been implemented. While both primary health care and mental health may require involvement by parents or other family members in the treatment process, this involvement is usually adjunct to the intervention provided to the child.

The state's role as parent demands consideration of ethical issues. In both the primary health and mental health public systems, professionals maintain the right to refuse an expensive treatment if the client is a poor candidate for success. Frail, ill, or aged clients may not be given (or prioritized for) organ transplants; resistant clients will not be given substance abuse treatment. Each system has procedures for assessing the client's likelihood of successful completion of treatment, thus allowing the system to undertake a cost/ benefit analysis of providing the

treatment to that client: Is the client likely to get better as a result of the intervention, thus making the expenditure of scarce resources on that client worthwhile? If the answer is no, the intervention may be denied (or placed at such a low level of priority that it will never be provided). This procedure represents a peace-time version of the concept of "triage."[4] This concept is otherwise known as the rationing of scarce resources. This rationing process occurs within all human services, including primary health care. Rationing can become controversial when it results in withholding treatment from clients in need.

The mental health system has always viewed itself as a voluntary service system, that is, clients must ask for services. Because of scarce resources, the mental health system has always been able to prioritize the provision of services.[5] Under managed mental health, clinical protocols are the guidelines used to determine who qualifies for the various types of services based on symptoms. These protocols may include criteria that are used to exclude clients in need as well. For example, a child's symptoms could meet all of the clinical criteria for acceptance into the service, but fail to meet "other related" mandatory criteria, which would result in his being rejected for that service. Examples of "other related" criteria include such conditions as:

- Family members or guardian will commit to necessary evaluations/ treatments as a condition of admission and continuing stay;
- At the time of admission, the discharge residence is known;
- The client is amenable to treatment and accepts the need for treatment; and
- The child's behavior would fit within the treatment milieu.

In the child welfare system, the state has custody of a large group of children. The concept of "custody" means that the state is acting as the parent on either a temporary or permanent basis. The system is swamped with adolescents whose emotional and behavioral problems are severe, and for whom the likelihood of successful "recovery," however defined, through costly residential

[4] Originally the concept of triage was intended to produce the greatest benefit from limited treatment facilities for war casualties, by giving treatment to those who were likely to survive because of it, but withholding treatment from those who were not likely to survive even with treatment, and those who would survive without it.

[5] While the mental health system has traditionally prioritized clients based on established criteria, their legal ability to do so changed for Medicaid-eligible children under the Omnibus Reconciliation Act of 1989 (OBRA'89). This law required that all services deemed necessary for Medicaid-eligible children must be provided. This eliminated the states' ability to refuse to serve clients or to place them on indefinite waiting lists for services. The requirements of OBRA'89 have not been fully recognized and implemented in all states. Where it has been implemented, some states have restricted services by narrowly defining medical necessity. The status of these requirements is uncertain under the proposed Medicaid block grants.

treatment is either unknown or low. Part of the child's poor prognosis may be due to the unwillingness of family members to participate, the failure of the child to accept his need for treatment, the child's behavior, or the parents' refusal to care for the child after treatment. (Some of these problems may be caused by the child's long term involvement in the child welfare system.) While the mental health system may refuse to treat these youth based on a set of mandatory conditions, *in the child welfare system, it would be unethical to refuse treatment to a child because of doubt that the treatment would be effective.* The state as parent must seek and pay for treatment for a child in need, regardless of that child's potential for recovery. There can be no rationing of resources that excludes a child because he is "too sick," or doesn't have the family characteristics of children who benefit from treatment. The child welfare field does not accept the premise that there may be some children who are beyond help.

The system has limited control over conditions and interventions. Another major difference in the child welfare system is that treatment needs are rooted in societal problems, which often are not fixable by a single intervention, specialist or system. Child welfare problems are rooted in social problems (e.g., poverty, unemployment, poor education, adolescent pregnancy, neighborhood drugs and violence, etc.) where the conditions that result in symptoms cannot be eliminated, and appropriate interventions can be neither easily determined nor achieved. Nor is the solution to the problem always fixable within the expertise of the child welfare system itself. In medicine, for example, a problem may require a range of medical specialists to resolve; in mental health, a problem may require a range of mental health professionals. A child welfare problem, on the other hand, may require child welfare expertise, medical specialists, mental health specialists, and a range of other professionals, including educators and social service workers from housing experts to homemakers. The ability or willingness of the needed range of professionals to understand and treat their specialties within the context of a broader set of problems and child welfare goals is often limited, as each specialist prioritizes his own professional goals. Moreover, the child welfare worker often must deal with a juvenile judge whose assessment of the problems and needed interventions may be very different, and who may order specific interventions regardless of diagnostic evidence to the contrary presented by the worker.

How Could Managed Care Benefit Child Welfare?

The nature of the child welfare system complicates and changes how managed care must be conceptualized and designed to meet the needs of the client population. Child welfare managed

care should not simply follow the path of managed care in primary health or behavioral health care. Certainly the pressure will exist merely to adapt already existing managed care systems without concern for the unique elements of the child welfare system. This type of approach is not likely to serve the best interests of children and families or the child welfare system itself.

An understanding of the nuances of the child welfare system will be paramount to undertaking this design effort. Managed care companies hoping to expand from primary health or behavioral health managed care into child welfare managed care will not be able to rely solely on their behavioral health experience in the development process.

The child welfare field requires an entirely new conceptualization of managed care, including a clear delineation of the goals to be achieved. While policy makers may regard managed care as a means to harness spiraling costs, managed care can have a different, more positive set of goals within the context of child welfare. *The design of managed care for child welfare should begin with identification of the weaknesses in the current system that may be addressable through managed care.* Key among these weaknesses are:

- The current system is one where major players (private providers) in the service delivery system do not have, and therefore will not take responsibility for how the system operates;
- The current system has fiscal incentives for providers to behave counter to the system's goals (i.e., incentives to keep kids in placement rather than return them home as quickly as possible);
- Child welfare diagnostic skills are weak, and there is little ability to empirically link symptoms, diagnoses, interventions and outcomes;
- Utilization data are fragmented or unavailable.

The current system is one where major players (private providers) in the service delivery system do not have, and therefore will not take responsibility for how the system operates. In most states, private child caring agencies provide a substantial portion of the care and services to families involved in the child welfare system. Most of these agencies are voluntary agencies that raise a portion of the funds used to provide care to public child welfare clients. These providers are essential to the system. Yet in most states, the private sector is not viewed as a partner in the service delivery process, but as a resource only. In support of the current system, it must be recognized, as stated earlier, that there are so few players in the system over which the child

welfare worker has any authority (e.g., the schools, the courts, medical and mental health professionals, etc.), that one can understand the reluctance a worker may feel in taking on a "partner." Nevertheless when tragedy occurs in the child welfare system, as it occasionally and inevitably does, the public child welfare system stands alone, and is often charged with hiding behind confidentiality to cover incompetence. In fact, during several of the child welfare class action lawsuits that have been filed around the country, the private child caring agencies provided some of the most damaging testimony against the public system. In many areas of the country, earned or unearned, there is little confidence in the public system. Partnering with the private sector in a reasonable way could serve to restore confidence by creating an oversight function in the public sector. In this way, there would be a sharing of responsibility for the system's actions.

The current system has fiscal incentives for providers to behave counter to the system's goals (i.e., incentives to keep kids in placement rather than return them home as quickly as possible). Private residential child caring agencies are traditionally paid based on a per diem rate provided for each child in care. This rate often is lower than the provider's actual costs. The rate may be based on a particular level of supervision and treatment provided within a particular program; based on an average level of cost among programs with similar characteristics; based on the characteristics of a particular child requiring care, based on available funding, or based on historic patterns. Regardless of the basis of rate determination, there is often little incentive built into the rate structure to serve the most difficult children within a defined category. If a difficult child requires more care than the average child within that program, it will cost the provider more to serve that child. Furthermore, if a child is relatively easy to serve within a rate category, the provider has an incentive to keep the child in care – the bed is filled, the costs are low relative to what they might be with a more difficult child. If the bed remains empty, there is no reimbursement. A reduction in the level of service provided to any child, because his level of functioning improves, will mean a reduction in the payment. All of these factors serve as incentives to keep children in care. Added to these perverse financial incentives, is the tendency for workers to focus on emergency situations, thus ignoring stable placements. The result is a system that is likely to have more children in out-of-home care than necessary.

Child welfare diagnostic skills are weak and there is little ability to empirically link symptoms, diagnoses, interventions and outcomes. In the primary health care system and, to a lesser extent, the mental health system, there is at least general agreement regarding symptoms, diagnoses, treatment, and expected outcomes.[6] In child welfare, the relationship between symptoms, diagnoses, interventions and outcomes is murky at best. The intervention needed to "cure" a child welfare problem is not always clear. The system has developed a limited set of interventions that are offered to address most identified problems. Frequently these interventions are offered based on availability more than on demonstrated need.

The diagnostic process in child welfare has not been well developed. Development efforts to date have focused on risk assessment and family assessment/ problem identification. Some of the instruments developed require highly trained staff to exercise professional judgment in completing them. This can be problematic when the neighborhoods and regions with the worst child welfare problems are more likely to be staffed with the least experienced and trained workers. Furthermore, staff are often not competent to diagnose some of the more serious emotional problems common within the child welfare system today.

Exacerbating, or perhaps underlying, the problem of diagnostic capability in child welfare is the lack of evaluative data linking symptoms, diagnoses, interventions and outcomes. Unlike primary health care (and to some extent the mental health field), child welfare has very limited outcome data. *Part of the reason behind this dearth of outcome data is that there is no general consensus within the field regarding outcome indicators or measures.* There have been few long term studies of the effects of various interventions on family or child functioning or child safety. Regardless of the efforts that have been made to treat child abuse and understand what interventions lead to successful outcomes, clinical research and evaluation is extremely limited. In child welfare, *the relationship between symptoms, diagnoses, interventions and outcomes is measured anecdotally rather than empirically.* The result is a decision making process that relies on what interventions are available, since it is not always clear what is needed.

This problem is one of the biggest impediments to the image of child welfare. Child welfare professionals simply do not have systematic evidence that the services they provide do any good. Without this evidence, the system is susceptible to attack at every budget hearing and unanticipated family tragedy.

[6] The term "diagnosis" is not used to imply a formal DSM-IV or ICD-9 category, but a more general social diagnosis of the family's and child's problems.

Utilization data are fragmented or unavailable. In the primary care and mental health systems, utilization data, essential to developing capitated rates, is usually available and relatively accurate. This is due to the uniform and detailed billing requirements of the Medicaid program.[7] In child welfare, however, systems development is not uniform across states, and frequently fragmented within a state. For example, often client tracking data is kept separately from service payment data. Furthermore, it is not unusual for contracts to be paid based on costs versus service units provided to individual clients. Therefore, developing utilization patterns, trends, and costs based on per client units of service provided becomes a nearly impossible task. Without these data, it is often difficult for managers to identify how many clients were provided with what services, at what cost, and over what period of time. Child welfare is often viewed by legislators as a large black box into which millions of dollars flow, but from which only a very general picture of what happens to the money emerges.

Each of these areas can and must be addressed in child welfare if managed care is to be implemented. Addressing each of these four areas would well serve the field of child welfare regardless of the success of managed care in saving dollars. Each agency designing managed care should identify their goals for managed care as they begin the design process.

Can Managed Child Welfare Save Money?

State and local public child welfare administrators studying managed care currently are doing so primarily due to budgetary concerns. Their budgets have been cut, their budgets are about to be cut, they have been warned of upcoming cuts, or they are anticipating the effect of the recent political tide on their budgets. That is to say that the primary impetus toward managed care has been budgetary. Managed care has been touted as the way to get human service budgets under control. But other than those portions of child welfare services that have fallen under behavioral health managed care, or very limited pilot projects, there is no real evidence that managed care can save money in child welfare. Furthermore, it must be clear whether the concept of saving money means spending less than is currently spent or curtailing the growth in expenditures. Obviously the former is a more formidable goal.

[7] This is also due to federal requirements for the development of Medicaid management information systems, and the availability of enhanced federal funding to pay for their development, which has been available in the Medicaid program for over a decade. Similar mandates for child welfare, along with enhanced federal funding, has only been made available in the last 2 years.

There are four competing factors within the current system that will effect whether managed child welfare can save money. Each state (and county within county administered systems) will have to weigh their position relative to each factor in order to gauge its potential for savings. They are:

- Current utilization of high cost residential placements;
- Current level of underserving children and families;
- Current provider payment levels; and
- Effect of screening/ investigations process on caseload size.

Current utilization of high cost residential placements. The clearest mechanism in managed care that saves money is the reduction in high cost placements. Once there is fiscal incentive to reduce the level of care, children are moved home or to less costly placements. In jurisdictions where there are large numbers of children in high cost residential placements, money will be saved under managed care. In jurisdictions where significant effort has been made to reduce these placements already, there will be less savings.

Current level of underserving children and families. In many jurisdictions, large numbers of clients do not get the services needed because of funding limitations. Under managed care, service provision would be based on clinical protocols, without reliance on waiting lists to ration resources. To the extent these protocols define a level of service that has heretofore not been provided, costs will increase under managed care.

Current provider payment levels. The donation of a portion of the cost of care, virtually non-existent in primary health or mental health[8], is common in the child welfare system among not-for-profit, voluntary agencies. If current provider payment levels are so low that the cost of care

[8] This donation is a true donation to the cost of care, supported by endowment and active fund raising efforts, not merely a foregoing of profits, which may occur among medical providers. Nor is this donation a Medicaid re-financing scheme, such as the "provider tax" imposed on medical providers in many states in the last several years, but now prohibited by the Medicaid program. In many states, provider donations can be as much as 20-50% of the cost of care. Child welfare is one of the few fields where there often is some expectation that providers contribute to the cost of the service they provide.

is substantially subsidized by the private sector, then there will be less potential for saving public money under managed care.

Effect of screening/investigations process on caseload size. Currently in most child welfare agencies there is an informal relationship between the screening/ investigations process and caseload size. During periods where intake increases, screening and investigatory staff control intake informally by applying stricter standards for cases to investigate and cases to open. This may be done consciously or unconsciously, without change in the formal intake criteria, just a subtle change in how staff may "read" the circumstances of the situation. Nevertheless, this shift serves to informally control the caseload size. The number of phone reports not investigated or the number of cases not opened as a result of these informal controls is unknown and likely varies from agency to agency and from staff to staff.

Should a child welfare system privatize its ongoing caseload through managed care, while still undertaking the investigations function, there would be considerably less concern on the part of the public agency screening and investigatory staff for the size of the caseload. Ongoing cases would be addressed by private agency staff paid out of someone else's budget. Under this scenario, the impact of opening a higher percentage of investigated cases would not be felt by co-workers. Hence, it is likely that more cases would be opened. The extent of this phenomenon is unknown, and is probably best estimated at the local intake level.

Additionally, there are a number of specific managed care design decisions that will affect the ability of managed care to save money for a system. These will be discussed in Part II of this paper. Until all of these issues are resolved, there is no way to estimate the cost of managed care, let alone the potential for savings.

What Are the Most Significant Development Issues for Managed Child Welfare?

While there are many design and operational issues that must be addressed in order to implement managed care in child welfare, a few of these issues will require a major developmental effort because their current state is weak and undeveloped. They are:

- The development and role of practice protocols;
- The development of new treatment modalities;

- Expectations and the definition of outcomes; and
- Control, capitation and financial risk.

The development and role of practice protocols. Clinical or practice protocols must be developed by child welfare experts in the public and private sectors within a state. The protocols are the key instrument that links symptoms, diagnoses, interventions and outcomes. They are the tool used to link the assessed problems (or diagnoses) with the interventions, to guide the length of time an intervention is to be provided, and to determine what outcomes are needed to reduce or terminate service provision. The protocols will be adjusted over time, based on systematically measured outcomes.

Currently, there is no single tool that links symptoms, diagnoses, interventions and outcomes. The child welfare field typically uses tools to link symptoms to diagnoses, and to link diagnoses to general categories of service (e.g., level of risk determining in-home versus out-of-home care, level of symptoms determining service/ payment levels for out-of-home care, etc.). But there are very few tools in use that link an assessment of problems with specific interventions and expected outcomes. Child welfare workers rely on risk assessment tools to determine in-home versus out-of-home services, family assessments to determine level of needs within the family, level of care assessments and service and placement availability to determine interventions to be provided, and their own experience to determine expected outcomes. The length of time an intervention is provided is dependent on many factors (e.g., the worker's caseload, the intervention being provided, the court system, the cooperativeness of the client/ family, administrative case reviews, the experience and training of the worker, demands for services, etc.).

The reliance on worker discretion in determining the services provided based on the identified needs represents both the strength and weakness of the child welfare system. The level of experience and training of child welfare workers varies considerably. Highly skilled and experienced workers often are able to craft an individualized service plan specific to each client/ family. However, the child welfare system in many states and larger urban areas is plagued by high caseloads, poorly trained staff, and inexperienced staff due to high turnover rates. Under these circumstances, reliance on worker discretion in determining and overseeing the service plan should not be considered a system strength.

Managed care in child welfare would result in a standardized assessment and decision making process, a relatively flexible range of interventions, a standardized set of conditions under which the interventions would be offered, clearly defined and measurable expected outcomes of the interventions, and pre-determined time frames for achieving those outcomes. *In spite of the fact that this standardization would reduce worker discretion, if the tools used were well crafted and*

continuously updated, they could in fact improve the decision making process, and still represent an individualized service plan based on the needs of each particular family. But a well crafted tool can only be developed with input from both the public child welfare system and the private child care providers, each of whose point of view and experience is critical and necessary to the process.

The public child welfare agency that delegates the development of this tool to a private managed care company virtually ensures that the bottom line will be primary. Conversely, *the public agency that actively controls the development of this tool can protect the child welfare system, as well as the children and families served, from many of the expected and dreaded predilections of managed care -- under-serving the client population.* This tool will be the key to the success of managed care with respect to the children and families served.

While standardization is required under managed care, child welfare practitioners must understand that protocols structure the decision making process, but still allow for justifiable exceptions. A justifiable exception would require a reasoned argument based on convincing evidence.

The structuring of the decision making process would allow for a more systematic and rigorous comparison of the relationship between symptoms, diagnoses, interventions and outcomes. This in turn, should result in a system that can benefit from experience, a trait lacking in the current system. Currently, it is only the individual workers who benefit from experience.

The development of new treatment modalities. The child welfare system has successfully developed and widely implemented only limited new treatment methods in the past 20 years (e.g., intensive, in-home family preservation services, day treatment, and specialized/ therapeutic foster care). Managed care, with unlimited flexibility of funds, should allow for the development of new treatment modalities. For example, it is not uncommon for emotionally disturbed adolescents in both the child welfare and juvenile corrections systems to be placed in residential treatment programs for 12-24 months. Yet in the commercial sector, the length of placement in a residential program is more likely to be 30-90 days. This difference is, no doubt, related to plan coverage, typically 30-90 days in the commercial health insurance sector. While 30-90 days may be too short a period to address adolescent emotional problems, there may be a level of useful treatment that could be completed in less than 12-24 months. In many cases we do not know if this is possible because there has never been a true incentive to minimize the length of stay in residential settings.

While the child welfare system has given lip service to "step down" services, they are not typically available. When a child enters a level of care, he stays at that level until the case

worker reduces his level, which may require finding a new placement for the child, which requires an affirmative action by the caseworker (for which there is a strong disincentive).

The child welfare system has been remarkably uncreative in developing and implementing new levels of care. For example, there may be youth who need episodic structured residential placements, but who can otherwise live at home. Or youth who need day treatment lasting until bedtime. While creative experiments exist, they are not disseminated nor replicated on a wide scale basis. No one ever learns from these innovative experiments, hence they are never tried elsewhere.

Managed care will not only offer the forum for innovation, it will assure that data documenting the successes and failures, advantages and disadvantages of these experiments is kept. Furthermore, it will assure that the data are used to refine and reinvent the system on an ongoing basis.

Expectations and the definition of outcomes. Managed care does not promise that it will cure all who enroll. It does not promise that those who enroll will be healthier. It is designed to provide financial incentives to practitioners to find and treat problems early, to provide quick and efficient services to enrollees, to insure that the client gets only those services clinically justifiable and only for as long as necessary, and still provide professionally competent care. It is a process of managing and allocating resources efficiently. It recognizes that some clients will not be cured, some will not improve, some may require long term expensive treatment, although most will not.

Doctors are not expected to prevent cancer; mental health practitioners are not expected to prevent mental illness. While both fields may know and understand many risk factors that are associated with illness, they cannot force people to avoid those risk factors. The same is true in the child welfare field. Professionals know many risk factors associated with child abuse, but they cannot assure that all children will live in households without those risk factors.

Both the medical and mental health fields have generally reasonable expectations placed on them. Unfortunately, expectations of the child welfare system are higher: The system is expected to prevent child abuse, prevent the murder of children at the hands of their caretakers, heal all children who are abused, and find parents for all children without them. While these expectations are outrageously unrealistic to those who understand the system, they are not unrealistic to the general public.

The process of defining outcome measures for the child welfare system should not begin with unrealistic expectations (i.e., a reduction in incidents of child abuse). Outcome measures should

include those indicators over which the system has reasonable control. They should address the impact of the interventions directed by the system itself.

Within medical and mental health managed care, one of the primary outcome measures is client satisfaction. Managed care organizations are quite adept at measuring client satisfaction with sophisticated surveys geared toward the educational level of the client. Another set of outcomes measured include process measures such as the number of rings before the phone is answered, the time required to get an appointment, the time spent in the waiting room, etc. The quality of the service actually provided is measured through quality assurance procedures and adherence to professional credentialing.

In both the medical and mental health fields, there is a general assumption of professional competence by the actual practitioners. Managed care is merely an organizational overlay that changes incentives and procedures. Therefore, the measures used to evaluate managed care are procedural and perceptual in nature.

Child welfare is different in two ways. First, acknowledging some exceptions, there is not a general assumption of competence within the current system. In most areas, there is considerable suspicion and skepticism about the competence of the child welfare system. Second, managed care in child welfare is not just an organizational overlay. Managed care has built-in incentives that undermine the single most important purpose of the child welfare system -- to protect children -- by failing to remove children at risk or returning them home prematurely. For these reasons, while child welfare should not over-promise on outcome measures, the measures developed for managed care in child welfare must be more substantive and extensive than those used in the medical and mental health fields.

Control, Capitation and Financial Risk. Due to issues raised in earlier sections of this paper, the child welfare system is not a particularly good candidate for capitation. The first issue is that of limited control over the conditions and interventions. Assuming financial risk requires some degree of control, it has already been argued that control is more limited in child welfare than in other fields that have implemented managed care. One of the biggest problems in that regard is the role of the courts. While most judges agree with and respect the advice of the child welfare worker, many do not. In these instances, many make their own decisions regarding the treatment type or even individual facility, without regard to the recommendations of child welfare professionals. This phenomenon means that the managed care provider would not have control over the treatment plan.

Another court related problem occurring in some areas is that the backlog is such that changes in custody status are not processed timely. This can result in children remaining at a level of

care longer than is clinically necessary. Again this would represent an expenditure outside the control of a managed care provider. These court issues represent some of the most troublesome issues for child welfare managed care. Some believe that over time the issue will resolve itself on the assumption that, rightly or wrongly, judges will become more comfortable with the clinical expertise and competence of the managed care provider than they have been with the typical public sector worker.

The second problem child welfare faces in developing a capitated system is the lack of reliable utilization data. The lack of a single information system, the reliance on manual record keeping, changes in the way data are kept, etc. will all affect the ability to develop reliable historical utilization data, which will be needed to develop a reliable capitation rate.

The third problem is the lack of information regarding how the basic capitation rate should be adjusted given assumed, but relatively unknown levels of over-utilization of current services and under-serving of current clients. These unknowns translate into unpredictable financial risk for a managed care provider.

The fact is that there may be too many unknown or uncontrollable risk factors for a managed care provider to be willing to assume financial risk under capitation. In the initial stages of Medicaid managed care, providers were given "no risk" contracts. One could argue that there are significantly more unknowns and uncontrollables in child welfare than there were in Medicaid at that time. Capitation and financial risk issues must be considered very carefully in the initial planning for managed care. Compiling the necessary data and evaluating its completeness and reliability will affect the willingness of a provider to assume financial risk. Even with a level of financial risk assumed, there may have to be "stop-loss" protections offered to ameliorate some of the risk.[9]

Conclusions

In answer to the question raised by the title of this paper, child welfare and managed care can be compatible if the concepts of managed care are adapted to the unique qualities and responsibilities of child welfare. The development of child welfare managed care cannot simply be an extension of Medicaid or behavioral health managed care. The child welfare system requires a re-conceptualization and re-design of managed care to meet its needs and

[9] The technical issues related to financial risk protections and the types of capitation methods are discussed in Part II of this paper.

responsibilities. This effort will require the collective thinking of child welfare management and line staff in both the public and private sectors. The complexity of the issues will require more time and energy than most governors and legislators may be willing to allow. Therefore it is crucial that this planning begin immediately. Whether child welfare managed care will produce any savings is unknown, but any effort to significantly change the system for the purpose of cost savings should be accompanied by an effort to *improve* the system as well. If the only purpose of implementing managed care is to cut costs, there are easier ways for the system to accomplish that goal (though few cuts will be painless to the children and families served). Managed care is a significant enough system change that it should not be undertaken unless its underlying goal is to achieve an overall improvement in the child welfare system.

This paper was written by Tracey Feild. Part 2 of the paper, still incomplete, will address specific design and operational issues in managed care for child welfare. If you would like to receive a copy of Part 2, please contact:

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Managed Behavioral Healthcare: History, Models, Key Issues, and Future Course

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Contents

I. Managing Behavioral Healthcare: Core Methods and Predominant Models

The mental health and substance abuse benefit packages that cover most privately insured Americans in 1994 involve some form of managed care. The approaches to managing care for patients with these disorders often require specialized knowledge and skills different from those needed to manage general medical care. For this reason, and in response to cost escalation in indemnity behavioral benefits, separate companies began forming in the 1980's that focus exclusively on managing behavioral healthcare. Many independent companies and insurers began offering separate "carve-out" behavioral healthcare insurance products to their customer accounts in addition to their regular insurance offerings. An increasing number of healthcare purchasers began and continue to buy behavioral healthcare carve-out benefits for their employees. The market response to behavioral carve-out vendors among self-insured employers has been strong and positive, resulting in rapid growth for the managed behavioral healthcare carve-out industry.

A. Core Methods of Managing Behavioral Healthcare

Managed behavioral healthcare is evolving from initial attempts to contain and manage direct expenditures and costs by managing benefits, through a stage characterized by innovative methods to improve value and quality by managing care, towards a new model based upon methods to reduce the demand for expensive services by improving the health status of defined populations. Each approach to managed care contains its own set of core technologies, some of which will be briefly summarized below.

1. Managing Benefits

During the 1970s and early 1980s, the primary methods used for cost-containment were actuarial manipulations use in managing benefits. There were, and continue to be, thousands of different benefit designs, each with built-in design elements that are used to control utilization and resulting expenditures, without regard to the impact of these benefit design manipulations on displacement of care into the general medical sector or upon the consequences of these restrictions, limitations and exclusions on indirect costs incurred by the employer, the community, and the beneficiary.

Traditional benefit design elements long in use include annual and lifetime maximums, deductibles, outpatient co-payments, and inpatient co-insurances. Certain specified forms of treatment and types of disorders may be excluded from coverage. Certain procedures, such as requiring the use of a specialized gatekeeping and obtaining prior authorization, serve as additional benefit design vehicles that restrict reimbursement. Taken together,

productivity, and reduce health care costs. The antecedents of many contemporary behavioral demand management initiatives can be found in EAP efforts.

Methods to manage health include providing health advisors, individual health risk assessments, health education programs, financial incentives for meeting personal health management goals, self-help groups, crisis debriefing services, outreach programs to high utilizers of healthcare services, and medical offset programs. Wellness programs employ measures to periodically assess the health status of the defined population they target.

Managed competition and related models of reformed health care systems include capitated financing mechanisms that have the potential to encourage managing for population-based health. We expect to see this focus increase in the managed behavioral healthcare of the future.

B. Contemporary Models of Managed Behavioral Healthcare

Managed behavioral healthcare organizations are structured and approach the task of managing care in many different ways. However, several predominant models exist by which most managed care organizations can be categorized.

1. Managed Behavioral Carve-Out Programs

Managed behavioral healthcare programs are characterized by: 1) management teams devoted exclusively to mental health and chemical dependency issues, 2) case management personnel who are specialty credentialed under the supervision of board-certified psychiatrists, 3) use of specifically developed mental health and chemical dependency level of care assignment and case management criteria that address medical necessity, medical appropriateness, and levels of care determination; and 4) specialty behavioral group, staff model, and PPO networks with a continuum of care, access to a full range of disciplines, and negotiated discounts (1). Other distinguishing features include continuous quality improvement programs, specialized behavioral information systems, outcomes management systems, clinical practice guidelines, and provider network management systems.

a. Delivery System Characteristics

The most common type of managed behavioral delivery system in 1994 is a contracted network of independent providers, although this is rapidly changing. The network providers are multidisciplinary specialists and generalists in behavioral healthcare services and are

organization to properly balance decentralization with some ongoing centralized functions, especially in the areas of information management and quality control.

b. Product Lines

The basic managed behavioral carve-out product offerings include telephonic utilization review, network-based managed care, and employee assistance programs. These products are structured around the provision and care management of any one or combination of mental health and/or substance abuse benefits. The benefit design can vary widely at the discretion of the purchaser, and can be based on either HMO, specialized behavioral, or managed indemnity benefits. At the request of a purchaser, managed care organizations can require that services be rendered only by providers within a predefined network, or they can offer point of service plans in which the reimbursement rate depends upon the provider's network status.

These products may be offered for customer accounts on an administrative services only (ASO), a risk-sharing, or on a fully at-risk basis. ASO offerings involve all aspects of care management except for final payment of provider bills; the latter remains the responsibility of the insurer. At risk offerings also include payment to providers.

Several other product lines may be offered by these companies. An employee assistance program offering is not uncommon. The elements of such a program are described on the following page of this report. Utilization review services, as described earlier in this report, may be a product offering separate from care management. An emerging product line is workers compensation stress claim prevention and management. There is an increasing need for such a product, and managed behavioral carve-out companies are well-positioned to offer it. The most commonly offered product is an integrated behavioral carve-out that includes EAP, psychiatric, and substance abuse treatment services provided through a structured network.

2. EAP-Driven Managed Behavioral Healthcare Programs

Managed behavioral healthcare has some historical roots in the EAP movement. Employee assistance programs are worksite-based, and are designed to assist in the early identification and resolution of productivity problems associated with employees impaired by personal concerns (3). EAP

behavioral healthcare product. Entities such as Bethesda Behavioral Health Systems in Cincinnati are able to contract directly with employers, collect premium, deliver and manage care through EAP plus structured network programs, and manage post-treatment workplace integration.

4. **Health Maintenance Organization (HMO) Managed Behavioral Healthcare Initiatives**

HMOs are characterized by certain features which have also been borrowed by managed behavioral health plans. These features include:

a. pre-payment financing on a per member per month basis
b. flexible service programs in which all levels of authorized care are reimbursed, and formulae for substitution of inpatient benefits are used to cover alternatives to hospitalization;
c. physician or behavioral health specialist gatekeepers, who manage the initial triage as well as decisions about step-down or step-up to different levels of care within the same course of treatment;
d. population-based healthcare measures that assess the overall behavioral health of the covered members at different time periods to determine the effectiveness of wellness programs as well as of illness treatment services.

The primary care gatekeeper model is the most common method used by HMOs to control utilization. Patients must first be evaluated and referred by their primary care physician before seeing a specialist, such as a mental health clinician. This model has been criticized for making access to mental health care more difficult, and for using physician gatekeepers who may lack sufficient training in diagnosing psychiatric and substance abuse disorders.

Some alternative models that allow multiple entry points into treatment do exist, the most well-known of which is Kaiser Permanente. Most of the contemporary non-HMO managed care behavioral health plans utilize some type of specialized mental health gatekeeper, rather than primary care physicians.

HMOs have suffered dramatic market share losses as managed behavioral carve-out vendors grew. Some employers, such as Digital Equipment Corporation, are now using formal quality and performance standards in their contracting process as a way of pressuring HMOs to offer expanded benefits, easier access, case management services and other managed behavioral carve-out features.

II. A Brief History of the Managed Behavioral Carve-Out Industry

The managed behavioral carve-out industry was probably started in 1981 by the original Metropolitan Clinic of Counseling (MCC - now a subsidiary of Cigna) in Minneapolis. The brief history of this industry has been eventful and characterized by innovation and rapid growth.

A. Historical Roots

The widespread adoption of managed behavioral healthcare is a recent, rapidly-evolving phenomenon. This model of care gained significant momentum between 1986-1993, primarily in response to cost-containment pressures and venture-capital financing of start-up companies that were created to take advantage of this business opportunity. However, the policies and methods upon which managed behavioral healthcare is grounded have much older historical roots. It will be helpful to briefly review these roots to better understand the industry's current approaches to financing, authorizing, and managing clinical care.

1. Community Mental Health

The national community mental health centers (CMHC) program that was initiated in 1963 encouraged the establishment of hundreds of CMHCs nationwide. A primary focus of the program was to shift the locus of care from state mental hospitals to community-based alternatives to hospitalization. Its strategy for accomplishing this was to develop well-coordinated, easily-accessed continuums of care in each community. Individual case management programs were implemented. Communities became catchment areas with defined populations for whose care they were responsible.

It is not surprising that many leaders of the CMHC "movement" went on to become executives of private sector managed behavioral healthcare companies. Perhaps as a consequence, the parallels between community mental health and managed behavioral healthcare are striking (5). They both place a high value on:

a. facilitating easy access to care
b. taking responsibility for a defined population of patients
c. triaging patients into the least restrictive care that is effective for the patient
d. providing care within a well-coordinated and complete continuum of care system.

inaccessible and too restrictive. Some HMOs provide care for this benefit through their current delivery system models, while others contract out the care management of such services to a specialized behavioral care management vendor. For example, Humana Health Plans purchased a 30% equity interest in CMG Health in the second quarter of 1994. CMG is a specialized managed behavioral carve-out vendor.

3. **Employee Assistance Programs (EAPs)**

EAP programs began as occupational health services for alcoholism services in the 1950's. They initially focused on early intervention for alcohol and drug abuse, but gradually expanded their service offerings. One of the strongest aspects of their programs is facilitating easy access and appropriate referral into a sometimes daunting behavioral healthcare system. They created an informal network of trusted providers, and developed criteria and procedures for triaging clients to the most appropriate care. These features have been incorporated by contemporary managed behavioral healthcare programs.

Managed care is now filling many of these rapid access, evaluation and triage functions. It is also going further to intensively manage the care after initial referrals are made. Consequently, EAPs are re-evaluating their role, which bridges between the internal human resources function in the workplace, and the "front end" of an integrated managed behavioral healthcare system. Some external EAP vendors have decided to expand their services and evolve into managed behavioral healthcare companies. Others have opted to focus exclusively on services unique to EAPs. The latter group of companies learn to effectively interface with managed behavioral healthcare companies for coordination of patient care. They are confident that EAP benefits will continue to be valued and provided by many corporations as an add-on to basic healthcare benefit packages.

4. **Telephonic Psychiatric and Substance Abuse Utilization Review (UR)**

Telephonic utilization review for psychiatric and substance abuse disorders is another precursor to managed behavioral healthcare which began and rapidly grew in the early 1980s. These benefit authorization programs used telephone-based preadmission and concurrent reviews for hospital admissions and inpatient stays. The UR company typically did not have contractual agreements with the hospitals, but made authorizations a requirement for reimbursement.

Seventeen UR companies were operating in 1979 (9) with this approach. Their focus was almost exclusively on disability and medical-surgical cases.

1. The Emergence of a New Market

During the early 1980's, a fledgling industry was created from demands that third party reviewers manage behavioral healthcare to assure cost-effective treatment. The managed behavioral healthcare approaches that grew from that beginning are essentially a system of checks and balances placed on a multi-billion dollar behavioral healthcare industry for which free market principles were not working. Price consciousness had ceased to be a functioning force regulating the market, since benefits were expansive and the consumers (patients) of services were no longer the payors. Neither was quality a strong market force, since little or no organized information was available about the comparative quality of behavioral healthcare providers and the services they provided.

a. Expanded Coverage and Lack of Diagnostic Related Groupings (DRGs) for Behavioral Healthcare

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) led to several new methods to control Medicare costs, the most well-known being diagnostic-related norms for reimbursement. These norms had tremendous impact throughout the healthcare industry, including for treatment of non-Medicaid patients. With the end of cost-plus reimbursement, hospital profits began to suffer and private investors became disenchanted with them.

The behavioral healthcare industry was relatively untouched by DRGs, because psychiatric diagnoses were regarded as unreliable, inaccurate, and lacking in predictive power for course of treatment. Venture capitalists, the public capital markets, and other entrepreneurs saw tremendous opportunities available in this still relatively unregulated market. Consequently, large, for-profit "chains" of specialty psychiatric and chemical dependency hospitals began to proliferate. Between 1979 and 1986, inpatient psychiatric treatment facilities grew by 40% (10).

b. Inadequacy and Exploitation of Indemnity Behavioral Healthcare Benefits

Indemnity mental health and substance abuse insurance benefits reflected existing prejudices and practices regarding behavioral health care disorders and services. Traditional benefits generously reimbursed inpatient services, since purchasers regarded hospitalization as a "real" treatment for such "genuine" illness symptoms as psychoses and suicide attempts. In contrast, purchasers

review companies to at least control unnecessary inpatient utilization.

d. Inadequacy of HMO, PPO, and UR Behavioral Healthcare

HMO mental health and substance abuse benefits were much less generous than those offered in indemnity insurance packages. In addition, access to care was not as easy. Either an appointment with a physician gatekeeper was necessary, or an appointment was required in an HMO-staffed mental health clinic that might involve a long wait. Criticisms were raised that HMOs contained costs through access barriers and undertreatment.

Preferred Provider Organizations (PPOs) began to develop in the early 1980s. These organizations were based upon groups of clinicians who contracted to serve a defined population on a discounted fee-for-service basis. The discounts sometimes lost their value to contracting organizations when the usual and customary rates began to rise more quickly with inflation. Also, during the early 1980s, the PPOs provided little or no case management. They were for all these reasons unable to effectively control costs.

The telephonic UR companies worked with treatment facilities after the patient had already arrived for admission. Because these companies did not refer business to the facilities, had no formal contracts with them, and reviewed cases after admission, the negotiations for number of authorized inpatient days were often adversarial. The UR companies' review process might shorten length of stay, but it would seldom entirely avert unnecessary hospitalizations. Because early UR companies had no contracted network of providers, they were not in a position to recommend and direct patients to hospital alternatives. They consequently were in a policing rather than a facilitating role, had only limited effectiveness in cost containment, and had limited control over enhancing the quality of care.

2. **Entrepreneurial Managed Behavioral Healthcare Start-ups**

Many companies in the managed behavioral healthcare industry had their beginnings in the early 1980s. They frequently began as an entrepreneurial clinic or an informal network of local providers in a narrowly-defined geographic community, with a few contracts to provide services to businesses and/or insurers. Some were EAP companies that gradually expanded their business into managed behavioral healthcare. Some were utilization review companies that gradually became more comprehensive, building a contracted

while simultaneously building a sound operational infrastructure very quickly to handle rapid growth. The infrastructure had to include expensive information systems, elaborate case management policies and procedures, a thorough provider credentialing system with an extensive network of contracted providers, and a highly qualified staff of well-trained professionals who could work well as a team to integrate their different functions.

This kind of development was expensive, and the deadlines were too short to allow for a gradual process fed by marginal profits. Instead, many companies sought large infusions of capital from venture capital firms which viewed these companies as part of a major growth industry. While this solved immediate problems of how to finance growth, it created new problems for many of these fledgling managed care companies. The corporate culture shifted from a relatively informal clinical orientation to a more efficient, bottom-line-oriented business enterprise. Many companies went through major shake-ups with reorganization and new leadership. Those providers, customer account representatives, and others regularly in contact with managed care companies during this time period frequently had the impression of instability.

2. Aggressive Marketing to ERISA Exempt Self-Insured Employers

Union-management labor negotiations in major corporations typically revolve around three-year contracts. During the late 1980s, the negotiating cycle throughout the United States focused both on enhancement of salary and on employee benefits. Naturally, health care was central in these negotiations. The promise from managed behavioral healthcare companies to improve access, assure quality and reduce costs enabled many self-insured companies to offer enriched behavioral healthcare benefits within a carve-out managed behavioral healthcare package at a fixed and often reduced price. These employers consequently became a prime market for managed behavioral healthcare companies.

Corporate purchasers of health care benefits, especially in the larger corporations, were strongly influenced by consultants from the major benefit consulting firms, who explained the value of managed care and helped with vendor selection. Venture-capitalized behavioral MCO's also invested heavily in marketing during this period.

In the late 1980s, most companies were still undecided about switching to carved-out managed behavioral healthcare, especially the small and mid-sized corporations that did not retain specialized benefit consultants. Managed care companies saw their marketing efforts at that time as primarily to educate the market about the value of their services. In the early 1990s, they shifted to a

a crossroad in strategic planning. They could stay a small to medium-sized regional player bidding only on local contracts and hope to stay viable or be acquired eventually. They could merge with or acquire similar companies and expand their coverage and market potential. They could be acquired by a larger company, especially a major insurance company, and guarantee their survival in some unpredictably altered form.

3. Insurance Carrier Acquisitions and Build-Outs

Managed behavioral healthcare companies must be creative, flexible, dynamic, innovative, and able to make rapid adjustments to the marketplace. They must willingly and readily respond to conflictual situations that arise between their payor-supported managed care policies and the demands of some patients and providers. They rightly regard these conflicts as an unavoidable part of their everyday business.

Insurance companies, on the other hand, tend to be older, more bureaucratic, very large and slow-moving organizations that resist change and attempt to avoid conflict. Whereas MCO's conceived of themselves as being in the care management business, insurance companies were essentially in the claims payment business during the 1980's. Marrying these two cultures has not been easy in any situation.

The very characteristics that make it so difficult for these two types of organizations to work well together are also the qualities that make them need each other to succeed. Because of their size and longstanding corporate culture, insurance companies could not build a fast-moving, dynamic managed behavioral healthcare enterprise without great difficulty. Most consequently found it easier to acquire one, and help grow it further. On the other hand, smaller managed care companies do not have the financial backing or infrastructure to keep up with the growing market opportunities on a national scale. Furthermore, acquisition by an insurance carrier provided a built-in market for the managed behavioral carve-out vendor to pursue.

a. MCC/Cigna

Metropolitan Clinics of Counseling is headquartered in Minneapolis, Minnesota and was founded in 1981. It is a national managed behavioral healthcare company with a mixed model of clinic sites and a network of providers throughout the United States. It was purchased by Cigna in 1988. Currently, MCC Behavioral Care covers approximately 5,000,000 lives. Its product lines include both the HMO and the managed indemnity (employer) markets, including

a. ABI Acquisitions-Medco Behavioral Care-Merck

American Biodyne, Inc. was founded in 1986 and grew through substantial contracts with Blue Cross/Blue Shield Plans and HMO's in many states across the country. ABI was profitable, and further expanded its reach by acquiring Assured Health Systems, Achievement and Guidance Centers, Inc., and Personal Performance Consultants. This multi-part entity was acquired by Medco containment services in 1992 and renamed as Medco Behavioral Care. It currently covers approximately 9,740,000 lives. In 1993, Medco Behavioral Care was acquired by Merck Pharmaceuticals as part of Merck's acquisition of Medco.

b. **Preferred-APM-Value Behavioral Health**

The largest merger in the managed behavioral healthcare industry occurred in September-December, 1993 when Preferred Healthcare and American PsychManagement formed Value Behavioral Health. Preferred Healthcare was a publicly traded managed behavioral healthcare company headquartered in Wilton, Connecticut. It focused on the managed indemnity market, and contracted almost exclusively with large self-insured employers. American PsychManagement was headquartered in Arlington, Virginia and also contracted with several large self-insured corporations. Together, they now cover 12,530,000 individuals and represent the largest of the managed behavioral healthcare specialty companies.

5. **Relationships with Pharmaceutical Manufacturers**

A recent development in the consolidation of the managed behavioral healthcare industry has been the formalizing of relationships between managed behavioral healthcare companies, pharmaceutical manufacturers, and mail-order prescription management companies. These relationships have emerged first between independent managed care firms and pharmaceutical manufacturers, rather than with the carrier-owned firms.

a. **Medco Containment Services/Merck Pharmaceuticals**

Medco Containment services is a highly successful mail order prescription management company. In 1992, it purchased American Biodyne, Inc. to form Medco Behavioral Care. The company is now headquartered in St. Louis, Missouri. MBC was purchased by Merck Pharmaceuticals in 1993 as part of Merck's drive for vertical integration across the pharmaceutical marketplace.

note is Johnson & Johnson Advanced Behavioral Technologies, which is converting its employer-based wellness programs into health plan-based disease management programs at this time.

and promotion initiatives are financially incentivised, and that access to acute care is initially easy at the milder, beginning stages of illness when less intensive care is needed. For some plans with underfunded mental health and substance abuse benefits, making services more easily accessible may mean expending more resources, in cost-effective ways, for mental health and chemical dependency treatment. However, the end result will be to reduce overall medical utilization (13).

In addition to using medical expense dollars to improve access and reimburse medically necessary and appropriate care, there are many other methods that may be used to allow delivery systems to expand access, reduce demand, and benefit from the medical offset effect. A review of these methods, and their policy implications, is beyond the scope of this paper.

B. Innovation

One overriding lesson of the managed behavioral carve-out phenomenon is that properly aligned market forces can produce behavioral healthcare service innovations that result in rapid and significant social gain. Within the last 10 years many organizations in the (de-politicized) private sector have taken advantage of their access to capital to innovate effectively in order to gain competitive advantage by increasing their levels of service integration and efficiency. Some recent data suggest they are also increasing levels of quality and customer satisfaction (14).

In behavioral healthcare, much innovation is still required to improve delivery systems. With proper access to capital and financial incentives, clinicians and clinician executives in a variety of private sector settings continue to develop creative new ways of delivering care more cost-effectively, improving access and accountability, measuring and improving outcomes, implementing guidelines, and improving the health status of defined populations. These innovations are made possible by including new therapeutic approaches, new treatment settings, computerized medical records and other new technologies, as well as new ways of bringing treatment to people in need, in rapidly evolving service delivery systems.

Health planners will benefit from being mindful of the forces that have permitted innovation to unfold in the private sector, and the forces that have slowed innovation and efficiency in many public sector settings.

It is important that health care reforms preserve and create additional incentives for innovation. With proper incentives and the right direction set, the private and public sectors can continue to innovate many socially beneficial advances that can promote the health and welfare of individuals with behavioral disorders, and their families.

costs by understaffing, the result is long waits and underutilization. This is a common source of subscriber complaints in some clinic-model managed behavioral healthcare organizations that operate within a HMO environment. Similar problems exist in county-owned mental health centers treating people covered by Medicaid and other non-private insurance benefits. Paradoxically, when the treatment used is appropriate and cost-effective, savings are significant despite increased numbers of people accessing care (16).

Many HMOs use a physician gatekeeper to triage people who need mental health or substance abuse treatment. This can facilitate easier access when a prospective patient has a trusting relationship with his/her physician and does not otherwise know how to access treatment. However, for other prospective behavioral healthcare patients the extra step of seeing a physician can impede access. Also, most physicians are not well-trained in the identification of psychiatric disorders, and may not make an appropriate referral.

Controversies regarding managed care abound among both providers and patients. One of the most common concerns is whether patients are granted sufficient access to the appropriate type of care they need. Economic incentives to undertreat may result in denial of care at the appropriate level of intensity and/or the appropriate amount. Poor clinical judgment by care managers may also occur, resulting in inappropriate denial of care. There are numerous anecdotes regarding such circumstances.

Managed care companies also relate many examples of inappropriate care demanded by patients and delivered by providers. It is difficult to determine how many of these complaints from either side reflect actual mistakes in clinical judgment and how many are simply differences of opinion. Data are not available. Nevertheless, it is clear that managed care company staff do make mistakes from time to time in their clinical decision-making, and that overzealous attempts to control costs may cause harm to individual patients.

Providers in organized systems of care that are reimbursed on a capitated basis have an economic incentive to undertreat. Since their monthly receivables are constant, they can only improve profits through cost controls. It is critical that the health care system build in checks and balances so this incentive does not overwhelm longer-term incentives to build quality services and population health status improvement programs. Otherwise, barriers to access will arise and morbidity will increase as a consequence of understaffing or overly strict criteria for treatment authorizations. Two important balances within the system to offset this trend would be to adequately fund behavioral healthcare benefits and services, and to find ways to measure and reinforce standards for the accessibility, appropriateness, quality, and effectiveness of treatment such as through "report card" delivery system performance indicators.

quality of care might be compromised. One of the most compelling determinants of quality is the clinical outcome of the treatments prescribed for specific patients. Some purchasers of behavioral healthcare benefits are beginning to require their contracting managed care organizations and delivery systems to develop outcomes management programs and to periodically provide data from them in order to demonstrate clinical effectiveness and value.

A quality control method related to outcomes management is the development and use of practice guidelines. Delivery systems that use research-based practice guidelines, and continually improve upon these guidelines through ongoing outcomes research, may be more likely to deliver consistent and high quality care, and thus have a competitive advantage in some markets. As outcomes management and practice guideline programs become more widespread, they will grow in sophistication and contribute to quality improvement by reducing practice pattern variation.

Outcome research in behavioral healthcare services has been conducted for many decades, often with highly sophisticated experimental designs. This research has considerably advanced our knowledge about the comparative effectiveness of different treatment interventions for a wide range of mental health and substance abuse disorders. However, as is also true in the medical field, there exists a wide gap between research findings and common clinical practices. The entire healthcare field confronts the dilemma of effectively disseminating best practices information in ways that busy clinicians can easily and quickly access and integrate into their work.

Efficacy research in behavioral healthcare services uses highly sophisticated experimental designs in controlled clinical trials. This research has considerably advanced our knowledge of what specific treatment interventions are most efficacious with which types of patients and disorders, and over what time frame, under experimental conditions. However, efficacy research has been notoriously unable to provide busy clinicians with the research findings that might add value to their practice by indicating which treatments are actually effective under naturalistic, real-world conditions.

In this time of dramatically increased accountability, organizations at every level from small group practices to large managed care companies are being asked to demonstrate their effectiveness with outcome data. This challenge to develop outcomes management programs within a busy clinical setting requires somewhat different methods than an academic researcher might use in a controlled treatment efficacy experiment. Behavioral healthcare organizations are currently struggling with how to balance sound effective research methods with the demands of a fast-paced market-driven business.

There is indication in the psychotherapy research literature of a positive relationship between therapeutic alliance and psychotherapy effectiveness. The data suggests a high correlation between patient satisfaction and clinical outcome, although there are also important differences between these two dimensions (18).

A challenge for the behavioral healthcare enterprise rests in integrating input from "consumers" and "customers." Several patient advocacy groups representing the interests of the severely mentally ill have worked with, and have been supported by public sector agencies in order to make services more responsive.

Input from these organized "consumers" (advocacy groups) is quite different from the "customer" input derived from health plan beneficiaries using standard market needs assessment techniques. For example, the National Committee on Quality Assurance has used customer input to guide its development of quality-oriented performance standards for HMOs. This customer input was derived from focus groups, survey research, and needs assessment methods that included many categories of health plan beneficiaries and end users.

American industry, including the healthcare industry, is more attentive than ever before to gathering data on customer satisfaction. We have learned from our competitors around the world and from the works of such quality leaders as W. Edwards Demming about the power of the competitive advantage that accrues when we learn from our customers and develop products and services that respond to customer needs. The behavioral healthcare industry is no exception to this growing trend of increasing the customer focus in healthcare.

E. Accountability to the Marketplace, to Accrediting Organizations, and to Government Regulatory Agencies

1. Market Forces

Health system planners are faced with the challenge of creating safeguards that will result in the accountability of behavioral health systems without creating unnecessary regulations that tend to stifle innovation and competitiveness. The private sector model for accomplishing this objective is quality-based purchasing, drawn from the supplier improvement methods of continuous quality improvement (CQI) and total quality management (TQM). Some sophisticated purchasers are beginning to require CQI programs and outcome data as evidence of quality service from their prospective managed

regulations, government regulation will be able to provide only limited incentives for managed behavioral healthcare quality.

4. Special Issues with Capitation

As our healthcare system continues to reform and evolve, integrated delivery systems are forming in a manner that will allow them to bid for comprehensive business and receive global payment on a capitated rather than fee-for-service basis. Under capitation, autonomy for providers is increased, if not entirely restored, because utilization review and case management functions are internalized rather than imposed from external organizations. However, this type of autonomy within capitated and integrated delivery systems requires a new level of responsibility.

Providers are increasingly aware of their responsibility to provide cost-effective care within the context of limited resources to pay for that care. Capitation contracting re-enforces that awareness. As information technology improves, and as providers become part of organized systems of care rather than remain solo practitioners, it becomes easier for behavioral healthcare organizations and the providers within them to measure and be held accountable for the kind of care they deliver. This is initially experienced by many providers as an uncomfortable development with many potential pitfalls. However, it can also become a very positive trend leading to the overall improvement of behavioral healthcare services (20).

Capitation financing forces plans to assume accountability for direct expenditures, but not for indirect costs or for quality. To accomplish these latter objectives, private sector initiatives focus on establishing performance criteria and indicators in the areas of accessibility, quality, customer satisfaction, treatment appropriateness, clinical outcomes at the individual patient level, and health outcomes at the patient population level, and perhaps prevention and promotion as well.. By measuring performance in accordance with standardized "report card" performance indicators and standardized data sets, capitated delivery systems will be incentivised to stay focused on results rather than process, health systems planners can avoid unnecessary regulation, harness the power of healthcare purchasers to require accountability for quality and to reward positive results. Additionally, long term (five year) rather than short term (one year) capitation contracts are more likely to allow integrated delivery systems to both invest in prevention programs, and realize the value of that investment.

Two other concerns should be addressed in regard to capitation; namely capitation rates and sub-capitation arrangements. Many capitated delivery systems limit behavioral healthcare services to about three percent of

$5 to employees for each dollar invested (21).

G. Behavioral Healthcare in Primary Care Medicine

Much of the treatment for psychiatric disorders is provided by primary care physicians, upon whom patients tend to rely for care of many of their healthcare problems (22). During office visits, physicians may provide very brief counseling and may provide medication for psychological problems. Unfortunately, few primary care physicians are adequately trained in the diagnosis and treatment of psychiatric and substance abuse disorders. From a systems perspective, we know that undetected and untreated behavioral healthcare problems can eventually lead to adverse outcomes and high cost medical utilization that might have been prevented (23, 24).

An ideal comprehensive healthcare system would provide multiple entry points for treatment, including direct access through self-referrals as is offered by managed behavioral health plans. If a patient had behavioral healthcare problems, it might be more efficient and effective to offer direct self-referral to psychiatrists and psychologists as primary care providers for these types of problems. These specialized behavioral healthcare providers would be expected to have adequate training in the detection and treatment of more medically-based problems, and know when to refer to medical specialists. They would be responsible for behavioral healthcare promotion, as well as for treatment of mental illness.

In organizations where this is not possible, and where physicians are gatekeepers, they should be well-trained in the diagnosis and treatment of behavioral healthcare disorders. They should also be well-informed regarding when and to whom to refer patients with these types of disorders.

H. Population-Based Behavioral Health Status Improvement

Behavioral health systems planners face the challenge of creating incentives and policies that redirect providers from treating mental illness to producing mental health. If long-term capitation arrangements become the primary mechanism for funding healthcare services, then organizations may have economic incentives to improve the behavioral health status of the populations they cover. As mentioned earlier in this report, an effective way to control costs and improve population behavioral health status is to reduce the demand for services by reducing the incidence of acute episodes of illness.

As the behavioral healthcare industry consolidates, and the populations that plans cover grow in size, the importance of behavioral health promotion may grow.

healthcare disorders. These are important policy issues that are not insurmountable, but must be addressed.

J. Computerization and other Technologies to Enhance Patient-Focused Care

Computer modeling and interactive software are enabling corporations in many industries to mass produce reliable, high-quality products and services that are also customized on request and available almost instantly at the customer's location. The implications for behavioral healthcare services are extraordinary, and are only beginning to be explored.

Patients in rural areas or who otherwise have difficulty going to a treatment facility will be able to access treatment from highly qualified experts hundreds of miles away through videophone. Prospective patients needing preliminary advice for minor medical problems or illness prevention will first consult the medical advice software program in their home computer. Those patients needing reminders for when to perform specific daily tasks, such as taking medications, will have the assistance of pocket-sized computers with voice technology. Direct mail communications and interactive computer bulletin boards are helping patients manage life with behavioral health conditions.

Providers will have vastly improved access to expert information for clinical decision-making. They will have instance access to treatment recommendations for specific disorders based on the most updated research findings, simply by clicking their computer's mouse. They will be able to consult when necessary with international experts through videophone, and will share relevant patient data through electronic transmission.

All managed care functions, including the integration of criteria-based decision-making, will involve sophisticated computer models. This will enable delivery systems and other companies with managed care functions to efficiently standardize their basic service lines and quality controls, and also to inexpensively customize them in response to specific account requests. Computerization of many managed care functions will also enable turnkey operations to be more quickly and easily established in diverse rural and urban areas, with the expectation that local presence will heighten customer responsiveness. Furthermore, the replacement of paper with electronic data interchange will make distances between managed care companies, providers, and behavioral health care purchasers less important.

The potential of this "virtual" managed care and delivery system is immense. Private sector managed behavioral healthcare firms and delivery systems are implementing many of the above-mentioned products and services at this time. Health systems planners need to anticipate the implications of computerization for

IV. Potential Short-Term Alternative Future Scenarios

During its brief history, the managed behavioral carve-out industry has emerged from humble origins to become a multi-billion dollar multi-national industry that has been characterized by dramatic innovations which have resulted in improved accessibility, quality, and cost effectiveness of mental health and addiction treatment benefits and services.

This impressive growth trajectory has been largely attributable to the interest of self-insured employers in enriched but managed EAP-behavioral-substance abuse benefit programs. Due to their ERISA exemption, these large employers were able to carve out their behavioral benefit packages and channel all employees to the program provided by their selected carve out vendor. These employers also provided adequate funding for the carve-out vendors to innovate and evaluate - often up to $15 per employee per month - a significant savings over previous unmanaged behavioral benefit costs.

This situation has changed, and managed behavioral health plans must now present themselves to a different customer base that includes state Medicaid programs, health purchasing cooperatives, regional business coalitions, carrier-owned health plans, regional and national HMOs, and regional integrated delivery systems. This changing customer base is driven in part by a renewed interest by employers in comprehensive health care programs, which may result in more employee freedom of choice between a limited number of plans, rather than the behavioral carve-out and channeling model of the last decade. It is also driven by reform in the small group market, by the privatization of Medicaid behavioral health services, and by the entry of insurers into the provider segment of the healthcare enterprise. Capitation and intense price pressure is resulting in a free fall in funding for managed behavioral healthcare, to the point that some low-end plans are being sold for $2.50 per member per month.

As a consequence of these dramatic changes, and in light of stalled healthcare reform efforts at the Federal level, the short-term future of the managed behavioral healthcare industry is uncertain. This short term future is contingent to a certain extent upon the evolution of healthcare reform initiatives at the state and federal level, as well as market reforms now under way around the country. This concluding section outlines possible alternative future scenarios for the industry.

A. Industry Consolidation and Domination

Downward price pressure confers competitive advantage on larger organizations that can benefit from economies of scale. As a result, there has been significant consolidation of the managed behavioral healthcare industry in the last three years. Some analysts believe that the managed behavioral healthcare industry will continue

healthcare industry is, in effect, owned and operated by the American insurance industry.

Large insurers are increasingly moving away from their origins in underwriting risk and paying claims, and into the business of direct healthcare delivery. As a result, insurers are building or purchasing delivery system capacity in most major metropolitan markets. As this trend continues, behavioral MCOs are "backwards integrating" into their parent health plans. This new "carve-in" model is resulting in new roles for behavioral MCOs to manage the behavioral services for proto-Accountable Health Plans (AHPs) and comprehensive organized systems of care.

Consequently, behavioral MCO domination by the insurance industry is a likely short-term industry evolution pathway which is likely to grow rapidly, resulting in a shift from a "carve out" focus to a "carve in" model in which the managed behavioral subsidiaries serve the health plans and delivery systems owned and operated by their parent companies. The evolution of this scenario which will be influenced by the role that these insurers have in reformed healthcare systems.

D. Managed Behavioral Healthcare Relations with Health Purchasing Alliances

Health purchasing alliances continue to emerge in many states, either in the form of employer purchasing coalitions or state-mandated agencies. These purchasing cooperatives, coalitions or alliances may have a significant impact on managed behavioral healthcare services in the short term to the extent that they continue to grow. Health purchasing alliances or cooperatives tend to specify a basic benefit package (or perhaps a basic and enriched package), and purchase from a limited set of authorized or certified health plans. While there is significant variation between alliances, these core functions are shared.

Behavioral healthcare policy analysts can benefit from studying how health purchasing cooperatives have viewed mental health benefits and services to date. Some health purchasing alliances (i.e. Florida) have initially turned to managed behavioral carve-out vendors, and have purchased "carved out" behavioral programs directly, as would any large self-insured employer. Other purchasing cooperatives (i.e. Minnesota business health action group) have specified a basic behavioral healthcare benefit package to be covered and provided by integrated delivery systems (Integrated Service Networks, ISNs) that provide behavioral as well as general medical/surgical care.

Some health purchasing coalitions are structured as an independent, state mandated or supported agency (i.e. Tennessee, California). In these environments, behavioral

The interest in purchasing comprehensive rather than carved-out health benefits, and the corresponding growth of AHP-like entities, poses certain strategic challenges for the managed behavioral carve-out industry. In order to remain viable within this environment, some behavioral MCOs may "carve in" and begin to function as the mental health departments of integrated delivery systems. This type of functional integration is most likely to happen with carve out firms that are owned by insurance carriers that are entering the integrated service delivery business. For example, HAI is becoming the behavioral health services provider for Aetna; MCC increasingly serves Cigna Health Plans, U.S. Behavioral Health increasingly serves Travelers/Met Life plans, and so forth.

In other instances, these integrated delivery systems may internalize the functions performed by managed behavioral carve-out vendors and learn how to provide managed behavioral benefits and services independent of managed behavioral healthcare entities. Alternatively, some managed behavioral health plans are currently discussing cooperative, joint venture, or acquisition arrangements with direct service providers as an avenue towards integration.

F. Public-Private Collaboration and Integration

Virtually all federal and state healthcare reform initiatives envision increasing public/private collaboration, with the integration of public and private behavioral healthcare systems as a possible long-term objective. As behavioral healthcare funding streams from Medicaid, Medicare, the Veterans' Administration, CHAMPUS, and other public payors are redirected to purchase privatized behavioral healthcare services on a capitated or discounted fee-for-service basis, managed behavioral healthcare firms are rushing to enter this new market niche.

The results of public-private integration efforts should significantly impact the short term future of the managed behavioral healthcare industry, resulting in the growth of privatized service capacity for the severely mentally ill and other publicly financed populations. States are looking at a variety of avenues towards privatization, ranging from reliance upon managed behavioral carve-out vendors, reliance on HMOs and integrated delivery systems that now care for other Medicare and Medicaid beneficiaries, and the development of internalized capitated managed behavioral healthcare systems at the county level.

In this regard, health systems planners must grapple with the need to create safeguards required by the severely mentally ill, and must determine methods to assure that coverage for "non-medical" social and rehabilitative wraparound services is included and provided within these privatized systems.

note how effectively properly aligned marketplace incentives have produced the social gains attributable to managed behavioral healthcare, and how much risk may accrue to our society from incentives that reward price at the expense of quality, efficiency at the expense of effectiveness, responsiveness to consumers at the expense of responsiveness to customers, and regulation at the expense of innovation.

down health care costs: strategies and solutions . Frederick, Maryland: Panel Publishers, a Division of Aspen Publishers.

12. Oss, M. (1993). *Managed behavioral health market share in the United States 1993: An open minds publication* (p14). Gettysburg, PA: Behavioral Health Industry News, Inc.

13. Pallak, M., Cummings, N., Dorken, H., and Henke, C. (1994). "Medical costs, Medicaid, and managed mental health treatment: The Hawaii study". *Managed Care Quarterly, 2* (2), 64-70.

14. Marques, C. Geraty, R., Harbin, H., Hoover, K., and Theis, J. (1994) "Quality and Access in the Managed Behavioral Healthcare Industry." *Behavioral Healthcare Tomorrow 3*, (5), 23-29.

15. Mumford, E., et al. (1984). "A new look at evidence about reduced cost of medical utilization following mental health treatment." *American Journal of Psychiatry, 141*, 1145-58.

16. Goldman, W. (1994). "Myths and potentials". *Managed Care Quarterly, 2* (2), 51-52.

17. Malueg, T., McIntyre, J., Smith, G.R., and Pallak, M.S. *Development and standardization of behavioral healthcare practice guidelines.* Presented at the Behavioral Healthcare Outcomes and Guidelines Summit, June 16-18, 1994, Minneapolis, Minnesota. Available on cassette from CentraLink at 415-435-9821.

18. Lipsey, M.W., and Wilson, D.B. (1993) "The Efficacy of Psychological, Educational and Behavioral Treatment" *American Psychologist 48* (12), 1181-1204.

19. Foster Higgins. "Survey on Outcomes Management." January 1994 technical report.

20. Trabin, T. (1994). "Towards greater accountability in behavioral health services: More science, less art?" *Behavioral Healthcare Tomorrow Journal, 3* (3), 1-8.

21. McDonnell Douglas Corporation Employee Assistance Program Financial Offset Study (1985-1989) 1990 white paper.

22. Regier, D., Narrow, W., Rae, D., Mandersheid, R., Locke, B., and Goodwin, F. (1993). "The de Facto US Mental and Addictive Disorders Service System." *Arch Gen Psychiatry, 50*, 85-94.

23. Fifer, S., Mathias, S., Patrick, D., Mazonson, P., Lubeck, D., and Buesching, D. (1994). "Untreated Anxiety Among Adult Primary Care Patients in Health Maintenance Organization." *Arch Gen Psychiatry, 51*, 740-750.

IMPLEMENTATION OF MANAGED CARE IN CHILD WELFARE: THE LEGAL PERSPECTIVE

presented by
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at the
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Leadership Circle Symposium
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Washington DC

IMPLEMENTATION OF MANAGED CARE IN CHILD WELFARE: THE LEGAL PERSPECTIVE

SIGNIFICANT LEGAL ISSUES ON THE FEDERAL LEVEL RELATED TO CHILD WELFARE:

- PERMANENCY PLANNING
- CATEGORICAL FUNDING
- TITLE IV-E, SOCIAL SECURITY ACT

PERMANENCY PLANNING

PUBLIC LAW 96-272
ADOPTION ASSISTANCE
AND
CHILD WELFARE ACT of 1980

UNDERSCORES THREE IMPORTANT PRINCIPLES:

- THE PREVENTION OF UNNECESSARY FOSTER CARE PLACEMENT
- THE REUNIFICATION OF CHILDREN IN FOSTER CARE WITH THEIR FAMILIES OF ORIGIN, WHEN POSSIBLE
- THE TIMELY ADOPTION OF CHILDREN UNABLE TO RETURN HOME

PERMANENCY PLANNING AND MANAGED CARE PRINCIPLES

It is noteworthy that these priorities are consistent with the principles of managed care in that they require the use of the most appropriate least restrictive setting for the shortest period of time possible.

Child welfare defines the desired outcome of this method of management of out-of-home placement as "permanence" for children in a family. Permanence implies a lifetime commitment between that child and family to stick by one another

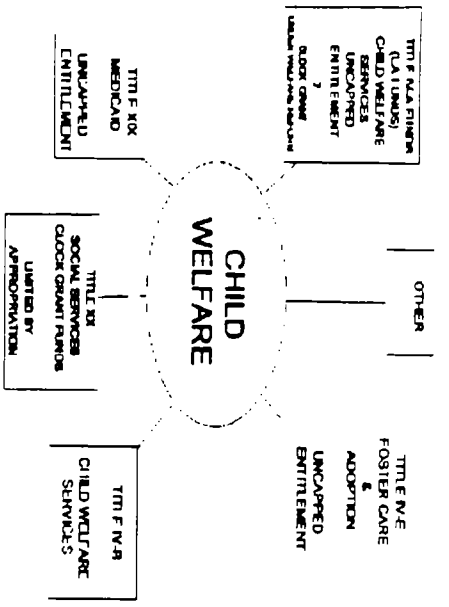
CATEGORICAL FUNDING

TO CARRY OUT ITS CHARGE UNDER PUBLIC LAW 96-272,

CHILD WELFARE RELIES HEAVILY ON A NUMBER OF DIFFERENT FEDERAL FUNDING STREAMS, EACH WITH THEIR OWN SET OF REQUIREMENTS.

THESE FUNDING STREAMS ARE:

- TITLE IV-E (foster care and adoption)
- TITLE IV-B (child welfare direct services, family preservation and support)
- TITLE XX (social services block grant)
- TITLE IV-A (emergency assistance)
- TITLE XIX (medicaid)



POOLED FUNDING STRATEGIES: A SOLUTION TO CATEGORICAL FUNDING?

TO CREATE FLEXIBLE FUNDING AT THE SERVICE DELIVERY LEVEL, SOME STATES HAVE LOOKED TO INNOVATIVE APPROACHES TO POOL FUNDING.

TITLE IV-E

OF ALL OF THE FEDERAL FUNDING STREAMS, TITLE IV-E POSES THE MOST SIGNIFICANT ISSUES FOR THE IMPLEMENTATION OF MANAGED CARE IN CHILD WELFARE.

THESE REASONS INCLUDE:

- THE ROLE OF THE JUDICIARY
- CLASS ACTION LITIGATION
- LEGAL CUSTODY AND CASE MANAGEMENT

ROLE OF THE JUDICIARY:
UNDER FEDERAL LAW

THE JUDICIARY ACT AS THE GATEKEEPER TO THE FOSTER CARE SYSTEM.

IN ORDER TO ACCESS TITLE IV-E FUNDS, THERE MUST BE:

* A JUDICIAL DETERMINATION, OR
* A VOLUNTARY PLACEMENT AGREEMENT (APPROVED BY THE COURT DEPENDING ON THE CHILD'S LENGTH OF STAY)

ROLE OF THE JUDICIARY
UNDER STATE LAWS

STATE LAW DETERMINES THE FULL EXTENT OF THE COURT'S AUTHORITY.

THIS AUTHORITY MAY INCLUDE APPROVAL OF:

PLACEMENT;

TREATMENT PLANS;

MOVEMENT OF CHILDREN WITHIN FOSTER CARE;

DISCHARGE FROM FOSTER CARE.

THEREFORE,

THE COURT'S AUTHORITY MUST BE CONSIDERED WHEN DESIGNING THE MANAGED CARE PLAN, ESPECIALLY IN TERMS OF AT RISK FINANCIAL ARRANGEMENTS, WHERE THE COURT'S AUTHORITY SUPERSEDES THE CONTROL OF THE ENTITY ASSUMING THE RISK.

COLLABORATION WITH THE JUDICIARY IS ESSENTIAL.

CLASS ACTION LITIGATION

CURRENTLY, A LITTLE LESS THAN HALF THE STATES IN THIS COUNTRY ARE INVOLVED IN CLASS ACTION LITIGATION REGARDING THE CHILD WELFARE SYSTEM.

THE MAJORITY OF THESE LAWSUITS HAVE BEEN RESOLVED THROUGH CONSENT DECREES THAT SPECIFY THE REFORMS THAT THE PUBLIC AGENCY WILL MAKE.

THE COURT GENERALLY RETAINS JURISDICTION OF THE CASE WHILE THE PUBLIC AGENCY IS IMPLEMENTING THE DECREE.

THE LEGAL BASIS OF CHILD WELFARE LITIGATION

THESE LAWSUITS HAVE BEEN BROUGHT FOR VIOLATIONS OF:

* FEDERAL STATUTORY LAW, MOST NOTABLY TITLE IV-E
* CONSTITUTIONAL LAW VIOLATIONS, SUCH AS DUE PROCESS AND RIGHT TO SAFETY WHILE IN STATE CUSTODY
* STATE LAW CLAIMS

SCOPE OF LITIGATION

CLASS ACTION LITIGATION HAS FOCUSED ON ALL ASPECTS OF CHILD WELFARE, INCLUDING:

* CHILD PROTECTIVE SERVICES
* PREVENTION SERVICES
* FOSTER CARE SERVICES
* ADOPTION SERVICES

THEREFORE,

THE PUBLIC AGENCY MUST CONSIDER THE TERMS OF THE CONSENT DECREE OR OTHER COURT ORDER IN DESIGNING ITS MANAGED CARE DELIVERY SYSTEM.

THE TERMS OF SUCH AN ORDER MAY IMPACT OR INTERFERE WITH THE PUBLIC AGENCY'S ABILITY TO IMPLEMENT MANAGED CARE.

IF SO, THE PUBLIC AGENCY MAY NEED TO EITHER CHANGE ITS SYSTEM'S DESIGN TO REFLECT THE TERMS OF THE ORDER OR SEEK A MODIFICATION OF THEM.

LEGAL CUSTODY AND CASE MANAGEMENT

THE TRANSITION TO A MANAGED CARE SERVICE DELIVERY SYSTEM REQUIRES PUBLIC AGENCIES TO REASSESS THE VIABILITY OF THEIR TRADITIONAL ROLES AND AREAS OF RESPONSIBILITY UNDER THE NEW SYSTEM.

THESE NEW ROLES AND RESPONSIBILITIES MUST BE CLEARLY DELINEATED IN THE MANAGED CARE PLAN.

A PARTICULAR ISSUE THAT STATES HAVE STRUGGLED WITH IS THEIR ROLE AS CASE MANAGER FOR CHILDREN IN THEIR CARE AND CUSTODY.

SECTION 472(a)(2)

STATES ARE RESPONSIBLE FOR THE PLACEMENT AND CARE OF CHILDREN IN THE LEGAL CUSTODY OF THE PUBLIC AGENCY.

THIS PROVISION, AS WELL AS STATE LAW, HAS CAUSED SOME STATES TO QUESTION THE EXTENT TO WHICH THEY MUST RETAIN CASE MANAGEMENT RESPONSIBILITY.

EVEN IF A STATE WERE TO DECIDE THAT IT WAS APPROPRIATE TO CONTRACT OUT THIS FUNCTION, UNDER FEDERAL LAW THE STATE WOULD STILL BE HELD ACCOUNTABLE FOR THE CONTRACT AGENT'S ACTS.

HOW DOES THIS RELATE TO AT RISK CONTRACTING?

THIS SCENARIO MAY SUGGEST THAT IT IS ONLY LEGALLY POSSIBLE FOR STATES TO CONSTRUCT SHARED RISK RATHER THAN FULLY AT-RISK ARRANGEMENTS WITH MANAGED CARE ENTITIES.

SO WHAT DOES THIS ALL MEAN?

IT MEANS THAT:

PUBLIC AGENCIES MUST CAREFULLY CONSIDER AND ADDRESS EACH OF THESE ISSUES IN THEIR MANAGED CARE PLAN AS WELL AS OTHERS NOT DISCUSSED HERE TODAY.

ALTHOUGH THESE LEGAL ISSUES GENERALLY DO NOT POSE AN ABSOLUTE BARRIER TO THE IMPLEMENTATION OF MANAGED CARE IN CHILD WELFARE, THEY WILL SURELY IMPACT THE SYSTEM'S DESIGN.

DRAFT

THE ROLE OF RISK-SHARING ARRANGEMENTS

BY
ANTHONY BROSKOWSKI

From *Managed Care: Challenges for Children and Family Services,*
A Report Prepared for the
Annie E. Casey Foundation by
The Policy Resource Center

Edited by Leslie Scallet, J.D.
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Patrick McCarthy, Project Officer

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INTRODUCTION

Risk provokes anxiety but it also provides opportunity. Policy officials will find it challenging to design and implement practical and effective risk-sharing arrangements within publicly-funded, integrated systems of care for children and families. However, this is an opportunity to build administrative and service-delivery structures that can have a positive effect on both the process of delivering services and on the outcome of the services that are provided. This may be accomplished if and only if *all* stakeholders have incentives to take reasonable risks and mechanisms are in place to prevent unreasonable loss. In successful systems, risk is *shared*, rather than shifted from one stakeholder to another.

This paper reviews risk and risk-sharing as they apply to managed care approaches and systems. Examples have been drawn from the arena of physical and mental health, since that has been the major testing ground for managed care. As other human service systems begin to incorporate the techniques of managed care, risk becomes an important issue for the design of their policies and programs. Therefore, risk-sharing mechanisms, techniques for risk evaluation, and risk-reduction strategies are discussed in relation to their applicability to systems serving children and families.

While risk-sharing has the potential to improve the flexibility and efficiency of services to families and children, it can also be the source of major problems if undertaken by naive payers or providers. If a payer passes on too much risk to providers who are not managerially prepared to handle it, the providers could fail financially, leaving the system in disarray. For a risk-sharing arrangement to be successful there must be a sufficiently large population of eligible lives, a well integrated service delivery network, and a considerable investment in clinical and administrative systems for managing the necessary care.

The appropriate allocation of risk requires that we understand it and determine how we can best minimize the uncertainty involved in estimating or projecting risk levels. This paper is intended to provide policy officials with a common framework of language and concepts on which to base their deliberations.

The paper is divided into several sections. The first, entitled **Framing the Discussion: Terms and Concepts**, provides some basic definitions and descriptions of the technical material. The reader should be able to use this section to answer certain questions: Who has a stake in sharing risk? What do we mean by risk, and what incentives can be used to encourage the sharing of risk? What mechanisms have been used in allocating risk among the various stakeholders in health and mental health systems? How can these and other mechanisms be applied to broader human service systems?

A brief overview of **Some Determinants of Risk** makes up the next section. Risk estimates are calculated by considering a variety of factors. The more precisely each factor can be delineated, the more likely it is that the risk estimate will be correct. Client factors, service cost factors, and plan factors are discussed. We would want to know some specific characteristics of the people who are potential users of service. Once we have determined who might become a client, we must try to determine which services (and how much of each service) the client is likely to use. It is also important to identify the cost of providing each unit of service, and that issue is discussed. Then we turn to the services and service systems themselves. Risk estimates require that we look at benefit plans in terms of what they will provide and who will be allowed or required to receive the benefits. Factors related to membership and enrollment are also included in this section.

This is followed by a section that looks at **Some Methods for Estimating Risk**. The actuarial method and the prospective modeling method are presented and discussed.

Some Contractual Provisions that Influence Risk are outlined next. These include various contractual features that can be used to mitigate risks. Rate adjustments, time limits, and the use of various loss-limiting conditions are discussed. Statistical techniques known as *risk-adjustment mechanisms* are beyond the scope of this paper, although planners will want to understand those mechanisms, also.

Finally, **Three Methods for Reducing Costs** are presented. Not all factors that have an impact on risk are easily amenable to change. However, many can be moved in a positive direction. For example, a prevention program may reduce the number of members with need for a more costly treatment program, a community-based treatment may be substituted for an institutional placement, and managers can take steps to reduce the direct and indirect expenses that make up the cost of a unit of care.

FRAMING THE DISCUSSION: TERMS AND CONCEPTS

Stakeholders

When risk-sharing systems are designed in the health arena, it is often assumed that financial risks or cost-sharing may be distributed in some fashion among five stakeholders:

- the employee/dependents, or *eligible user* of services, (e.g., sharing costs through payroll deductions to help pay the premium);
- the employer or government (taxpayer) that pays all or most of the premium;
- the insurer, or in recent years the managed care organization (MCO), that sets up and runs the system of services and accepts some or all of the risk if use and costs exceed the premium;
- the patient or *actual user* of services (e.g., sharing costs through copayments and deductibles; at risk for needing services not covered by plan);
- the provider of services (e.g., discounted fees, global fees, case rates).

In broader human service systems, the eligible recipients and actual users often have low incomes and are not in a position to pay premiums, make copayments and deductibles, or purchase services beyond those offered by the "Plan." Thus, they would not fit into this model of financial risk-sharing, although they might be at risk for underservice.

Financial vs. Nonfinancial Risks

This review is primarily concerned with **financial** forms of risk, although other, **nonfinancial** forms of risk can and do occur.

Nonfinancial risks (the risk of a good or bad outcome for a client receiving educational or juvenile justice services, for example) are not easy to describe in measurable terms. Those that can be measured often occur over a longer time frame than that of the relevant payers and providers, who commonly deal with single-year budgets and contracts. In addition, good or poor outcomes tend to be multicausal and derive from a mix of services larger than those within the purview of any single categorical agency or contract. Therefore, nonfinancial risk is rarely taken into account in any explicit fashion during the design or implementation of risk-sharing mechanisms.

Nonetheless, note that nonfinancial risks *can* be converted to financial measures. The risk of a good or bad outcome for a patient can be subsumed under the broad definition of financial risk if the risk for the cost of care is spread out over a sufficiently long time period and a sufficiently broad set of services. With a long time frame and responsibility for a wide range of services, a bad outcome will translate into the need to provide still more services. Good outcomes will translate into a lower percentage of eligible persons showing up to demand needed services.

Financial Risks are somewhat easier to conceptualize and measure. Financial risk may be defined as the *total cost of providing a defined scope of services to a defined population of potential users over a defined time period.* We will utilize the term **"total risk"** and define it as equivalent to **"total cost"** (over population, time, and scope of services), arriving at the following very useful formulation:

Total Risk = (Number of Users/1000) x (Units per User) x (Price per Unit)

It is a challenge to measure these three components of risk, but they can indeed be measured. That assumption should be kept in mind when reviewing the concept of distributing or *sharing* Total Risk among various stakeholders. It is also a challenge when the population in need may be at high risk for poor health yet low utilizers of healthcare services in the past. In these cases the historical data used to estimate future risks could provide misleadingly low estimates unless previous underservice is explicitly considered.

Incentives

Incentives are powerful determinants of behavior. Behavior may change in response to the fear of a penalty or the hope of a reward. As the state distributes risks, it must also distribute rewards in some approximately proportional measure or the systems will not stay in balance. When the total amount is finite, the more that is held by one group of stakeholders, the less will be held by others. If one group has all the risks and the other group has all the rewards, the system will be marked by gaming, over-control, and higher-than-necessary costs. Therefore, in order to maintain proportionality, as we distribute more risks to one set of stakeholders,

we must be willing also to reallocate the possible share of total rewards.

Financial Rewards: If we measure financial risk as equivalent to cost, we must also keep in mind its inverse, namely financial reward. While many stakeholders in health and human service systems have incentives that transcend financial rewards, we would be naive to assume that financial savings and financial rewards are not important motivators for behavior change.

Control over Resources: To the extent that the state wishes to have nongovernment agencies assume greater risk for costs, it must consider relinquishing some degree of control over the management of available resources. Assumption of control over resource management is generally correlated with assumption of risk and the concomitant opportunity for reward.

Utilization Risks and Price Risks

At least two distinctive types of risks are shared or spread around. One can be called the *risk for utilization*, while the other is the *risk for cost or price*. Each must be addressed separately. Their interactions must also be examined, since the combined effects may be larger than the effects of the individual factors. Levels of risk are estimated based on the probability that certain things will or will not happen. Actual service use and actual costs will vary, and the greater the variation, the greater the risks.

Risk for utilization: This includes two distinct kinds of uncertainties or unknowns. The first asks *how many* persons will use care (i.e., how many "eligibles" will become "clients") The second asks *how much* care each client will use.

Estimates of the probability of a person using at least one service (i.e., becoming a client) are calculated on the basis of a *carefully defined population* of persons. The number and amount of services each person will use must also be estimated. The broader the scope of services, the more difficult it becomes to estimate the probabilities of the many different service utilization patterns, or *combinations*. Even services that providers want all eligible beneficiaries to use will rarely reach 100 percent usage. For example, despite efforts of HMOs to assure that all children receive full immunization by age two, many factors can intervene, including poor family compliance, to hold the level to 80-90 percent at best. Treatment compliance is a major challenge in all service delivery systems, but emerges as a greater concern for providers who share risk and have greater potential for losses arising from poor compliance.

Risk for cost or price: This speaks to uncertainty about what a unit of service will cost. It is often easier to estimate cost or price than utilization, since providers usually have better records about and more control over costs. *Note that cost and price are not the same thing.* The provider's cost describes actual cost (e.g., salary + phone + rent). The provider's charge (price) is likely to exceed the provider's cost. That price becomes the payer's cost.

Any plan to undertake risk-sharing arrangements must be based on a sound unit-costing accounting process based on standardized definitions of services and methods of counting service units. It should not come as a surprise that many providers do not undertake rigorous unit-cost accounting and therefore have little idea of what it really costs to provide different types of services. For years many providers may have shifted revenues and expenses among a wide range of alternative funding sources in order to comply with multiple and conflicting payment rules and regulations. For example, charitable donations may be used to offset losses due to public sector payments that are far below real costs.

Furthermore, in accounting for the cost of a service unit, seldom are all costs recognized (e.g., depreciation, volunteer time). Further distortions may be introduced by reimbursement schemes that pay for only some types of services but not others, leading providers to allocate more overhead than appropriate to programs providing reimbursable services. Or, deficit-reimbursement-based contracts may have weakened the incentives and abilities of providers to bill for some services that may be reimbursable from other sources. In the final analysis, payers and providers must agree on a level of realistic and measurable costs, based on sound methods of accounting for all revenues and expenses and for allocating all overhead and administrative expenses to direct service units.

Variation: The variation that occurs in both cost and utilization in health and human service systems must not be forgotten in allocating risk. An important source of variation results from standards that require unique or customized services for individual users. The more customized features that are required and provided, the higher the cost of the overall system. This fact has been addressed in health care systems by trying to reduce treatment variations that are based on providers' or

patients' preferences rather than their demonstrated effects on treatment outcomes. Increased sensitivity to subpopulation characteristics also means increased variation and its consequences, increased service costs. For example, if direct service providers must be multi-lingual, or if they must support multiple access points in a neighborhood, then costs will be greater.

Standards for defining services and programs are essential to estimating risks, since risk implies potential variation from an expected average and is inherently based on the ability to count, and measure service events and service costs. Standards for treating different types of problems are also essential for the provider to manage risk successfully. The fact that each family and child is unique does not mean that each intervention must be idiosyncratic. Initial resistance to treatment guidelines in managed health care systems has largely given way to widespread acceptance as a method for improving the quality of care and reducing unnecessary costs.

In a competitive environment, a provider hopes that responding to customer concerns will lead to retention of the customer. Further, more responsive customer service may increase treatment compliance, perhaps yielding better outcomes in the long run. This argument breaks down in the public sector if consumer choice and provider competition are limited, and if customer-responsiveness does not show results within a short time frame.

Provider Reimbursement Mechanisms

Managed care does not imply any particular method of reimbursing providers for their services, and a considerable variety of methods is used. Overall, payers use reimbursement mechanisms to encourage providers to consider effective alternatives to costly forms of care, and to encourage them to use innovative and cost-effective clinical practices. These are expected to reduce utilization by improving treatment planning and implementation. Access to care, quality of care, and member satisfaction should be maintained or improved. In other words, distributing risk goes beyond cost control to serve as a mechanism for promoting quality. We will discuss the types of provider reimbursement and show how the degree or extent of risk (whether for utilization, price, or both) can be adjusted by modifying the *unit* on which the risk is based.

If the time frame is suitably long, risk does have great potential to promote quality. For example, cutting back on service content to offer a "discount"(e.g., providing special education without comprehensive health education) may lead to increased problems and service costs (e.g., teen pregnancy, HIV, STD episodes). A provider who is responsible over time for all outcomes under a case or capitation rate will think carefully how and where to cut back on services. However, risk-based reimbursement methods disrupt the traditional alignment of provider with client. Therefore, as we design risk-sharing methods for providers, we must invent countervailing mechanisms to maintain and strengthen an alignment between the client and the provider.

Rungs of the Risk Ladder

Figure 1 illustrates the "*risk ladder*," the continuum of payer and provider risk-sharing. The provider's risk increases with each step *up* the ladder; the state's increases with each step *down*. Both parties stand to gain when they find a point on this continuum where both feel comfortable with the *balance* of risk. In health care, other stakeholders would also participate in assuming risk (e.g., eligible employees or patients and their families). State officials may want to consider identifying ways in which families using broad service systems might share the risk of utilizing care.

We will look at the reimbursement mechanisms as rungs of a risk ladder on which the ***provider's risk goes up as the payer's risk goes down***. On the ground at the foot of the ladder, providers would have been reimbursed either for the full amount of the fees they set (i.e., fee for service, or FFS) or for their cost of providing the service plus an amount representing profit (i.e., cost plus). The rungs of the risk ladder address methods for allocating risk that range from negotiating discounted fees per unit of service or for a "globally defined package of services," to paying case rates on a per patient basis, to prepaying monthly capitation rates, to paying a percentage of the collected premium.

- **Discounts Off Normal Charges**

On the lowest rung of the ladder, providers are asked to give the state a *discount* off their normal fees for a given service unit. The unit may be a day of inpatient care or an hour of therapy. In exchange, the provider expects an increased flow of client referrals. The provider is at risk only for the cost incurred in the process of providing the unit of service. Success will depend on how much of the unit cost is made up of *fixed* vs. *variable* components (discussed

Figure 1
Progression of Provider's Risks

Degree of Provider's Risk	Type of Reimbursement	Unit of Risk	Nature of Risk; Uncertainty
Lowest Risk	Fee-For-Service: paid at "usual and customary" rate (e.g., Up to 80 percent of U&C)	The service unit; procedure; visit; day, etc.	The cost of producing the unit of service is above the Xth percentile paid by most insurers
	Discounted Fixed Fee per discrete Unit of Service	Each discrete type of service unit	The above risk plus - variation in the variable component of the cost of producing each unit
	Discounted Global Fee	Global package of discrete services bundled into one price	All of the above risks plus - variation in the number and types of discrete units consumed by each patient given the global package.
	Case Rate	Each patient identified as an instance of that case	All of the above risks plus - variation in the number and types of services consumed by each patient
	Capitation	Each enrolled member	All of the above risks plus - variation in the number of members who become patients
Highest Risk	Percent of Premium	Each contract sold	All of the above plus all operating expenses

below as determinants of risk) and how well the provider manages costs so that they do not exceed the negotiated fee.

While the provider's level of risk is low, the state is at greatest risk here because it pays more when numbers of eligible persons, numbers of persons who utilize service, or amounts of service used by each person go up. The state may seek deeper discounts from providers or may own and operate its own programs. However, the state remains at risk for utilization and price and, often, the state's unit costs may exceed those of the private sector.

- **Fixed Fees per Service Unit and Global Fees**

When payers learned that providers might increase their "normal charges" to minimize the cost-savings from discounts, they began to ask providers to take the next step up the risk ladder. This type of reimbursement is called *fixed fee per specific service unit*, and the fee is set at a level below the prevailing average fee and fixed over all the payer's clients who are provided that unit.

A variation is to "bundle" formerly small, discrete service units into larger "global service units." For example, a hospital may have billed at a discounted fee for each service received by a patient each day in the hospital (e.g., group therapy, medication, laboratory and diagnostic tests). Each day's charges would vary directly in proportion to each individual patient's consumption of specific services. The payer might then negotiate a global per diem rate, based on the average of all individual services billed on a daily basis for a large number of patients. This arrangement puts the hospital at risk for variations among patients in the number and type of services they need each day, as well as variations across days in the services needed

by any single patient. However, the hospital is not at risk for additional days of care, the patient's total length of stay.

The provider's risk, of course, is still limited to managing the cost of services at a level below the negotiated fee, and negotiating a fixed fee that takes into account any increase in variable costs due to the increase in patient volume. With global fixed fees, the provider is at risk for variations within and among patients on any given day, but *not* at risk for the underlying rate of patients/1000 in the population. The state as a payer still bears the risk for the underlying use rate and the average units per user.

In child welfare some providers have compensated for "discounts" by diversifying funding for a unit of service, e.g. recouping for educational therapy separately from board and maintenance during a residential treatment center episode. Additionally they may "rob Peter to pay Paul" and charge managed care commercial companies higher rates for a bed than they charge a state.

- **Case Rates**

A case rate is a fixed fee *per patient, per treatment episode*, usually based on some diagnosis or the assignment of the patient to a given type of treatment. For example, a provider may be paid $900 for every depressed patient referred for an episode of treatment (i.e., outpatient psychotherapy). The provider then determines the number and type of therapy sessions provided to each patient.

When a case rate is paid for conditions that have *time-limited, acute episodes*, the provider assumes *no risk for the underlying rate of patients/1000 lives* in the populations, nor for the *number of treatment episodes* a patient may need within a year. The provider is at risk, however, for the variation across patients in the average level of service needs per treatment episode, as well as for the underlying cost of the services provided. In other words, the case rate carries with it all the risks (and potential rewards) of fixed fees and global fees, *plus* risks (and possible rewards) for differences across individuals (i.e., cases) in total service units (e.g., days, visits, medications) each case receives during an episode of treatment.

One variation on case rate reimbursement is to define the treatment episode as a fixed time period, usually a year for individuals with a chronic condition. An example of an annualized case rate is $20,000 per child with serious emotional disturbance (SED) who is referred into a comprehensive service network. The network provider is paid a fixed amount per defined service user per defined time period. In addition to all the risks noted earlier (such as variations in need per day or per active treatment episode), the network is at risk for variations in the number of times during the defined time period when the child's condition may become exacerbated, requiring more intensive and expensive interventions. In other words, the network is at risk for variations in the type of services needed by each defined case. For example, the Massachusetts Comonworks RFP proposed $4,000 per month or $48,000 annually for a child in care. The going rate is $40-80,000/year for a residential treatment center. There are many case rate experiments in child welfare, such as Commonworks, Home Rebuilders, and Connections.

The state as payer can reduce its risk for the high degree of variation resulting from the use of many high cost services provided to children if it can establish a reasonable case rate over a sufficiently large number of children. A provider with a case rate, a sufficient volume, and a multi-year contract has an incentive to find the lowest cost service that will achieve the desired outcomes.

- **Capitation**

Capitation rates are based on the total number of persons who are eligible to receive services, but may or may not use a service. The provider receives a fixed payment in advance for all persons covered by the arrangement. These people are usually referred to as "members" of the "Plan" who are "eligible" to receive that provider's services and who choose to enroll with that particular provider, whether or not they ever become active patients or clients. Usually, members enroll with a given provider for a month. The provider usually competes with other providers for the share or percentage of total members enrolled.

In capitation, the state has its lowest level of risk. The provider is at risk for the cost per service unit, the number of services used per patient per episode, and the total number of persons who become active patients (i.e., the rate of patients/1000 members or per the underlying level of illness in the population). The provider's increased level of risk is accompanied by an increased potential for reward. The provider will be paid for many persons who never use services, presumably because they are healthy. Over a long term time period, the smart

provider would try to increase the percentage of healthy enrollees who will never seek care.

The extent of capitation may vary, ranging from *partial* to *full*. In full capitation, the provider is at risk for *all* services defined by the Benefit Plan or scope of contracted services. Partial capitation refers to instances where the provider is at risk for only *some* services, such as outpatient, and is not liable for others, such as inpatient or residential. Sometimes, partial capitation refers to circumstances where only some special *subset of a population* is the responsibility of the provider. These arrangements are also referred to as **"carveout"** models.

- **Percent of Premium**

At the highest rung of the risk ladder, the provider accepts as payment a percentage of the premium collected for each member. The premium revenue would be expected to cover both administrative and treatment expenses, with the remainder serving as the provider's "profit."

The provider's revenues would respond directly to changes in membership and premiums. In some ways, it is as if the provider were a shareholder in the Plan, with incentives directly related to growth and profitability. The provider has incentive to increase the Plan's *healthy* membership so that utilization rates do not grow proportionately to membership growth. If price competition leads to premium reductions, the provider would experience a direct reduction in revenues, but this would likely occur under other reimbursement schema, also.

Percent of premium payment schemes are relatively rare and are unlikely to be an option for children's service systems. The equivalent to percent of premium in a state-funded system would be a circumstance where the provider receives a percent of tax dollars collected.

- **Additional Rungs**

The risk ladder was developed with health care in mind. Levels of risk have additional implications when recipients of service have high-cost, low-incident disorders such as those experienced by children and adolescents with serious emotional disturbances or severe problems in their family environment. In going at risk for such conditions, the provider can be 100 percent certain that the identified "member" (every eligible person) will indeed be a user of services. In other words, there is *no potential reward* for the provider in case rate reimbursement, which is based on the number of "users per 1000 covered lives." The provider's only opportunities for *financial* improvement when accepting risks for chronic conditions are in changing the mix of services and the volume of each service type. Therefore, state officials will wish to consider using a number of *additional mechanisms* for adjusting the balance of risk between the state and the provider.

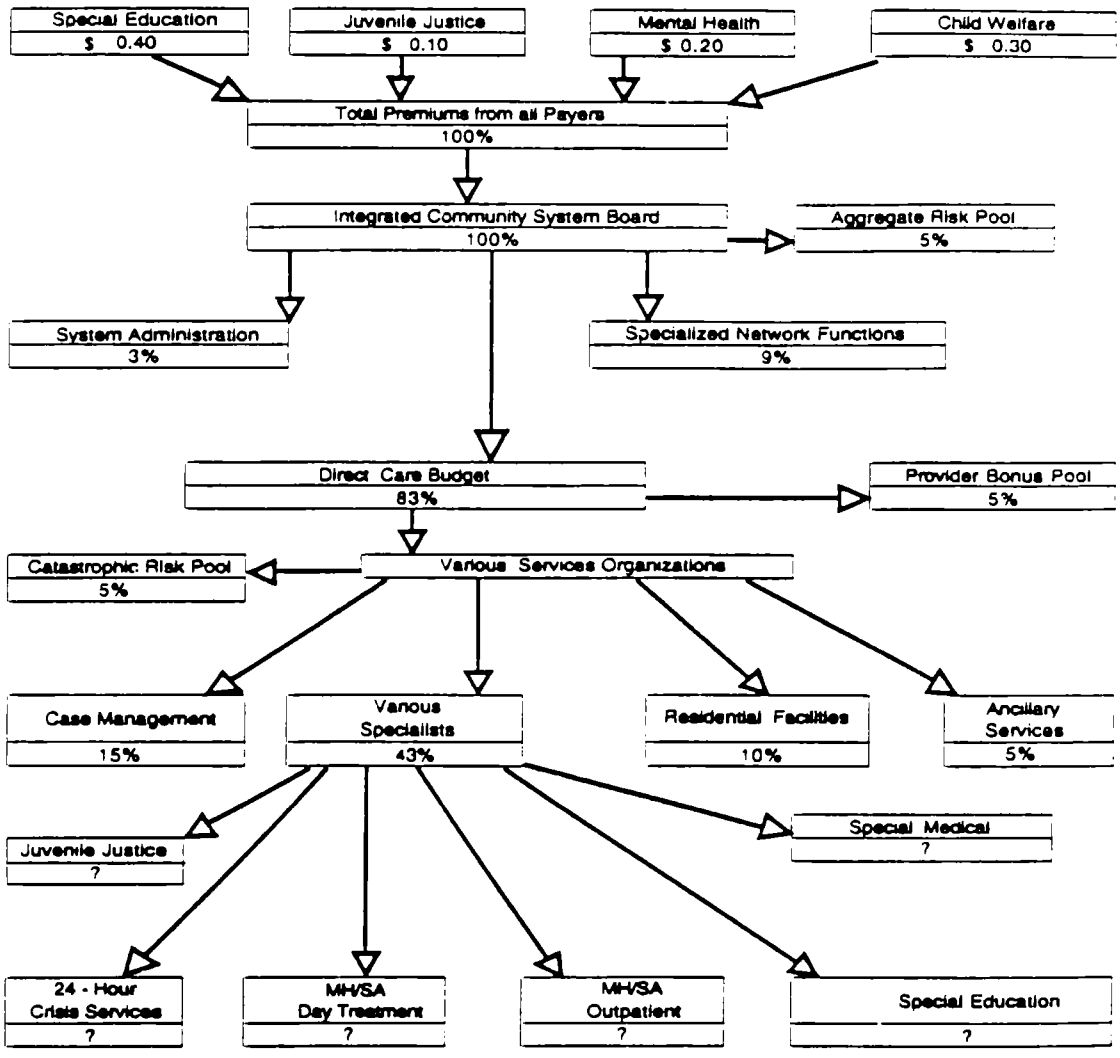
One such mechanism is the **pooling and redistribution** of risk. Various types of riskpools can be created to spread risk for low-incident, high-cost conditions, or to buffer a risk-bearing provider from a single, catastrophic cost that is outside the provider's control. **Figure 2** illustrates how an integrated Child-Adolescent Service organization might distribute the total amount of available funds. The figures in the various boxes are illustrations, not recommendations. Not all systems will use all features of this design, which are as follows:

- *All payer funds are pooled.*
- Some funds are set aside as an *aggregate risk pool* for use if the total cost of all care exceeds some targeted amount.
- A *catastrophic risk pool* is established for use when an individual child's care exceeds a given amount. (Rules must ensure that these funds are not used to bail out poorly performing providers, but are used to pay for extraordinary care that was beyond a provider's control.)
- *A provider's bonus* fund sets money aside to reward providers who achieve certain performance goals established at the beginning of a stated period (usually a year). The goals might be different for different providers, but the bonus should be in proportion to a provider's contribution to overall system performance. The bonus fund may also serve as reserve money to be tapped if both the other risk pools are depleted.

Bonus pools should be set at a fairly narrow range of 3-5 percent of total service dollars. The design of the bonus system must carefully consider and balance incentives against the risk that providers will engage in behaviors that are not in the best interests of clients, in order to maximize the bonus. For example, incentives tied to a reduction in the volume of services required per episode of care could be tied also to penalties if there is an increase in the number

Figure 2

An Illustration of a Premium Allocation Formula and Risk Distribution System



of clients who reappear for services (i.e., increased recidivism).

Figure 2 does not illustrate how the dollars might be paid, but there are many possible combinations that might be considered, based on a system's particular characteristics. For example, a Community Systems Board could accept risk on a capitation basis (per member per month for a large population of children and adolescents). It could use negotiated fees or case rates to pay some providers who only serve children who are the most seriously disturbed. Subcapitation could be used for services to children who are classified as less severely disturbed. Case rates could also be established for certain children who are eligible on the basis of a categorical need (e.g., child welfare).

Another variation on risk distribution within a service delivery organization is the **high-risk client carveout**, which is based on the type of service (or type of disease) *and* the severity of need of a class of clients with a particular disease or disorder. Specialized service systems that treat children with SED are an instance of this design. Under such designs, the capitation rate would be high, in that it would be almost certain that all, or most, enrollees would frequently use intensive services.

From a strictly statistical perspective, a single capitation rate may appeal to the primary risk holder, but it may carry significant downside risks for the specialty provider who accepts a subcapitation and the responsibility for the high-cost patients. For one thing, a risk is always greater when there is a smaller number of patients. Smaller groups have greater "variability" associated with them, so changes in any one client can have a significant impact on the "average" for the group of clients. Conversely, the larger the group, the lower the variability and the lower the chances a single patient can influence the average.

Secondly, in a high-risk carveout, it is highly likely that most "eligible members" will use services. The provider cannot hope that prevention or other strategies will lower the rate of users/1000. However, the provider can try to control the intensity and frequency of each patient's service utilization, as well as the cost per service unit.

For example, if government wishes to plan and implement a capitated, population-based system for a "population" defined in terms of known prior users (e.g. only for known cases of children and families already using services), knowledgeable providers would insist on very high capitation rates to cover the higher expected rate of use among a small number of "enrollees." Better yet, the provider would try to negotiate an adequate case rate, since there is little chance of influencing the rate of users /1000.

Some Determinants of Risk

Estimating risk requires that a variety of factors be explored and considered. Any of these factors might be expected to influence the provision or utilization of care.

Client Factors

Population Characteristics: Many characteristics of a population of potential service users may affect their service use patterns. Examples include: the ratio of males to females; poor housing conditions; race/ethnicity; the number of each who fall into various age groupings; and the number who live in single-parent homes, have low income or education, or lack jobs or other social supports. When these characteristics are known, reimbursement systems can be tailored to ensure that risk levels are addressed adequately. For example, the capitation rate or fee might be the same for serving younger children of either gender, but different fees or rates might be warranted for serving "high risk" male and female adolescents. Absence of research on risk clusters and causal relationships between risk attributes and emotional and social supports make these ratios difficult to explore.

Patterns of Use Among Members in the Population: The term *patterns* is meant to convey a combination of factors that directly affect financial risks. How many persons will seek treatment? What kind of treatment will they seek? Will the treatment be effective or will they have to repeat treatment? If given a choice, will they go to high-cost or lower-cost providers? Historical utilization data or data from secondary sources usually answer these questions.

The more you know about the *patterns of utilization*, the better you can assess and measure the risks in a given payment scheme (i.e., discounted fees, case rates, or capitation). A few examples of utilization patterns are:

- families who use a lot of episodic emergency care but nothing else;

- families and children who overuse emergency room and inpatient or out-of-home treatment;
- families with multiple inpatient/out-of-home episodes but few completed outpatient treatment episodes, wraparound services, or intensive case management meetings;
- families who use multiple programs across systems (e.g., education, courts, mental health), simultaneously and repeatedly;
- families who receive and comply with treatment or service plans, and are not seen again that year; and
- families who require linguistically tailored services.

Service Cost Factors

Payers and providers alike have a stake in ensuring that appropriate attention is paid to the **"cost per unit"** of service when risk-sharing arrangements are negotiated. Accounting systems use various methods for measuring the elements that are used in determining the unit cost for a service within the scope of services covered by a particular system.

Direct vs. Indirect Costs: *Direct costs* are the expenses associated with the time and materials directly used or consumed in the process of providing a service (e.g., staff salaries, medication costs, and food or laundry service provided to a patient on an inpatient unit). *Indirect costs* are the expenses associated with items that have to be in place but are not necessarily directly used or consumed by the patient or therapist at the time the service is provided (e.g., administrative overhead units such as medical records or business office). *Cost allocation* is the process of allocating a fair share of the indirect "overhead" expenses (cost centers) to the various direct service programs (revenue centers).

Fixed vs. Variable Costs: *Fixed costs*, such as office rent, do not vary with patient volume. *Variable costs* are expenses directly associated with patient volume, such as food. (A third category sometimes used, *"step-variable"* costs, refers to costs that are fixed up to a certain point. If you expect 1,000 patients and purchase the minimum lot of 1,000 intake forms for $300, you will need to purchase another lot of 1,000 for another $300 if patient volume rises above your expectation.) The distinction between fixed and variable costs is critical when a provider negotiates a discounted fixed fee in exchange for more referrals (volume). If a large percentage of the provider's expenses proves to be variable, the provider may suffer significant losses.

The cost of delivering a unit of service has important implications for program design. For example, programs that require considerable capital outlays and have relatively high fixed costs (e.g., inpatient programs) probably would be unsuitable in full risk systems. There would be too much temptation to keep them filled up and too much pressure to cover those fixed costs, even when the service offered did not meet the client's need.

Plan Factors

Benefit Plans: *Benefit Plans* are traditional risk "management" mechanisms, used by insurers long before utilization review, case management, and provider risk-sharing were ever considered. Indeed, a Benefit Plan may be designed to attract or repel persons who have particular diseases or social service needs or patterns of service use. Benefit Plans control risks by setting various types of "limitations" on such factors as:

- the persons to be covered by the benefit,
- the number and type of services to be covered,
- the types of authorized providers (patients could choose any "eligible" provider), and
- the amount of money to be paid out by the insurer and the patient.

In some cases, the eligible recipient may view a Benefit Plan as entitling him or her to the upper limits of care, rather than as services that are only available if deemed necessary. However, coinsurance and co-payments create financial disincentives for patients to seek care or consume many units of care. Providers who accept a case rate or a capitation payment to assume risk for a population may use the Benefit Plan as a tool for limiting their risk of having to provide services that are ***wanted*** but not ***needed*** by the patient. Note, though, that when service recipients are not expected to contribute financially through deductibles and copayments, it is particularly important that clinical service decisions be made through a case management system that is built on objective treatment guidelines.

The Benefit Plan is important, but its relative importance in evaluating risk, as compared with such factors as population served and service continuum, is generally overestimated. In fact, as one moves up the risk ladder to full capitation, and moves toward full systems of care, the role of "covered services" or "levels of coinsurance" becomes less meaningful. Most importantly, Benefit Plans can never anticipate all the idiosyncratic aspects of every family's circumstances. In some circumstances, in fact, a *traditional* Benefit Plan that limits units and types of service would make no sense. For example, every child in a population of children with SED that is covered under a capitation contract should be expected to use a considerable amount of service. The appropriate mechanism for addressing the provider's risk is a "stop-loss" provision, as discussed below under the heading, **Some Contractual Provisions that Influence Risk.**

One advantage of managed care arrangements is that they can cover services not specifically identified as covered benefits. Self-insured employers often permit the MCO that administers its health plan to "flex the benefit" for an individual patient under special circumstances. To avoid creating new "entitlements," such exceptions would be granted informally rather than written into the Benefit Plan. For providers who accept full risk through capitation, flexibility might permit paying for benefits that were not specifically addressed in the Plan (for example, child care) but that would promote a more cost-effective outcome.

The effects of copayments and deductibles are typically considered in calculating utilization, cost, and revenue expected under various Benefit Plan scenarios. Patient out-of-pocket payments can increase the provider's revenue under a negotiated fee-for-service agreement and, as noted earlier, patients are less likely to use services when they must pay a portion of the cost. However, after the maximum out-of-pocket payment level is reached, the individual patient has no further financial disincentives to demanding more service. This tends to mean that Plans with lower out-of-pocket payment requirements charge higher premiums in anticipation of greater medical costs. Note that copayments and deductibles may not be relevant for impoverished clients in public service systems. State officials may want to address this population by considering other ways to encourage them to use less service. For example, in an analagous approach to the recent change in welfare policy, clients might be required to "pay" for a unit of service received with a certain number of hours of volunteer work.

Risk levels in partial capitation arrangements, or **benefit carveouts**, should be evaluated in relation to the potential effects of the set of benefits and reimbursement systems at work within the larger system. For example, if specialized mental health services are carved out from a larger system of medical services, physicians who are capitated for primary care may increase their rate of referrals to the mental health provider. This may have a positive effect on patients needing specialty mental health care, but it may have a negative effect on mental health providers if increased referrals were not considered in calculating the partial capitation rate they receive.

An additional concern about partial capitation programs is that they can provide incentives for shifting the risk of high cost clients through inappropriate referrals. For example, a specialty provider who is capitated only for outpatient services might be inclined to increase referrals to hospitals. If correctional services are not included in the scope of services, there may be incentives to have children classified as delinquents. In general, the more the overall premium dollar and benefit package is "carved up and split up" among separate provider organizations within the same community serving the same covered population, the more likely it is that some providers will try to shift risks to other providers.

Enrollment: Predicting the level of risk in any service system is heavily dependent on determining who is to be served in the system. We have already discussed the importance of looking at client factors. It is also important to consider the number of clients who will enroll, and the process by which enrollment is accomplished.

The overall **size of the membership** is the number of persons in the group whose care is to be managed, which includes those persons who are likely to become enrolled as members and utilize care. The greater the size of the membership, the more predictable the statistical averages on which case rates and capitation are based and, therefore, the more reliable the estimate of risk. Although it may seem counterintuitive, public sector systems should try to include as many children and families as possible in the risk group. The more restricted the size of the risk population, the more difficult it will be to implement reasonable risk-reward arrangements with providers.

State officials also must pay close attention to the rules they will set to govern the process by which eligible population members are identified and enrolled. The most important of these is whether enrollment in the managed care system will be **voluntary** or **mandatory**. In either case, enrollment is complicated by the discontinuous nature of Medicaid eligibility. Voluntary enrollment allows continuity of care by permitting patients to maintain existing relationships with out-of-network providers. It eliminates the need for state Medicaid projects to seek a waiver from federal freedom of choice laws. And by allowing disenrollment, it increases providers' sensitivity to the wishes of the membership. Unfortunately, voluntary enrollment may also offer opportunities for "creaming," which means attracting or selecting the "best" or "healthiest" or "most desirable" members. This strategy may reduce the individual provider's risk, but it does a disservice to the people who are not selected and to the total system.

Voluntary enrollment can also create some significant risks for providers. For example, it increases the chance of having only a small group of enrollees over which to spread the risks. If a provider must participate in recruiting and enrolling the members, administrative costs and time will increase. Administrative complexity may also increase, in relation to records management and billing processes, if the provider sees some persons who maintain traditional coverage along with those who elected managed care. However, the biggest concern is that voluntary enrollment processes can increase the risk of a higher per-person cost than was estimated when the capitation rate was set using historical averages. While voluntary enrollees in an HMO may be seen as *less* likely to have illnesses because they have no strong loyalty to a non-HMO provider, just the opposite may be true of persons who volunteer to enroll in a behavioral health carveout plan. A mental health/substance abuse (MH/SA) carveout might appeal to persons with serious preexisting problems who have had difficulty in accessing services, are dissatisfied with existing services, or have reached their maximum limits of service under a traditional plan.

The effect of mandatory versus voluntary enrollment on risk is grounded in the concept of **adverse selection**. Adverse selection refers to any process or circumstance that would result in a "sicker than usual" number of persons enrolling in your system. For example, when potential members can choose among several Benefit Plans, the HMO that advertises the best MH/SA services (all other things being equal) is likely to attract more members with MH/SA problems than will an HMO that downplays these types of services.

Once the system designers and payers decide that enrollment is mandatory or voluntary, they must further decide whether to give enrollees a choice among provider systems. The enrollment process is **exclusive** when limited to a single provider system or **competitive** when there is a choice of two or more provider systems. An initial "fair share of the relative risks" spread among competing systems may be enforced by **assigning** members to a given provider network, as has been done in some state-sponsored Medicaid programs. The assignment process can be random or based on an algorithm to ensure initially a balanced enrollment of the various levels of severity among all competing provider networks.

Auto-assignment must take into consideration client access, by requiring providers to have at least minimal services relative to population locations. It is generally a mechanism to start out the enrollment process; members can then transfer to other providers based on performance or satisfaction. Competition in this sense does not relate necessarily to high or low bidders, but simply implies choice. For example, in Tennessee multiple carve-out vendors may be competing for membership, but all vendors are paid the same rate per member per month. The most competitive provider may not be the lowest cost provider but one with a smaller profit margin, which chooses to compete on quality and make money by getting a larger market share.

When members can choose among competing provider systems, they will be influenced by factors such as ease of access, the provider's reputation, perceptions of quality, or past experience with the particular system. Those who choose a particular provider system may be healthier or sicker than the total population of potential members. The direction of this bias toward adverse or favorable selection cannot be specified in advance for all conditions. Being selected may be a good or a bad outcome for a provider, depending on the nature of the risk arrangement. State planners should weigh the benefits of competition (e.g., providers who are more responsive to clients) against the complexities introduced in estimating a fair share of the risk among competing providers.

SOME METHODS FOR ESTIMATING RISK

Actuarial Approach

One of two basic approaches to developing estimates of risk, the actuarial approach uses historical data to predict what will happen in the future. It relies on retrospective analysis of such factors as patterns of service utilization and cost of units of service. The approach is flawed to the extent that a) the historical data may not be complete and credible and b) the future service system is almost certain to differ from the one used in the past.

Insurance companies use the term "credibility" to refer to the degree of reliance that can be based on past claims experience in making forecasts of future experience. Credibility is a direct function of the size of the group (data set) from which a sample of data is drawn. The larger the group's size, the less variation one would expect from the overall historical average. However, if the past system used a style of payment and service delivery that is very different from what is being planned for the new system, the data from the past may have ZERO credibility regardless of the size of the database. For example, if past paid claims are used, one does not know the true unit cost if payments were based on arbitrary rates or providers billed for only certain services in order to "game" the system.

Prospective Risk Simulation

Because of the limitations of historical data, or because significant changes in the delivery system or reimbursement method are being planned, state payers and providers should consider using prospective simulation techniques to estimate risk.

Statistical modeling, or simulation, is a method of planning and forecasting that allows the system designers to be explicit with regard to the probabilities of given values that can influence various outcomes. Using computer software, decision makers can enter any number of critical "input" variables, "output" variables, and formulas that define the relationships among and between inputs and outputs. The program will provide a model of possible outcomes and the probability that each will occur. By changing the size or content of a variable or formula, the decision-maker can simulate the probable effects of making such a change.

State officials should note the many benefits of modeling and simulation. For example, models can:

- Make explicit the assumptions underlying the system design for providing existing services or new services, or dropping existing services, estimating cost-savings, or accepting financial risks.
- Support contract negotiations between payers and providers around alternative risk-sharing arrangements.
- Estimate savings and reserves that might be realized through alternative use of resources or use of alternative treatment paths for different service consumer groups.
- Create a shared vision among designers, leaders, managers and staff with respect to ongoing expectations for administrative and clinical performance and productivity.
- Reinforce a comprehensive view of the entire product or service organization, by allowing explicit display and analysis of interdependencies and continuity across staff, teams, or work units.
- Free program planning and financial forecasting from the constraints of "the average patient", "the average staff" mode of thinking and incorporate a more realistic assumption that "variation happens."
- Support a philosophy of *Continuous Quality Improvement* that suggests that quality is reflected in the reduction of controllable variation and matching consumer variations to individualized treatment protocols.
- Support the planning and analysis of new programs or services needed in order to better accept and manage financial risks, by helping to estimate the *Return on Investment* in new programs, services, or patient/population interventions.
- Permit conversion of a forecasting or prediction model into a tracking and trending model that supports an ongoing comparison of the assumptions and predictions made when the system was planned and implemented, with the actual results shown in utilization and cost reports.

SOME CONTRACTUAL PROVISIONS THAT INFLUENCE RISK

Various methods, called "*risk-adjustment mechanisms,*" can be used to level the playing field prospectively or retrospectively for at-risk provider systems under situations where voluntary or mandatory enrollees may choose among competing providers. However, mathematics alone cannot solve all the potential problems of risk-sharing and other contractual features may be useful in apportioning risk.

Adjustments in Rates: Historical information about utilization and financing is often flawed, and capitation or case rates must be prospectively adjusted prior to negotiating a contract. However, if the adjustments seem inadequate, the provider may wish to negotiate contractual clauses that allow for retrospective adjustments under certain conditions. For example, children may have been underserved in the past, or past services may have been inadequately documented. Large numbers of people with mental illness and substance abuse disorders may have gone unrecognized or been misdiagnosed because of poor benefits for MH/SA services. Risk estimates should incorporate adjustments for the cost of caring for the people who might come "out of the woodwork" to use a system that provides the services they need. The mechanisms for such adjustments are generally agreed upon in the contract and then made retrospectively, based upon actual evidence that such utilization patterns did in fact change from what history would have led one to expect.

Rate adjustments may also be based on inflation and tied to some formula for inflation of the cost of services (e.g., the Consumer Price Index or the Medical Cost Index). Changes in laws and regulations that occur after the initial contract is signed may also lead to rate adjustments.

Risk-Limiting Mechanisms: Payers are concerned that the good providers will lose money and drop out of the market. They also fear that the risk-bearing provider will make excessive profits at the client's or payer's expense. Therefore, contracts may have a range of reimbursement rules, known as **risk-reward corridors**, that limit the provider's downside risks as well as any upside profits. For example, a fixed limit may be placed on the percentage of revenues that a provider can use for administration and profit, and documentation may be required to show that the balance was spent on patient care. (Some would argue that this is not really risk-reward sharing but a disguised form of old-fashioned contracting and budgeting, with only downside risks for the provider.) A downside risk for the government, taxpayers, and patients is that money is taken out of the system and therefore out of patient care. A variation of this allows payer and provider to share in both savings and risks. Generally, the more that providers are protected against loss, the more limited will be their potential for profit.

Risk-reward corridors limit providers' losses to a percentage of total losses, but do not necessarily protect providers against catastrophic losses. A primary function of government is to serve as the ultimate bearer (and distributor, through tax policies) of risk when catastrophic events occur or poorly insured systems fail to operate properly. Examples include governmental responses to wide-scale floods and fire, to local government defaults, and to collapse of savings and loans institutions. In the arena of human services, too, the federal and state governments bear ultimate risk when other risk-sharing arrangements have failed. Therefore, the state has a stake in ensuring the success of provider organizations.

Stop-loss protection is used to protect providers against catastrophic losses. One type of stop-loss mechanism, the use of **risk-sharing pools**, was discussed in conjunction with Figure 2. These are important for enhancing the providers' willingness to accept risk and his or her potential ability to continue to participate in a risk-based system. A risk pool may be in order when multiple providers serve a limited number of enrollees, so that no one provider may have a sufficiently large pool of covered lives. Payer and providers may agree to spread some of the risk for excessive and unpredictable expenses over *all the providers*. Funds for the pool are *withheld* from each provider's monthly payment and set aside. They are used in accordance with rules established for their use. If funds are left over at the end of the year, they are distributed to the providers according to an allocation formula, such as in proportion to each provider's average monthly membership.

Other stop-loss mechanisms may include **negotiated agreements** between an individual provider and the payer that place limits on the provider's level of risk, as well as the **independent purchase of insurance** against catastrophic loss by an individual provider.

Note that arrangements must consider how to balance the interests of the payer and provider and the client. Since any substantial savings are

likely to come from reduced care as well as reductions in customer service and/or administrative overhead, it is important to ask whether the reductions in cost will come at the expense of necessary care and/or quality of care. Instead, savings should be realized through provider efficiency, improved treatment effectiveness, greater patient compliance, and the elimination of unnecessary or harmful patient care.

Duration of Contract: Most risk calculations are based on annual utilization and cost information. However, relatively greater stability results from using a longer time frame. It is both intuitively and statistically true that patterns of random fluctuations will average out over longer time periods.

If we think of a contract as a series of monthly bets, the provider is betting that the average cost of care each month will be less than the average monthly payments. If payments were calculated realistically, it is likely, but not 100 percent certain, that the average of 12 months of expenses will not exceed the average of 12 months of payments. However, the provider's chances of winning are improved if averages are taken over 24 months, or better yet over 48 months. As the time period is extended, the provider will gain the experience and skills needed for consistently profitable operation.

The state as payer may see some advantages to holding an annual competition among providers to secure a new contract. But the payer also incurs risks and costs in an annual rebidding process, and if the provider is reasonably successful in providing quality care within reasonable costs, there is little advantage to either provider or payer in costly annual competition. In addition, a longer-term contract reduces the risk that a provider will terminate services unilaterally. Especially in child-serving systems, it is important to encourage preventive services and foster long-term treatment relationships between patient and provider. This requires consistent investment and long-term commitment by all players.

Covered Populations: Even payers and providers who are relatively new to risk-sharing payment agreements understand that risk-sharing involves uncertainty, and a major source of uncertainty is directly related to the size of the population on which risks are being shared. Public payers (perhaps a group of agencies that fund services for children) may be starting the new program with a relatively few identified lives. Although they may expect to expand the size of this group, they would like to have providers accept some degree of risk. The provider organizations may be fairly small and have limited capacity to accept risks over a very large group of lives or across the full continuum of services.

When the covered group size is small and very likely to need considerable service, capitation efforts raise two concerns: the total level of revenue is certain to be low, since "per member per month" revenue is directly related to size; however, the level of uncertainty about utilization is very high. Under such circumstances the provider may seek a minimum guarantee of income. If the minimum number of lives is expected to be fewer than 1,000-2,000, consideration should be given to avoiding capitation and negotiating a sufficient case rate.

Even when a large number of lives is covered, a given provider may be assigned relatively few of them. This small panel could result from many factors, such as members' choice of other providers, or the provider's location in a rural or sparsely populated area. Contracts may be adjusted to deal with such circumstances, but the payer will want to be sure that the low panel size is not related to mismanagement factors.

THREE METHODS FOR REDUCING COSTS

A well-designed risk-sharing system with the potential to reward all stakeholders must be designed with an understanding of various factors that may influence risk. Some of these factors, such as the underlying level of illness in a specified population, are difficult to measure or control. Others, such as the services that will be included in a Benefit Plan or the enrollment procedures that must be followed, can be influenced at the policy or program design level. The single, most important set of factors that can affect the total level of risk is the *provider's ability to influence and change the historical pattern* of utilization and administrative processes that have produced the current high level of costs. However, no one provider is likely to have sufficient resources to manage a full continuum of care. Therefore, state officials should focus on developing systems wherein multiple providers are included in an integrated delivery system, sharing risks over multiple levels of members and services.

Risk-sharing payment mechanisms alone will not be sufficient to change existing patterns of utilization and treatment costs, to say nothing of

administrative practices and waste related to service system fragmentation. Therefore, once a provider has assumed a certain level of risk, cost-control measures can be implemented to limit the potential for loss or to increase the potential for reward.

Three main strategies for reducing costs are addressed in this section. By carefully reviewing the specific risk factors that go into total cost and that can be measured and influenced to change, one can begin to think about the strategies that would alter historical patterns of care or improve efficiency. Goals would be to reduce the rate of users/1000 among members, to reduce the rate of inappropriate use per user, and to reduce the cost of providing a unit of service.

The trick of course, is to achieve these goals without reducing access when it is needed, and without reducing quality and other positive outcomes. First and foremost, it must be stressed that *an integrated, risk-sharing service delivery system cannot responsibly explore strategies for reducing risks without concurrently monitoring quality and outcomes.* It is no longer credible to argue that all steps taken to reduce utilization will necessarily and inevitably reduce quality. At the same time, it cannot be assumed that activities undertaken to cut utilization will not have an impact on quality and outcomes. Therefore, measurement of quality and outcome must go hand-in-hand with efforts to reduce costs by reducing utilization.

Reducing the Rate of Users per 1000 Members

Leaving aside for the moment the many inappropriate ways to reduce the user rates, the best strategy is **primary and secondary prevention.** Prevention programs can improve the health status of many members, thus reducing or eliminating their need to receive other services. Of course, we may not know how to prevent certain disorders (such as some mental illnesses), so there will always be a minimum number of individuals whose service needs will not be reduced through prevention efforts.

Barriers to effective use of prevention can be related to a variety of factors:

- Funds must be available to implement prevention programs;
- It is often hard to demonstrate that preventive interventions are effective;
- Results may not be achieved within the time frame of the contract;
- Providers may not benefit from their efforts to prevent illness if voluntary members later choose to enroll with a different set of providers.

Only when there is near universal coverage will it be in the interests of all risk-bearing providers in the community to invest (collectively or independently) in a range of prevention programs. Membership disenrollment and migration would not be as critical since all the providers would be more likely to share equally over time in the positive and negative effects of such membership migration.

Reducing Inappropriate Use per User

These strategies include: activities designed to divert patients from unnecessary and expensive levels of care into positive alternatives; continuous review of service utilization by patients within a given level of care to assess their need for ongoing treatment in that particular program; and development of *treatment guidelines* that offer recommended treatment protocols and their associated units and volume of services for specific conditions.

Other actions that will reduce units of service include those that are designed to **prevent reuse, or repeated use.** For example, a case manager might follow children leaving an inpatient psychiatric unit to ensure they receive the outpatient therapy they need to avoid rehospitalization. Similarly, community-based relapse-prevention programs may reduce the need for substance abusers to receive additional detoxification services. When they choose to focus on the small group of patients who use the most services, providers have found that intensive and assertive case management programs, coupled with incentives for patient compliance, can be very effective in **reducing the overuse or inappropriate use** of services.

Note that all efforts to change historical patterns of use depend on the **availability of effective additional or alternative services that are accessible to clients and their families.** Providers relate that utilization of "covered" services by children with serious or chronic conditions in the past was greatly influenced by the presence or absence of additional supportive or enabling services (such as transportation or home health assistance). Unfortunately, there is little statistical information about these out-of-

system services, in terms of either cost and usage or quality and outcome.

Risk reduction efforts must address the total array of services that are likely to be needed. An example drawn from the concept of behavioral health "carveouts" in Medicaid programs shows that people who are seriously mentally ill and eligible for SSI payments may have a relatively low historical treatment cost pattern. This reflects their receipt of out-of-system benefits, such as subsidized housing and psycho-social rehabilitation, that made it possible for them to minimize mental health treatment. If mental health treatment costs are shifted to a capitation rate and outside funding for their housing and support is diminished, the at-risk provider would certainly be faced with a much greater financial risk than anticipated. The provider might address this risk by requiring a very high capitation or case rate. The payer might address this by allowing contractual adjustments when critical systems are altered by changes in laws or other policies that are outside the control of the provider.

To avoid some of the potential for increased risk, state officials might consider the significant cost-saving potential inherent in providing for a larger set of comprehensive alternative services. This may require the investment of funds for developing or purchasing services not already available. Many factors must be considered in making such decisions, and a few are substantially related to the nature of the risk-sharing arrangement.

- Do the terms of the risk-sharing contract offer incentives or disincentives for the investment of capital in new programs (e.g., length of contract terms, limits on level of potential reward through savings)?
- Do the potential savings to be realized in a given time period offset the cost of the investment? Are subsequent savings and profits likely to be realized if the contract is renewed or will the payer attempt to recoup all the savings from the provider's investment?
- Is the new alternative one that has a high ratio of variable costs to fixed costs, so it can be used only on an as-needed basis?
- Can the development of a new, but high cost, alternative immediately allow the total elimination of a more expensive program?
- Are there alternatives with low capital start-up costs and low fixed-operating costs (e.g., in-home crisis intervention) which, even if not 100 percent effective (e.g., reducing hospital costs), are sufficiently effective to offset their low investment need?

Reducing Cost per Unit of Care

The provider must be able to measure or estimate the cost of delivering a unit of service. The calculations will include the direct expenses associated with delivering the particular service and the indirect costs that have been allocated to delivering that service. Policy officials are well advised to be very familiar with how the total costs were calculated, and what percentage of those costs were allocated as compared to direct.

When a unit cost is too high to be competitive, managers may take steps to reduce costs and make a risk-sharing arrangement more acceptable for both the payer and the provider. For example, if food is considered to be a direct expense, the provider can seek a food supplier who charges less for the food that must be purchased. If the salary of a night nurse in a residential treatment program is considered a direct expense, that cost might be eliminated by substituting community-based day treatment services for the same client.

Indirect expenses, such as administrative overhead, can also be reduced (e.g., limiting travel or long distance phone calls; reducing the number of administrative staff). In addition, there are a variety of accounting methods that may be used to allocate costs among the service programs (revenue centers) within a provider organization. Different allocation formulas can lead to quite different results in the calculation of a revenue center's "cost per unit." However, simply revising the formula to change the percentage of allocation will not help unless there is another revenue center within the organization that can absorb the reallocated overhead expenses and continue to offer services at a competitive price.

In Conclusion

This paper has addressed a variety of issues related to risk in a child- and family-serving system of care that uses managed care techniques. A strong emphasis has been placed on *sharing* rather than *shifting* risk. It is difficult to achieve an appropriate balance of incentives for payers, populations of potential

clients, actual clients, and various types of providers. However, success is reached only when *all stakeholders* are given incentives to create and maintain efficient and effective systems that offer high quality care. At the heart of this discussion of risk lie the following points:

- There is a range of reimbursement methods that may be used to apportion risk between payer and provider. These mechanisms were illustrated as the rungs of a ladder on which one party's risk rises while the other's falls. Some of the mechanisms often utilized in managed care approaches to health and behavioral health care are: negotiated discounts on the fee for providing a unit of service or for providing a "globally defined package of services;" payment of a case rate for serving an individual client; prepayment of a monthly capitation rate; and payment of a percentage of the collected premium. Additional mechanisms, such as the use of risk pools or high-risk carveouts, may prove useful in aligning risk properly among payers and providers in the broader arena of human services.

- Risk is affected by a variety of factors. *Client factors* include characteristics and service usage patterns of the population. Direct versus indirect costs and fixed versus variable costs are *service cost factors* that have an impact on risk. *Plan factors* relate to the benefits that are offered and to the enrollment of members.

- Contractual provisions can be used to influence risk. Examples include rate adjustments, risk-limiting mechanisms, longer or shorter duration contracts, and smaller or larger numbers of enrollees.

- Providers use three main methods for reducing costs, thereby avoiding losses or reaping profits. These include reducing the rate of users per 1000 members, reducing inappropriate use per user, and reducing the cost of delivering a unit of service.

For the service system to meet its objectives, there must be balance among the interrelated factors of access, quality, satisfaction, and cost. How to optimize or balance competing interests is still an imprecise art, but most would agree that successful implementation of a comprehensive service system for children and families will depend in large part on identifying potentially competing interests and realigning them so that all parties share the same interests. Too much risk can paralyze; too little risk can limit creativity, resourcefulness, and industry.

CULTURAL COMPETENCE STANDARDS IN MANAGED CARE MENTAL HEALTH SERVICES FOR LATINO POPULATIONS

The National Latino Behavioral Health Workgroup

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DEFINITIONS

Alternative/Traditional Healers (folk healers):

- Community people who are culturally respected and have knowledge to cure people of their physical and emotional afflictions within their cultural beliefs sometimes using spirituality herbs as a form of healing. Healing may be done in absences of or in combination with the medical system.

- Individuals designated by a cultural group or tradition with the authority and power to perform rituals, ceremonies, or utilize medicinal substances for physical and spiritual healing.

Comparability of Benefits:

- That benefits afforded different cultural/ethnic or socioeconomic groups be equally comparable to each other and to the majority populations, including any adaptations necessary to reach equal access and utilization.

Cultural Competence:

- The ability to demonstrate skills and knowledge which enables a person to work effectively across cultures; the ability to provide mental health treatment within the cultural understanding of the consumer (reality conditions).

- The ability to provide effective services to people of different cultural background, including different from the provider(s).

Health Plan/Plan

- Managed care plan or network; equally applies to public agencies delivering managed services.

Interpreter

- Individual trained and certified in facilitating communication between two people of different cultures and languages using in-depth knowledge not only of the language but also cultural values, beliefs and expressions.

Latino Mental Health Specialist:

- A mental health professional who either through his/her Latino heritage and language fluency or formal training in the Latino culture, is able to integrate cultural knowledge and competency into the clinical/service interaction with Latino consumers.

(*Latino*)/Minority Mental Health Specialist:

- A professional with demonstrated skills and knowledge of all dimensions of mental health needs of ethnic minority consumers/family. This knowledge can be expanded to the specific clinical dimension of how ethnic minorities experience mental health needs.

Minimum Representation Criteria

- A minimum percentage of representation in the covered population of an ethnic or cultural minority group necessary before a plan can invest in more intensive or extensive services specific to that group.

Personalismo:

- The ability to relate to consumers in such a way that consumers feel at home and among people who value them, are concerned about their problems, and are determined to assist them with finding solutions within their own reality conditions.

- A Latino cultural value which prescribes warmth, individual attention, other orientation and a certain level of informality and openness in human interactions.

Respeto

- A Latino cultural value which prescribes respect and deference in human interactions, but particularly in interactions with Elders, professionals, and people in positions of authority.

Translator

- Individual trained to translate information from one language to another often literally

Value - Added:

- Greater clinical or cost-effectiveness in a service when it is provided in a different on or modified manner (different technique vs more experienced practitioners, etc.)
- A person with skills to perform more than one task, i.e. professionally serve the English speaking consumer and a Spanish speaking consumer.

TABLE OF CONTENTS

I. GUIDING PRINCIPLES

I. GUIDING PRINCIPLES

1. Principle of Cultural Competence

- includes the attainment of knowledge, skills, and attitudes to enable practitioners and systems of care to provide care for diverse populations, i.e. to work within the person's reality conditions, in particular minority populations; acknowledges and incorporates variance in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness and incorporates those variables into assessment and treatment.

2. Principle of Consumer-Driven Systems of Care

- includes the promotion of consumer and family advocacy,
- includes the fitting of self-help concepts and models for minority cultures, and
- includes making the family an important part of the treatment efforts, when possible.

3. Principle of Community-Based Systems of Care

- includes a full continuum of care with a focus and heavy investment in basic, up-front, less restrictive services,
- includes community resources which are recognized and valued by Latino consumers, and
- includes using the home or the extended home as a base for system of care whenever possible.

4. Principle of Managed Care

- ✓ includes cost-effectiveness,
  - o individualized and tailored services,
- ✓ outcome-driven systems,
- ✓ the importance of added-value for ethnic/cultural groups as treatment partners, and
- ✓ comparability of benefits/added-value across ethnic/cultural groups,

- includes an emphasis on managing care, not costs/dollars; it assumes that costs/dollars will manage themselves if overall care is well managed, and
- includes recognition of Latino/group specific variables which have significant implications for individualized assessment and treatment.

5. Principle of Natural Support

- natural community support and culturally syntonic practices are viewed as an integral part of a system of care which contribute to desired outcomes in a managed care environment, and
- the use of traditional healing practice, i.e. naturalists, curanderos, espiritistas, when relevant or possible.

II. OVERALL SYSTEM STANDARDS

II A. CULTURAL COMPETENCE PLANNING

- The Cultural Competence Plan should designate an individual responsible at the top management level (*at what level? state, county, division?*) to be accountable for cultural competence planning. That individual should have demonstrated training and experience which renders him/her culturally competent.
- Governing and advisory bodies, as well as plan administration, must be demographically representative of those they serve.
- Cultural competence planning should be conducted by a team involving representation from top and middle management, front-line staff, consumers, families and community stakeholders.

The Cultural Competence Plan should include:

1. A criteria/process for describing (using criteria of cultural guidance principles) and understanding the communities served through Management Information System-based population profiling (age, gender, language, ethnicity, SES). (*Is this information in place anywhere?)*

2. A process for determining (using criteria of cultural guidance principles) unique regionally-based needs and ecological variables within the communities served.

3. Stipulation of staffing patterns/skills (including licensing, certification, credentialing, privileging) for all staff clerical through top management.

4. Identification (using criteria of cultural guidance principles) of service modalities and models appropriate to the communities served e.g., rural vs. non-rural, migrant workers, minority subcultures, population densities.

5. Identification of community resources, strategic alliances and other providers e.g., public health workers for coordination.

6. Identification of natural supports, e.g., family members, alternative healers, churches, civic clubs, community organizations.

7. Proactive collaboration/partnerships with Juvenile Probation, Education, Social Services, and Health agencies to follow consumers across systems.

8. Identification of key issues and approaches to address them to assure cultural competence at each level of care within the system e.g., inpatient, outpatient, residential, home-based.

9. Assurance that equal access will be provided to all services available through the Plan.

10. An incremental/ (increments in proportion to need and resources of Latino consumers) strategic approach to implement elements of cultural competency the overall organization or provider network.

11. Stipulation of rewards/incentives/sanctions, e.g., salary, promotion, bonuses, for cultural competence performance.

12. The use of formal cultural competence assessment tools for individuals and systems, adapted for minority cultural values and beliefs in developing, implementing and monitoring the Cultural Competence Plan.

13. Ongoing Plan maintenance and review (*by state and/or MH Division or county?*).

14. Specific outcomes relevant to served populations, including data on utilization patterns, levels of care, regional variation in utilization/services, consumer functioning, indicators of successful rehabilitation (decreased hospitalization, increased employment), consumer-

driven/consumer-specific goals, quality of life, consumer satisfaction, use of less restrictive interventions /modalities.

15. **Specific planning for implementation in the following areas**:

- Staff development, recruitment, retention, particularly as it pertains to the availability of culturally competent practitioners and administrators.
- Development of policies and procedures which promote and support culturally
- appropriate services
- Management practices, support, leadership.
- Staff supervision either directly or in consultation with Minority Mental Health Specialists.
- Training and support for governing and advisory board members.
- Needs assessment of the Latino population served to determine levels of need and equitable distribution of resources.
- Strategic planning re: political climate, timing of actions, being proactive vs reactive, being inclusive vs exclusive, and acknowledging all accomplishments.
- Culturally-informed eligibility criteria, benefit design, individualized assessment and treatment.
- Resource allocation, including clear definitions of resources, e.g., staff, budget, for use in implementation of Plan.

II B. GOVERNANCE

A governing board should be representative of the consumer population served and the community at large, including age and ethnicity. In this manner,

- The community served will have active involvement and decision making responsibility in RFP development and vendor selection. (Some consideration should be given to representation in direct proportion to the population's needs.)

- The Plan should include a formal grievance procedure with minority community and professional input, participation, and involvement. Consumers should be informed of this procedure in their own language and dialect at intake and at the time of any appeal i.e. confidentiality, privacy of services. Information about this should be publicized in Spanish and other languages.

- The Plan should appoint an ombudsperson from the community served. The ombudsperson should not have a conflict of interest that might interfere with the performance of his/her responsibilities. The ombudsperson should have independence from the plan, and there should be formalized procedures for resolving differences of opinion between the ombudsperson and the plan administration's governance. A Latino or minority ombudsperson should be involved in all appeals by Latino clients.

- The governing and contracting board should have final authority over all appeals and grievances.

- The Plan should maintain a record and report annually on all appeals, grievances, and law suits differentiated by specific provider and ethnicity of complainants and report these to the governing board on a regular basis. Trends in disproportionate access must be addressed by incorporating measurable, incremental corrective actions within reasonably accomplished dates.

- The Purchaser should determine, as part of the RFP, an equitable percentage of profit to be reinvested in minority community-based services and preventive programs on an ongoing basis and a disproportionate percentage when inequities to access exist.

- The Plan should address the needs of both sponsored and unsponsored Latino populations and should provide for unsponsored access in proportion to general industry practice.

- The Plan should develop interagency agreements or pool funding to coordinate its services with other agencies, e.g., public health, social services, corrections, youth services. [This should focus on practice rather than formal written agreements].

- Liability coverage for the Plan should be plan-wide rather than provider or practitioner specific so as to ensure a team approach and continuity of care.

- The Plan should define a process of practitioner and provider credentialing and privileging incorporating cultural competence standards which will determine participation in the plan and the use of intrusive, specialized or restrictive interventions and specific treatment modalities.

- Policies governing practitioner ethics and behavior should take into account and provide for differences relevant to the context of Latino cultural values, e.g., gift giving by consumers, interactions with consumers outside the service setting (such as accepting invitations to special family events), confidentiality, etc., governed by such values as "respeto" and "personalismo".

- Contract continuation and renewal should be contingent upon successful compliance with performance standards specifically defined for Latino and other undeserved populations.

- The Plan should make de-listing criteria for providers and practitioners open for review and accountable for differing service needs of diverse populations, including Latino populations.

- The Plan should report justifications for de-listed providers and practitioners, identifying them by ethnicity for public review to the governing board.

II C. BENEFIT DESIGN

- The Plan should not make arbitrary restrictions in benefit level. Cost-effectiveness should be accomplished through care management and utilization review mechanisms rather than arbitrary cut-offs and limitation of benefits.
- The Plan should ensure comparability of benefits across populations and age groups.
- Coverage should incorporate and integrate alternative treatment modalities, particularly alternative healers, in order to enhance the acceptability and cost-effectiveness of care.
- Coverage should incorporate services by a qualified Minority Mental Health Specialist and supervision by MMHS's for practitioners who do not qualify but are serving minorities.
- Coverage should incorporate the coordination of services across service agencies and systems impacting on the client in order to ensure seamless care.
- Coverage should provide for access to a full continuum of care, from most to least restrictive in ways which are comparable, though not identical, acknowledging that culturally competent practice provides for variance in individualized care.
- The Plan should provide information, education and written education materials to consumers and families regarding covered services and procedures for accessing and utilizing services in their primary language(s) and dialect(s). Such information should be made available through partnership with community organizations in addition to conventional means of dissemination.
- Eligibility criteria *(for service provision and/or receiving services?)* should be defined primarily by the assessment of behavior and functioning and secondarily by diagnosis, given the limitations of diagnostic systems in cross cultural applications.
- Eligibility determinations should be performed by culturally and linguistically competent staff. Utilization review and eligibility determinations must include minority mental health specialists.
- Written correspondence regarding eligibility should be in consumers' and families' primary language(s) and dialect(s).

- The plan should provide consumer choice of provider.
- The Plan should make provisions in the benefit design for unsponsored lives in the covered Latino population and in proportion to industry standards and practice e.g. 75% to 25% ratio.
- The Plan should make provisions in the benefit design for people who leave the plan, including service planning and a transition process to new plans.
- Benefits should include a subcapitation approach or other adequate risk-adjustment strategy specifically for consumers at-risk for serious persistent mental illness/emotional disturbance and/or with actual multiple, long-term service needs, in order to ensure adequate funding for more intensive services. [*Is this consistent with managed care benefits?*]

II D. QUALITY MONITORING AND IMPROVEMENT

- The Plan should have a regular quality monitoring and improvement program with defined indicators applicable to evaluating services to Latino and other minority populations (e.g., culturally competent interviews by bilingual and bicultural staff, peer reviews by Latino and Minority Mental Health Specialists, review of service patterns and drop-out rates, evaluation of service intervention strategies for effectiveness).

- The overall quality monitoring and improvement program should include sampling approaches which yield results representative of the covered Latino population.

- For plans with limited Latino workforces, Latino Mental Health Specialists external to the Plan should be brought in as consultants in the quality monitoring and improvement plan development until the workforce is no longer limited.

- The Plan should implement quality improvement teams focused on indicators related to culturally competent care, composed of a representative team of Latino and Minority Mental Health Specialists. [*what is the difference between this one and the one above? HB*]

- If irregularities or deficiencies in care are found in quality indicators in Latino and other minority populations, special quality studies should be undertaken to identify causes and address root causes/processes.

- The absence and/or significantly lower levels of complaints by Latino consumers and families should be interpreted as an inadequacy of the Plan (including the quality monitoring and improvement program) unless demonstrated to be otherwise. This would indicate that the Plan has not engendered sufficient trust from the Latino community to overcome tendencies to non-response engendered by "respeto" and hopelessness about positive results.

- Consumer satisfaction surveys should be translated into local languages and dialects, implemented by members of the community independent from the Plan, and available in various formats to facilitate the participation of lower SES and non-reading populations and to facilitate

validity of responses. Sampling should include outreach to plan drop-outs and facilitate, when possible, alternative services.

- The Plan should have periodic assessment of functional outcomes which are valid and applicable to Latino populations for consumers and families receiving services, as well as for the entire covered population.

- Quality and outcome monitoring data should be able to separate out data for Latino consumers and families by provider and should be reported on a regular basis to the governing and contracting authority, especially prior to contract renewal.

- Credentialing and privileging standards, specific to different disciplines, should include culturally and linguistically competent clinical skills, knowledge and attitudes relevant to the Latino population. These should include a continuing education process with specific Latino-oriented content as part of the overall re-credentialing and re-privileging process.

- Quality monitoring and improvement should include rewards and/or sanctions specifically for the incorporation of Latino and Minority Mental Health Specialists in the gatekeeping and treatment process.

- The Plan should incorporate sufficient numbers of Latino and Minority Mental Health Specialists to accomplish its quality goals and objectives.

- The Plan should incorporate sufficient Latinos who are clinically, linguistically and culturally able to provide services in direct proportion to the needs of the Latino community.

II E. DECISION SUPPORT AND MANAGEMENT INFORMATION SYSTEMS

- Consumer data should include accurate and desegregated coding for gender, ethnicity, SES, linguistic proficiency and sexual orientation (at the consumer's option).
- A unified clinical record should be maintained for each client across all levels and the entire system of care.
- The Plan should develop and maintain a database which can track Latino consumers across all levels of care, including the above-mentioned demographic elements.
- The Latino ethnicity category should be broad and inclusive, including a capacity to code all and multiple Latino subgroups and those of mixed race/ethnicity. The Latino category should be distinct and monitored separately even when consistent with US Census Bureau practice.
- The Plan should track diagnostic and assessment information, service utilization trends, drop outs and utilization patterns across modalities, as well as, behavioral and functional outcomes.
- Individual consumer data should be kept confidential with data sets coded in a de-identified manner.
- The Plan should track geographically-coded data to allow monitoring of differential service utilization and planning across various locales.
- Data findings should be used to continuously assess, improve and inform strategic planning for services to Latino and other consumers and families.
- The Plan should require the tracking and reporting of performance data, specific to Latino consumers and families, to the governing and contracting authority for purposes of accountability.
- Information tracked should be used for improvement of services to Latinos based on their needs, not only on the number of Latinos in the community, but the number in the community that need help.

II F. STAFF TRAINING AND DEVELOPMENT

- Staff training and development should be implemented at all levels, across disciplines and for management and support staff as well as for governing and advisory bodies.

- Specific continuing education requirements should be established for the development, maintenance and continuance of clinical competence as a Latino or other Minority Mental Health Specialist.

- Career ladders for the development and advancement of Latino and other minority staff should be developed, particularly to advance Latino and other minority staff to administrative and supervisory positions.

- The Plan's clinical workforce should include and make special effort to recruit and retain a representative percentage of Latino and other minority mental health professionals.

- The Plan should develop performance evaluations and promotion opportunities which remove the glass ceiling for Latino and other minority staff and managers and which reward cultural competence among all staff.

- Language fluency exams must be performed to determine the ability of clinicians to provide comprehensive clinical care services. Bilingual deferential pay to be contingent on passing the fluency exam.

- Differential pay rates should be developed and implemented for specialized skills in cultural and linguistic competence in general and for Latino and Minority Mental Health Specialists in particular.

- Incentives should be established to get current Latino and minority staff to use their linguistic, cultural, and clinical skills.

- The following areas of knowledge, skills and attitudes should be essential components of continuing education for cultural competence among all staff:
  - Training in the dynamics of monocultural ("traditional"), acculturating ("transitional"), bicultural and biracial consumers and families.
  - Training to understand culturally-based folk healing systems and traditions across different Latino subcultures and communities.
  - Training in specialized engagement and therapeutic alliance building techniques, as well as culturally acceptable and therapeutic boundary setting.
  - Training in interdisciplinary team interaction and functioning to promote effective care.
  - Specialized training for the treatment of Latino sexual minorities, particularly the stress of "triple stigma" (mental illness, ethnic and sexual minority status).
  - The use of language in the treatment process.
- Knowledge of:
  - Differences in symptom expression and symptomatic patterns in Latinos with mental illness/emotional disturbance.
  - Differences in thresholds of distress and help-seeking behaviors in Latino clients.
  - Differences in the attribution of mental illness (religious, supernatural, etc) and issues around stigma specific to Latino cultures.
  - Differences in the acceptability and effectiveness of different treatment modalities in Latino populations.
  - Culture-bound syndromes associated with Latino populations and subcultures.
  - Understanding of the historical factors which impact the mental health of minority populations, such as racism and immigration patterns.
  - Understanding and skills addressing cultural differences between different Latino subgroups, including differences related to history, traditions, values, belief systems, acculturation and immigration history, reasons for immigration, language fluency and differing dialects.
  - Understanding of the particular psychosocial stressors relevant for minority patients. These include war, trauma, migration/acculturation stress and socioeconomic status.

- Understanding of cultural differences with the minority groups.
- Understanding of the minority patient within a family life cycle and intergeneraltional conceptual framework in addition to a personal development framework, which includes the acculturation levels within the individual.
- Understanding of the difference between "culturally acceptable" behavior or psychopathological characteristics of different minority groups.
- Understanding of indigenous healing practices and the role of religion in the treatment of the minority clients.
- Understanding of a community mental health service continuum of care for minority clients.
- Understanding of the public administrative issues in developing, implementing and evaluating programs for minority populations.
- Understanding of the dynamics of language use in monolingual and bilingual clients.
- Knowledge of the limitations of clinicians if they are not bilingual and being creative to compensate for this.
- Understanding the process and the effects of the acculturation process on ethnic majority clients.
- Knowledge of the culture (history, traditions, values, family systems, artistic expressions) of ethnic minority clients.
- Knowledge of the impact of class and ethnicity on behavior, attitudes, and values.
- Knowledge of the helpseeking behaviors of ethnic minority clients.
- Knowledge of the role of language, speech patterns, and communication styles in ethnically distinct communities.
- Knowledge of the impact of social service policies on ethnic minority clients.
- Knowledge of the resources (agencies, persons, informal helping networks, research) that can be utilized on behalf of ethnic minority clients and communities.
- Recognition of the ways that professional values may conflict with or accommodate the needs of ethnic minority clients.

- Knowledge of power relationships within the community, agency, or institution and their impact on ethnic minority clients.

515 ◆ Skills to:

- Interview and assess minority clients and families based on psych/social/bio/cultural/ political/spiritual model
- Communicate and listen effectively across cultures.
- Diagnose minority clients with an understanding of cultural differences in
520 psychopathology. Ability to avoid under-diagnosis, misdiagnosis or over-diagnosis.
- Formulate culturally sensitive treatment plans that are appropriate for the client and the family's concept of mental illness.
- Create multidimensional treatment plans which include, culture, family and community.
- Utilize culturally appropriate community resources (i.e. church, self-help group, etc.)
525 • Provide psychotherapeutic and psychopharmacological interventions, with an understanding of the cultural differences in treatment expectations and biological response to medication.
- Knowing when to recommend culturally sensitive psychological assessment for minority clients. (Also to know when not to use tests which are biased towards minority clients).
530 • Conduct culturally sensitive community research.
- Provide psychoeducational interventions which empower families and communities.
- Use client's language to elicit the range and nuances of emotions, feelings, dynamic, etc.
- Know when and how to use interpreters and understand the limitations of these.
- Learn the particulars of the engaging protocols within specific cultures.
535 • Know when you don't know!
- Be humble and a student of your clients: cultural competence is a process not a product.
- Use techniques for learning the cultures of ethnic minority client groups.
- Ability to communicate accurate information on behalf of ethnic minority clients and their communities.
540 • Ability to openly discuss racial and ethnic differences and issues and to respond to culturally-based cues.

- Ability to assess the meaning ethnicity has for individual clients.
- Ability to differentiate between the symptoms of intrapsychic stress and stress arising from the social structure.
- Interviewing techniques reflective of the worker's understanding of the role of language in the client's culture.
- Ability to utilize the concepts of empowerment on behalf of ethnic minority clients and communities.
- Capability of using resources on behalf of ethnic minority clients and their communities.
- Ability to recognize and combat racism, racial stereotypes, and myths in individuals and in institutions.
- Ability to evaluate new techniques, research and knowledge as to their validity and applicability in working with ethnic minorities.

III. CLINICAL STANDARDS

III A. ACCESS

- Gatekeeping and service determinations to Latinos should be performed by culturally and linguistically competent clinicians.
- Comparable 24 hour and 1-800 access (with needed language capabilities) to programs and services should be provided for all covered populations meeting minimal representation criteria.
- More restrictive placements for minority consumers should be made only with involvement of culturally competent or Minority Mental Health Specialists prior to placement, particularly prior to initiation of involuntary treatment and placement in locked settings.
- Access criteria for different levels of care should be based primarily upon behavior and functioning and secondarily upon diagnosis. (*This is a good point, but will need further elaboration to get acceptance*)
- Access should be facilitated through various outreach approaches, including strategic co-location with Latino community agencies and social service agencies, neighborhood locales accessible to public transit, and in-home / in-community / mobile assessments. A single point of entry will not be acceptable and/or effective. (*Keep in mind that this is not a way to pay an agency to do the work of the vender-or avoidance of the job to be done*)
- Legal documentation should not be a requirement for service and should not serve as a barrier to service access.
- Specific procedures should be developed to ensure comparability of access across populations.
- Access to services should not be individually-oriented only, but also family-oriented in the context of Latino and other minority cultural values.
- Confidentiality requirements should be adapted to incorporate cultural values, particularly the inclusion of families in care access decisions, so as not to serve as a barrier to care.
- Access to interpreter services should be available at the point of entry or access and assessment at no additional expense to the consumer or family, given that Latino and other groups for which English is not their primary language, often use the primary language when in crisis and

given the importance of non-verbal communication. Interpreter should be used only as the last resort. Developing a workforce with bilingual skills should be the first priority to manage care and cost.

- Interpretive services should not be a substitute for Latino staff, competent and able to use the language and the cultural knowledge in their clinical work.

- The Plan should institute regular reviews of policies and procedures to assess for discriminatory effects on access to services.

III B. TRIAGE AND ASSESSMENT

- Latino Mental Health Specialists should be involved in triage and assessment processes, especially at the time of care determination and prior to more restrictive placements, especially involuntary placement and treatment.

- All consumers should receive a comprehensive assessment which includes a multi-dimensional focus, a functional assessment, health, psychiatrist and social and family supports to an addition to evaluation of cultural and stressors of socioeconomic factors affecting their presenting problem.

- Assessments should include evaluation of individual, family and community strengths, assets and resources.

- Cultural and ethnic factors that might contribute to misdiagnosis should be incorporated within the assessment (e.g., linguistic barriers, differences in symptom expression, culture-bound syndromes, etc).

- Culture issues in the assessment process relating to age, gender, sexual orientation and relational roles should be addressed in the assessment, e.g., gender of clinician vs gender of consumer, such as a younger man interviewing an older woman and not being told about a serious gynecological problems, because of her discomfort with a younger man as clinician, or inquiring about parental behavior through children who because of family loyalty may not openly share this kind of information.

- The assessment should contain a cultural component which identifies the beliefs and practices of the culture which the client adheres to, culturally prescribed family organization and relational roles, history of immigration and assimilation/acculturation, impact of ethnically related stressors such as poverty and discrimination, beliefs around health-mental health, attribution of their condition (spiritual, supernatural, etc) and previous attempts at help-seeking.

- The assessment should be family-oriented, incorporating key members of the nuclear and extended family, especially family decision makers and power brokers.

- Clinical rating scales utilized in assessments should be culturally appropriate and validated for Latino populations. All assessment tools (tests-psychosocial or psychological) need to be validated by the testing of similar populations or its reliability could be questioned.

- Treatment procedures should be developed and utilized, including ethnographic techniques and culturally appropriate informants (e.g., alternative healers).

III C. CARE PLANNING

- Consumers and family members should be equal participants in care planning. Care plans should involve culturally indicated family leaders and decision makers. Informed consent should be explained in detail.

- Care plans should be consistent with the conceptual framework and community environment of consumers and family members (*Within the patient's own reality conditions is an old, sacred principle in psychotherapy)*

- Care plans should address culturally-defined needs (e.g., religious / spiritual, level of acculturation, use of alternatives healers / therapies, interdependence among family members, use of language familiar to the consumer and family, nutritional practices, subcultural differences, locus of control beliefs) and socioeconomic needs, relevant to the client's condition and stressors.

- Care plans should incorporate consumer-driven goals and objectives that are functionally defined and oriented toward rehabilitative outcomes.

- Care plans should include consumer and family education about problems/conditions being treated and treatment modalities, particularly addressing cultural beliefs and attitudes about health and mental health, as well as education about preventive approaches, thus empowering families through education and information for maintaining their own mental health.

- Care planning should be supervised directly or in consultation with a Latino Mental Health Specialist.

- Care plans should address and coordinate the mental health needs of the entire family, including coordination among multiple providers with a single point of clinical accountability for the entire family.

- Care plans should incorporate the use of natural support systems, community organizations and interagency resources.

- Care plans for Latino consumers and families should include involvement in Latino-oriented self-help organizations, giving consideration to the degree of acculturation and the cultural identification of the consumer. First and second generation would react differently to this issue than third and fourth generations of Latinos.

- Care plans should address coordination of mental and physical health according to the health beliefs and practices of the individual consumer and family for both integrated and carved-out plans.

- Care plans should include provisions for the inclusion of alternative healers and therapy as available services.

III D. TREATMENT SERVICES

- Treatment should be performed by culturally competent, clinically qualified Latino mental health professionals. The absence of sufficient Latino workforce, unqualified staff should receive supervision from Latino Mental Health Specialists.

- Treatment selection and implementation for Latino consumers and families should be supervised directly or in consultation with a Latino Mental Health Specialist or should be part of a system of care that promotes and nurtures the Latino staff's growth in clinical and cultural effectiveness.

- .The Plan should include, contract with, and utilize community-based Latino and other minority service providers in its network; seen that such services can deliver services by competent and qualified Latino staff.

- The Plan should include a full array of available treatment modalities, particularly modalities which are culturally acceptable and effective with Latino populations e.g., family therapy, specialized group therapy, behavioral approaches, use of alternate healers and outreach

- Medical and mental health services for Latino consumers and families should be coordinated with a focus on the most prevalent health needs in the Latino community, e.g., hypertension, diabetes, substance abuse, cancer.

- Psychotherapeutic modalities should be conducted within a context of Latino cultural values (e.g., proactive treatment, family-oriented approaches) and should address psychological issues specific to Latino communities (e.g., acculturation, intergenerational and gender role conflicts and transitions).

- The Plan should include mental health promotion of early intervention and prevention strategies, including consumer and family education, community education with an emphasis on destigmatization and early treatment utilization.

- The Plan should recognize, legitimize, facilitate and compensate the utilization of alternative healers and therapies.

- Psychopharmacological interventions should be conducted by psychiatrists trained in culturally and ethnically based biological differences, differential medication response and culturally competent approaches to treatment consent and family education.

- The principle of least restrictive level of care should govern treatment and placement decisions with family placement preferable unless otherwise indicated. Level of care decisions should be governed by protocols to ensure timely and expeditious decision making and should be carried out, under the supervision of Latino Mental Health Specialist.

- The Plan should provide for Latino and other minority centered, treatment based research.

- The Plan should develop specialized approaches to maintain continuity of care and prevent recidivism to more restrictive and expensive services, e.g., medication compliance, treatment drop-out, lack of regular preventive care, differential hospital rates.

III E. CASE MANAGEMENT

- Case managers should be central to the operation of the interdisciplinary treatment team with equal status to other team members.
- Case managers should have training in cultural competence as part of their privileging and credentialing standards within the Plan.
- Case managers should preferably be from the local community and knowledgeable about local resources and natural support for local minority communities, including Latino communities.
- Case managers for Latino consumers and families should be supervised directly or in consultation with a Latino Mental Health Specialist.
- Case managers should involve family members in case management activities and decisions.
- Case managers should have access to ongoing continuing education and opportunities for advancement.
- Case management should be continuous and case managers should act as a single point of contact across all levels of the system of care.
- Case managers should have access to flexible funds for the provision of wrap-around services.
- Practice privileges should be afforded to case managers across the entire system of care, including more restrictive settings such as inpatient facilities.
- Case managers should have special skills in advocacy, access of community-based services and systems, and interagency coordination.
- Case managers should have a career ladder that promotes growth, knowledge, skill development and rewards them accordingly.

II F. LINGUISTIC SUPPORT

- Linguistic support should be provided at the option of consumers and families at no additional cost.
- Interpretation services should include both verbal and non-verbal communication in the context of the individual consumer's and family's culture, preferably by an individual from their own geographic and subcultural group who is conversant in the local dialect.
- Interpreters and translators should be utilized only in the absence of culturally, linguistically competent Latino mental health staff and/or specialists, who should supervise assessment and treatment.
- The use of a certified interpreter should not be treated as a substitute for treatment supervision by a Latino Mental Health Specialist.
- A threshold for the mandated availability of linguistic interpretation and translation should be established based upon population size, e.g., 2% or 500 people in a given.
- The use of family members as interpreters (especially children) should be strictly prohibited and the use of tertiary telephonic interpreters, e.g., AT&T telephone interpretation should be discouraged. In areas where there are limited linguistic support resources, qualified telephonic interpreters with training in mental health may be utilized as long as they receive access to immediate backup from qualified staff.
- State and court certification standards, in addition to mental health, cultural competency and confidentiality standards, should be used to certify interpreters in the system.
- All pertinent consumer and family materials and forms, especially informed consent and statements of rights, should be translated for all linguistic groups. Materials should be pre-published for groups which meet the threshold requirements.
- Bilingual skills for all linguistic groups meeting the threshold requirement should be treated as value-adding for clinical staff and should be compensated equitably as such.

- Training should be provided to monolingual clinicians in the use of interpreters, so they can also provide more effective, relevant, and culturally competent services in the absence of a Latino provider.

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The Human Impact of Managed Care in Child Welfare

As managed care is implemented in child welfare, many questions remain about how this important change will impact on the children and families served by the system. Will a managed care or privatized child welfare system provide adequate services to vulnerable children and families? Will the child welfare system retain the ability to fulfill its legal and ethical mandate to protect children? Can managed care succeed with a population that has not chosen, but is instead required, to participate in services? Most importantly, what will be the shape, direction, and values of a child welfare system that is driven by managed care concepts or run primarily by private enterprise?

No one can now answer these pressing questions with certainty. As the articles in this issue of Protecting Children make clear, it is exceedingly important that the child welfare community take the lead in shaping the future of a privatized or managed care child welfare system. Without the insistence of child welfare advocates that the interests of children and families take primacy, it is apparent that the system will be shaped instead by cost and claims processing considerations.

The goal of child welfare professionals must be to keep the focus on values — specifically on the value of child protection. Although there are promising dimensions to a managed care environment for child welfare, for example, an opportunity to support more prevention and early intervention activities, the wholesale importation of managed care concepts from the health care arena, such as limited "treatment" and selected provider groupings, must be carefully assessed for their impact on children and families. If these paradigms are inappropriate in child welfare, they must be reshaped so that they will adequately protect children.

Indeed, limiting treatment for serious family issues leading to abuse or neglect will, in the short run, leave children unprotected. In the long run, it will result in even greater costs, as the children who survive face escalating behavioral problems, with serious individual and community consequences. Similarly, limited provider groups that do not include smaller community-based service agencies will have lost the opportunity to reach child welfare clients on their own terms and on their own turf.

Although child welfare providers are aware of these issues, many may feel compelled simply to learn the managed care system and join it. This approach is dangerous. It neglects the current challenge to shape this opportunity for consensus building by embracing the most effective intervention strategies for at-risk families, and developing protocols which maintain protection of children at the very core. Most managed care organizations are inexperienced in the child welfare field and need the guidance of child welfare professionals in shaping their own direction. With every contract for services that is entered into and every network that is built, the child welfare community now has the chance to insist that privatization of services and managed care include specific procedural safeguards and principles that will make the system values-driven. If state agencies and private child welfare providers all keep this goal at the forefront, the development of managed care will be a more collaborative process, and the system and those whom it serves will be the better for it.

– Karen J. Farestad, Ph.D.
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Angelina Fyl

BACW
BLACK ADMINISTRATORS
IN CHILD WELFARE, INC.

MANAGED CARE

DRAFT- Working Document Prepared by
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Managed Care

Managed care for health services, while not new, is fast becoming the primary method for the delivery of all health care. The salient components of a managed care system are: strict utilization review, preauthorization of certain services, and negotiated rates for defined levels of service. Managed care also espouses a health delivery system that is based on the principle of preventive care and coordination of the consumer's total health program.

Although the concept of managed care is good, the process by which it is delivered is problematic. The primary source of these problems are the rules by which the managed care health delivery system, Health Maintenance Organizations (HMO), operate. HMOs are a hybrid of a for profit business entity and a health service delivery system. In order for HMOs to deliver service at the most efficient level, a selected group of medical providers are either contracted with for a defined salary and/or paid a predetermined per patient fee(capitated rate) for all medical services. All persons enrolled in a managed care program must adapt to some restrictions: choice of physicians, access to specialist services and length and type of medical services.

Issues:
Economics

African Americans: Currently the African American medical and business community have been slow to accept the inevitability of the coming of managed care and its economical impact. African American physicians failing to either become participating physicians with some managed care system or form medical networks among themselves will ultimately find themselves as physicians without any one to heal. The greater proportion of the patient load of the average African American physician has medical insurance from either a group medical plan provided by their employer or by Medicaid, entities that are the leaders in the move towards managed health care. Equally absent in the groups forming managed care systems is the African American business community. In spite of the fact that, for now, HMOs are among the high profit business ventures.

Human Services System: The human services provider, particularly those providing services to the at-risk client population, will have to make some significant adjustments. The degree of control over services, inclusive of type, length, and provider, and the questionable level of payment for services rendered may cause some agencies to fold. This fate is even more likely for agencies with limited resources that serve children and families with high social and medical risk factors.

Services

African Americans: For the African American patient there are some major concerns as to the quality of service they will receive and its degree of accessibility. These two concerns are particularly troublesome for those in the low income category. Because most HMO physicians receive fiscal incentives for controlling the rate of specialist referrals, there is the possiblity that their patients, covered by more restrictive insurance programs, will be least likely to receive specialized services. Most of these types of insurers are among those providing coverage for indigent individuals. In addition to the poorer African American patient having a greater probability of not receiving the more complete level and type of medical services, they also will find fewer medical services in their communities. As the individual community doctor is squeezed out of the medical network and HMOs move more to centralized medical centers or as the community based enrolled HMO physicians move out of certain urban area communities, medical services will be further removed from the residents residing in the poorer neighborhoods.

Human Services System: While a major impact of managed care falls on the individual consumer, it also has some significant impact for the human services provider, particularly those involved in the provision of mental health, drug and alcohol, child welfare, disabilities and the indigent elderly services. Many of the services provided to these populations are provided under Title XIX(medicaid). The type and length of service is driven currently more by assessments made by members of the human services profession. However, this is fast changing and soon most treatment services will be defined and approved more by an uninvolved HMO representative. This requires service agencies to learn the tools and process for effectively presenting their client's service needs which would allow a more defensible appeal process when HMOs deny services. Even with the acquisition of this body of knowledge, social agencies will have to learn a new way of doing business. Duration of services will be much more limited, the level of staff approved for the provision of certain services will change and what will be allowable reimbursable services and rates of reimbursement will be greatly altered. In addition, the human service provider must move more towards a medical model with less emphasis placed on the social elements. This transition will be even more exacting for programs such as wrap around services and services to children in their own home.

Because a great percentage of the population receiving services from the public agencies is African American, the above changes will have a significant impact upon this community. It, therefore, behooves the African American professionals involved in the delivery of these services to become more visible participants on the issue of managed care. While there may be many ways in which this involvement can occur, the arena of **Education** and **Advocacy** are most critical.

Education

African Americans: It is critical that African American health and human services community begin to form groups who can start educating the African American consumer about the economic and service issues of managed care. There needs to be education about how to select a provider, how the process truly works, what are some key questions to ask any HMO entity actively soliciting their membership, and to be clear on what, if any, service limitations may exist. There is also the need to find some method for educating the African American professional about the economic opportunities as well as difficulties inherent in the managed care system.

Human Services Systems: As to the human services provider, there is clearly a need for this body to begin to form training groups for developing the knowledge and expertise in the development of treatment plans and medical services request that are explicit in: diagnosis, service objectives, outcomes and service time frames. Attention must be given to staff qualifications and the justification of specific personnel for all service functions.

Advocacy/Activism

The African American community and particularly the human services providers must become involved in knowing what are the plans for managed care in their community. A primary area of focus must be their legislative body, because it is in this body where many of the rules of the game are established. This is particularly true for systems involved with the medical assistance program. While there is little to no possibility of stopping the move to managed care, there is the ability to ensure that certain safe guards are put in place. Specifically, there can be the requirement that all managed care systems have medical providers that reflect the racial composition of the area and population served. Standards of availability and accessibility can be required, as well as establishing of clear and fair appeal procedures. There is also the ability to have certain in-patient services, particularly child welfare services, excluded from the set capitation payment process. This exception probably will have, however, more restrictions placed upon it as the managed care system matures and government moves for further cost controls and savings.

Options

Services Consortiums

In the managed care environment it will be increasingly more difficult for the lone human services agency to survive. Moreover, the fact that the authorization for psycho/social services will be more in the hands of the managed care organization, places the quality and quantity of services in jeopardy. As a means of minimizing the impact, there is the need for diverse human service agencies to come together and form service consortiums. Such a move has the ability to provide clients with a comprehensive continuum of care.

and allow the agencies to be more cost efficient by defining a set rate for services. Greater efficiencies can be realized if there is a coordinated continuum of care and a sharing and consideration of certain administrative functions.

Managed care provider

A daring but creative approach is to join in the managed care environment by becoming a primary provider for a managed care system. This option is especially viable for our service agencies that provide behavioral health services. As a provider, the agency becomes an approved service group and receives a monthly capitation rate for all enrolled members or some other set fiscal arrangement. The capitation payment is attached to each enrolled user and is not related to level of usage but by mere enrollment of the consumer. **The advantages to the provider option are**: guarantee of customers, control over quality and quantity of services, and a guaranteed level of funding. **This set level of funding also has the potential for being a high risk factor. Should a provider have a preponderance of customers with illnesses that require frequent and protracted treatment, then there is the potential for the cost to exceed the monthly capitation rate.** There are, however, means by which a provider could design its methods of service delivery and administrative oversight to minimize these risk. In fact in some ways it may move agencies to be willing to move away from the traditional one on one service modality or the more conservative treatment methods, to increasing their willingness to take risk, experiment and be more creative. It will also move agencies to begin to evaluate cost factors and create more effective oversight and quality assurance within their programs.

In an analysis of the issue associate with managed care and its relationship to the human services community, it is clear that the group must become more proactive in their involvement.

Whether a National Organization such as BACW, CWLA or FSA becomes an HMO, or another route is taken, it is clear that agencies must begin to map out strategies for ensuring their survival in this new environment.

Managed Care and Child Welfare

Will it work?

By Tracey Feild

There is an undeniable surge of support for managed care as a quick fix for a range of public human service problems. Child welfare is one area of human services that has had its share of problems—problems that seem to overwhelm the system and that help put child welfare in a position to become "managed." Child welfare is moving inevitably toward managed care for several reasons.

The child welfare system is seen as broken and in need of fixing. The myriad of class-action lawsuits and service integration and system reform initiatives in the past 10 years attest to the "broken" state of child welfare. Lawsuits in both child welfare and juvenile corrections assert a range of problems throughout the system, focusing considerable attention on the quality of care and the length of stay for children placed in out-of-home care. Remarkably, although most of these lawsuits have resulted in significantly increased resources for child welfare, most of the affected systems are still plagued with problems—in some instances, problems that have plaintiffs' attorneys threatening contempt actions.

Service integration and reforms have been developed across systems within local jurisdictions and within entire states, or they have focused on single systems while attempting to address the continuum of care. Some have been supported financially and technically with generous foundation grants. But although a few of these initiatives have produced interesting and promising service delivery alternatives, none have resulted in consensus that the child welfare system is "fixed" or can be fixed through any particular approach.

Changes in federal funding will force more discipline on the system. Inevitably, federal funding for child welfare will change in the next couple of years, and states will undertake a greater share of the costs. And although the federal government may reduce federal requirements, most states have codified federal child welfare statutes and will have difficulty removing these requirements, even if they should want to do so. As states begin to adjust to federal funding changes, child welfare will not be the only area affected. States will also feel the impact on income maintenance and Medicaid. Any efforts to offset federal funding through state or local revenues undoubtedly will affect funding available for child welfare.

As funding changes, child welfare managers will have to develop ways of rationing services while still protecting children. In the past, family preservation programs have been cut in favor of foster and residential care; but the services being cut are relatively inexpensive, so there are few savings. In lieu of cutting family preservation programs, taking percentage cuts across all providers, or cutting investigative or foster care staff, good managers will attempt to find areas that can be cut without seriously impairing the program. Overuse of residential care is an obvious target in most jurisdictions. One of the best ways to control overuse is through managed care.

Managed care is becoming widespread for Medicaid clients. Most states are developing primary-care managed-care systems for Medicaid clients, many of these managed-care systems include behavioral health care as well. Managed care is generally perceived as successful in curtailing the rate of growth in Medicaid expenditures. In many states, managed care has been implemented for child welfare clients through other service systems, mostly primary care or behavioral health services.

In a managed-care system, the child welfare worker is responsible for making sure that clients get what they need but has little power in the decision-making process. No longer can the worker simply take the client to the appropriate provider and authorize treatment. The worker serves primarily as an advocate for services rather than as the authorizing agent.

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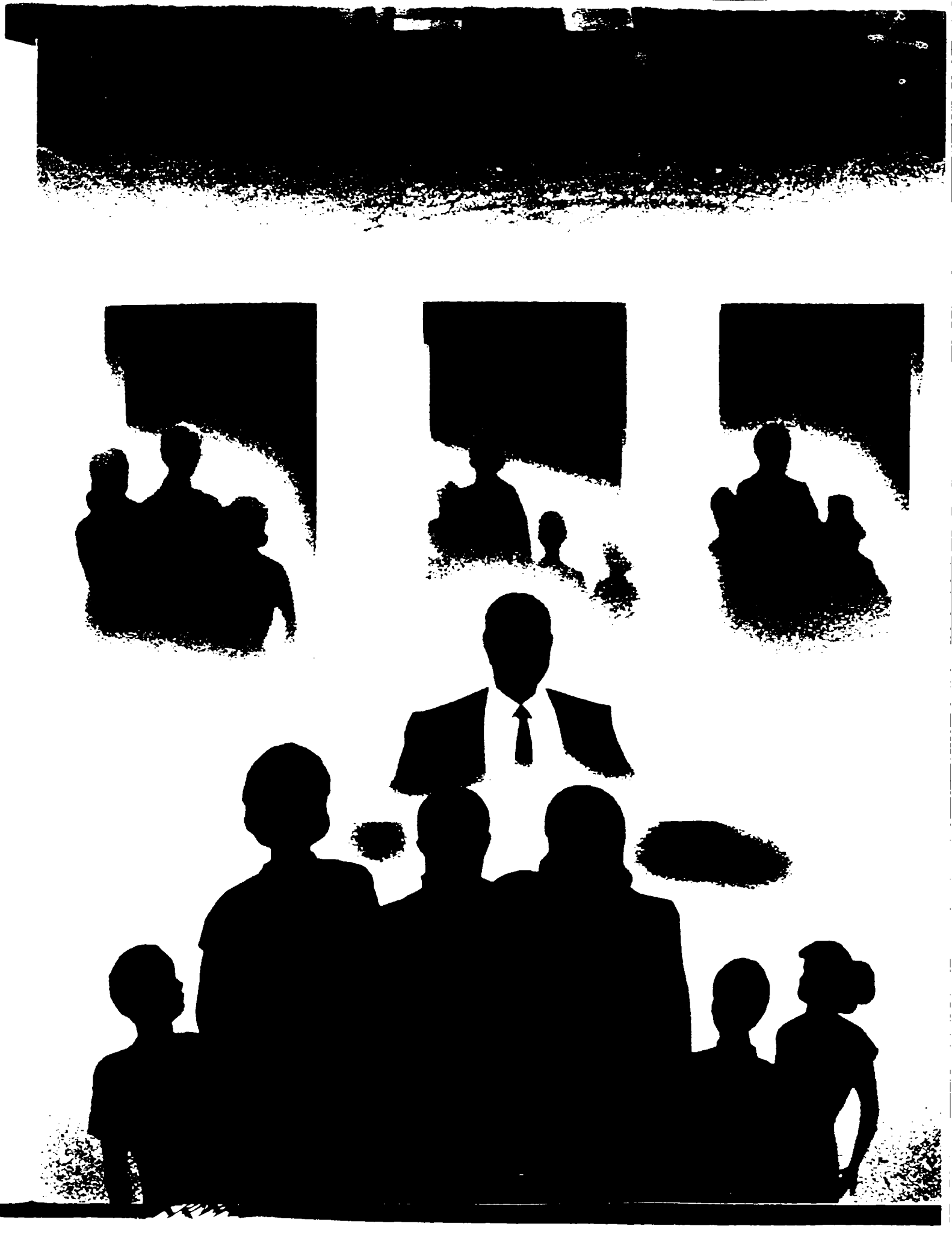

One solution to the dilemma of control over service authorization is for the child welfare system itself to pay for the services; then no approval from managed-care gatekeepers would be required. This alternative, however, requires that the child welfare system forgo Medicaid reimbursement on the services purchased. Although the importance of this decision may change under a Medicaid block grant, it is a costly decision under the current entitlement program.

Where managed care under Medicaid is being implemented on a large scale, there is tremendous commitment to its success. Good news about its success fills press releases, thus ensuring continued and growing support. Child welfare is likely to be pulled into managed care as legislators and governors ask: If managed care works in Medicaid, why can't it work in child welfare?

Managed care is seen as the solution to out-of-control human service budgets. While managed care has become popular, if not mandatory, under Medicaid, it is becoming the solution of choice for controlling human service budgets. After Medicaid, child welfare is considered one of the most out-of-control item in many state human service budgets. After some gains in controlling the foster care population in the mid-1980s—as a result of the Adoption Assistance and Child Welfare Act of 1980—the costs of out-of-home care for children and youth with special needs have soared.[3]

Private child welfare providers are developing managed-care systems for other payers. Although children's mental health, child welfare, and juvenile corrections often are located in separate state or local public agencies, the private agencies serving children, youth, and families often serve all three groups of clients and are paid by all three systems. Many private child welfare providers already have begun planning for or implementing managed care through the mental health system. Since it makes sense for them to design a system of care that serves all clientele, many private providers are beginning to approach child welfare agencies with proposals for managed care. Through provider associations and professional organizations, information, technical assistance, and actual experience on how to undertake managed care are becoming increasingly available. There will be tremendous pressure from private providers over the next several years to privatize segments of the child welfare system.

How Does Child Welfare Differ from Other Systems with Managed Care?

Child welfare differs in several fundamental ways from other fields that have implemented managed care. Because of this, managed-care models developed for child welfare will have to be different as well.

The nature of child welfare. The primary and most significant difference is the involuntary nature of child welfare. Clients do not usually come to the child welfare system looking for help, unlike the mental health and primary health care systems. In those systems, people looking for help want it badly enough to advocate on their own behalf. If they are sick, they go to the doctor, they take prescribed medicine, if they do not get well, they go back to the doctor. Patients' interests in their own well-being motivate them to advocate on their own behalf.

Child welfare differs in several fundamental ways from other fields that have implemented managed care.

Child welfare clients do not usually come to the system looking for help. Once in the system, they often are resistant, if not hostile, to the help that is offered. Further, they do not have the opportunity to determine when they are "well" and no longer in need of system interventions. In fact, child welfare interventions may be imposed on unwilling families by the courts or police.

The goals of child welfare. Another significant difference between the child welfare system and other systems that have implemented managed care is the overriding goals of protection and permanency and how these goals affect the treatment process. Child welfare cases are opened because the system assesses a threat to the child's well-being. The factors that contribute to this assessment include family, household, and community considerations. Unlike other systems, the goal of the intervention involves more than stabilization or improvement in the child's individual level of functioning. The child welfare system concerns itself with the entire family environment in which the child will grow and develop. The impact of this mandate is that the family is critical to the intervention provided to the child. Further, the interventions provided to the parents may be critical to, or may be the only intervention provided on behalf of, the child. In some instances, the intervention provided to the child cannot be undertaken apart from the intervention provided to the parent.

The goal of permanency, which is fundamental to the child welfare system, results in case decisions that might be foreign to the mental health system. The child welfare worker must look at the long-range relationship between the parent and child and decide how best to maintain or strengthen that relationship until the age of majority. For example, a child welfare worker will place value on leaving the child in the home for treatment to ensure parental involvement and "connectedness" with the child, versus removing the child to an alternative setting—even when that alternative may be an easier treatment setting for the child—if the worker believes

that the parents' involvement would otherwise wane. Such a decision results from the overriding goal of permanency for the child.

Conversely, the child may have to be removed from his or her home if the risk of harm is deemed to be too high. Further, the child may not return home until the risk factors within the home are reduced. Under these circumstances, the child's primary needs may be interventions provided to the parents. Recalcitrant, hostile, or uncooperative parents may prolong the intervention required for a seemingly simple problem.

When parents are not available to the child, the goal of the system is to find parents or an otherwise suitable and permanent living arrangement that will offer appropriate interventions, supervision, and guidance until the child reaches adulthood. This responsibility is far broader than any role defined in other systems where managed care has been implemented. Although both primary health care and mental health may require involvement by parents or other family members in the treatment process, this involvement is usually adjunct to the intervention provided to the child.

The state's role. Another major difference between the child welfare system and others that have implemented managed care is the impact of the state's role as parent, which demands consideration of ethical issues. In both the primary health and mental health public systems, professionals maintain the right to refuse an expensive treatment if the client is a poor candidate for success. Frail, ill, or aged clients may not be given or prioritized for organ transplants; resistant clients will not be given substance abuse treatment.

Each system has procedures for assessing a client's likelihood of successful completion of treatment, thus allowing the system to undertake a cost-benefit analysis of providing the treatment to that client: Is the client likely to get better as a result of the intervention, thus making the expenditure of scarce resources on that client worthwhile? If the answer is no, the intervention may be denied or placed at such a low priority that it never will be provided. This procedure is a kind of triage and is otherwise known as the rationing of scarce resources. This rationing process occurs within all human services, including primary health care. Rationing can become controversial, however, when it results in withholding treatment from clients in need.

The mental health system always has viewed itself as a voluntary service system—that is, clients must ask for services. Because of scarce resources, the mental health system always has been able to prioritize services.[1] Under managed mental health, clinical protocols are the guidelines used to determine who qualifies for the various types of services based on symptoms. These protocols may include criteria that exclude clients in need as well. For example, a child's symptoms could meet all of the clinical criteria for acceptance into the service but fail to meet other related mandatory criteria, which would result in the child being rejected for that service. Examples of other related criteria commonly used in behavioral health managed care include:

Rationing can become controversial when it results in withholding treatment from clients in need.

- family members or a guardian will commit to necessary evaluations and treatments as a condition of admission and continuing stay,
- the discharge residence is known at the time of admission,
- the client is amenable to treatment and accepts the need for treatment, and
- the child's behavior will fit within the treatment milieu.

In the child welfare system, the concept of custody means that the state is acting as the parent on either a temporary or a permanent basis. The system is swamped with adolescents whose emotional and behavioral problems are severe and for whom the likelihood of successful "recovery," however defined through costly residential treatment is either unknown or low. Part of the child's poor prognosis may be due to the unwillingness of family members to participate in the treatment process, the failure of the child to accept the need for treatment, the child's behavior, or the parent's refusal to care for the child after treatment. Some of these problems also may be caused by the child's long-term involvement in the child welfare system.

Although the mental health system may refuse to treat these youth based on a set of mandatory conditions, it would be unethical in the child welfare system to refuse treatment to a child because of doubt that the treatment would be effective. The state as parent must seek and pay for treatment for a child in need, regardless of that child's potential for recovery. There can be no rationing of resources that excludes a child because he or she is "too sick" or does not have the family characteristics of children who benefit from treatment. The child welfare field does not accept the premise that some children may be beyond help.

Control over conditions and interventions. A final difference between child welfare and other systems that have implemented managed care is the degree of control over conditions and interventions. Child welfare problems are rooted in social problems—poverty, unemployment, poor education, adolescent pregnancy, drugs, and neighborhood violence. The conditions that result in

symptoms cannot be eliminated and appropriate interventions cannot be easily determined or achieved.

Nor does the solution to a child welfare problem always lie within the expertise of the child welfare system itself, unlike in medicine or mental health. In medicine, a problem may require a range of medical specialists to resolve; in mental health, a problem may require a range of mental health professionals. A child welfare problem, on the other hand, may require child welfare expertise, medical specialists, mental health specialists, and a range of other professionals, including educators and social service workers from housing experts to homemakers. The ability or willingness of the needed range of professionals to understand and treat their specialties within the context of a broader set of problems and child welfare goals often is limited, as each specialist prioritizes his or her own professional goals. Moreover, the child welfare worker often must deal with a juvenile judge whose assessment of the problems and needed interventions may be very different and who may order specific interventions regardless of diagnostic evidence presented by the worker.

Can Managed Care Benefit Child Welfare?

The nature of the child welfare system complicates and changes how managed care must be conceptualized and designed to meet the needs of the client population. Child welfare managed care should not simply follow the path of managed care in primary or behavioral health care. Certainly there will be pressure merely to adapt existing managed-care systems without concern for the unique elements of child welfare. This approach, however, is not likely to serve the best interests of children and families or the child welfare system itself.

Understanding the nuances of the child welfare system will be paramount to undertaking this design effort. Managed-care companies hoping to expand into child welfare will not be able to rely solely on their primary and behavioral health experience in the development process.

The field of child welfare requires an entirely new conceptualization of managed care, including a clear delineation of goals. Policymakers may regard managed care as a means to harness spiraling costs, but managed care can have different, more programmatically positive goals within the context of child welfare. Designing managed care for child welfare should begin with identifying weaknesses in the current system that can be addressed through managed care.

Responsibility. In the current system, the major players—private service providers—do not have and therefore do not take responsibility for how the system operates. In most states, private child-caring agencies provide a substantial portion of the care and services to families involved in the child welfare system. Most of these are voluntary agencies that raise some of the funds

Child welfare managed care should not simply follow the path of managed care in primary or behavioral health care.

they use to provide care to public child welfare [illegible]. These providers are essential to the system. Yet [illegible] states, the private sector is viewed not as a partner [illegible] service delivery process, but as a resource only. [illegible] port of the current system, there are so few players [illegible] system over which the child welfare worker has [illegible] thority—the schools, the courts, and medical and [illegible] tal health professionals, for example—that [illegible] understand a worker's reluctance to take on a [illegible] partner.

Nevertheless, when tragedy occurs in the child welfare system, as it occasionally and inevitably does, the system stands alone and often is charged with hiding behind confidentiality to cover incompetence. In fact, in several child welfare class-action lawsuits throughout the country, private child-caring agencies have provided some of the most damaging testimony against the public system. Justified or not, in many areas of the country there is little confidence in the public system. Partnering with the private sector in a reasonable way could serve to build or restore confidence in the public system by separating direct service from oversight. In this way, responsibility for the system's actions could be shared.

Fiscal incentives. The current system has financial incentives to keep children in placement rather than return them home as quickly as possible. Private residential child-caring agencies traditionally are paid per diem rates for each child in care. Regardless of how the rates are determined, there is often little incentive built into the rate structure to serve the most difficult children. If a difficult child requires more care than the average child within that program, it will cost the provider more to serve that child. And if a child is relatively easy to serve within a rate category, the provider has an incentive to keep the child in care—the bed is filled, and the costs are low relative to what they might be with a more difficult child. If the bed is empty, there is no reimbursement. Reducing the level of service provided to any child because his or her level of functioning improves means a reduction in the payment.

All of these factors serve as incentives to keep children in high levels of care. Added to these perverse financial incentives is the tendency for public agency workers to

focus on emergency situations, thus ignoring stable placements. The result is a system that is likely to have more children in out-of-home care than necessary, for longer periods of time than necessary.

Diagnostic capability. Child welfare diagnostic skills are weak, and there is little ability to empirically link symptoms, diagnoses, interventions, and outcomes. In the primary health care system, and, to a lesser extent, in the mental health system, there is at least general agreement regarding symptoms, diagnoses, treatments, and expected outcomes. In child welfare, the relationships among symptoms, diagnoses—used in the general sense, not in reference to specific mental health or medical diagnostic codes; interventions; and outcomes are murky at best. The intervention needed to "cure" a child welfare problem is not always clear. The system has developed a limited set of interventions that are offered to address most identified problems. Frequently, these interventions are offered based more on availability than on demonstrated need.

The diagnostic process in child welfare has not been well developed and has focused on risk assessment—the risk of future harm—and family assessment or problem identification. Some of the instruments developed require highly trained staff to exercise professional judgment in completing them. This can be problematic when the neighborhoods and regions with the highest caseloads and the most serious child welfare problems are more likely to be staffed with the least-experienced, least-trained workers. Further, staff often are not competent to diagnose some of the more serious emotional problems common within the child welfare system today.

Exacerbating or perhaps underlying the problem of diagnostic capability in child welfare is the lack of evaluative data linking symptoms, diagnoses, interventions, and outcomes. Unlike primary health care, and to some extent the mental health field, child welfare has very limited, if any, outcome data. Part of the reason for this dearth of outcome data is a lack of consensus within the field regarding outcome indicators or measures. There have been few long-term studies of the effects of various interventions on family or child functioning or on child safety. Regardless of efforts to treat child abuse and understand what interventions lead to successful outcomes, clinical research and evaluation is extremely limited. In child welfare, the relationships among symptoms, diagnoses, interventions, and outcomes are measured anecdotally rather than empirically. The result is a decision-making process that relies on what interventions are available, since it is not always clear what is needed.

This problem is one of the biggest impediments to the image of child welfare. Child welfare professionals simply do not have systematic evidence that the services they provide do any good. Without this evidence, the system is susceptible to attack at every budget hearing and unanticipated family tragedy.

Those considering managed child welfare must clarify whether "saving money" means spending less than is currently spent or curtailing the growth in expenditures.

Utilization data are fragmented or [illegible] primary-care and mental health systems [illegible] data, essential to developing capitated rates [illegible] available and relatively accurate. This is due [illegible] form and detailed billing requirements of the [illegible] program.[illegible] In child welfare, however, systems [illegible] ment is not uniform across states—and [illegible] fragmented within a state. For example, client [illegible] data often are kept separately from service [illegible] data. Further, it is not unusual for contracts to be [illegible] based on costs rather than service units provided [illegible] dividual clients. Developing utilization patterns [illegible] and costs based on per-client units of service [illegible] therefore becomes nearly impossible. Without these data, managers often find it difficult to [illegible] many clients received what services at what [illegible] over what period of time. Legislators often [illegible] welfare as a large black box into which millions of dollars flow but from which emerges only a very [illegible] picture of what happens to the money.

Each of these areas can and must be addressed if child welfare if managed care is to be implemented. Addressing each of these four areas would serve the field of child welfare well, regardless of the success of managed care in saving dollars.

Can Managed Child Welfare Save Money?

State and local public child welfare administrators studying managed care are doing so primarily due to budgetary concerns. Their budgets have been cut or are about to be cut, or they are anticipating the effect of federal changes on their budgets. Managed care has been touted as the way to bring human service budgets under control. But other than those portions of child welfare services that have fallen under behavioral-health managed care, or very limited pilot projects, there is no real evidence that managed care can save money in child welfare. Further, those considering managed child welfare must clarify whether "saving money" means spending less than is currently spent or curtailing the growth in expenditures. Obviously, the former is a more formidable goal.

Four competing factors within the current system will affect whether managed child welfare can save money. Each state—and each county within county-administered systems—will have to weigh its position relative to each factor to gauge the potential for savings.

Current utilization of high-cost residential placements. The clearest cost-saving mechanism in managed care is reducing high-cost placement days. Once child welfare agencies face a fiscal incentive to reduce the level of care or the length of stay, they move children home or to less-costly placements. Jurisdictions with large numbers of children in high-cost residential placements could save money under managed care. Jurisdictions that already have made significant efforts to reduce these placements will see fewer, if any, savings.

Current level of underserving children and families. In many jurisdictions, large numbers of clients do not get needed services because of funding limitations. Caseworkers do not bother to assess the need for services that they know are not available. Under managed care, service provision would be based on clinical protocols without reliance on waiting lists to ration resources. To the extent that these protocols define a level of service that heretofore has not been provided, costs will increase under managed care.

Level of current provider payments. The donation of a portion of the cost of care, virtually nonexistent in primary or mental health, is common in the child welfare system among voluntary, not-for-profit agencies.[5] If current provider payment levels are so low that the cost of care is substantially subsidized by the private sector, there will be less potential for saving money under managed care.

Effect of the screening and investigation process on caseload size. Currently in most child welfare agencies, there is an informal relationship between the screening and investigation process and caseload size. When intake increases, screening and investigatory staff "control" intake informally by applying stricter standards for cases to investigate and cases to open. This may be done consciously or unconsciously, without a change in the formal intake criteria—just a subtle change in how staff may "read" the situation. Nevertheless, this shift serves informally to control the caseload size. The number of phone reports not investigated or the number of cases not opened as a result of these informal controls is unknown and likely varies from agency to agency and from staff to staff.[6]

Should a child welfare system privatize its ongoing caseload through managed care while still undertaking the investigation function, the public agency screening and investigatory staff would have considerably less concern about the size of the caseload. Private agency staff, paid out of someone else's budget, would address ongoing cases. Under this scenario, coworkers would not feel the impact of opening a higher percentage of investigated cases. Hence, more cases likely would be opened. The extent of this phenomenon is unknown, but is probably best estimated at the local intake level.

The development of child welfare managed care cannot be simply an extension of Medicaid or behavioral-health managed care.

Additionally, there are a number of specific managed care design decisions, including the impact of implementation on the size and responsibility of public agency staff, that will affect the ability of managed care to save money for a system.

Child welfare and managed care can be compatible if the concepts and technologies of managed care are configured to address the unique qualities and responsibilities of child welfare. The development of child welfare managed care cannot be simply an extension of Medicaid or behavioral-health managed care. The child welfare system requires a reconceptualization and redesign of managed care to meet its needs and responsibilities. This effort will require the collective thinking of child welfare management and line staff in both the public and the private sectors. The complexity of the issues is likely to require more time and energy than most states may be willing to allow. Since it is quite possible that the decision to implement child welfare managed care may occur without the input, support, or concurrence of public child welfare administrators, it is crucial that this planning begin immediately. Whether child welfare managed care will produce savings is unknown, but any effort to significantly change the system through managed care for the purpose of cost savings should be accompanied by an effort to improve the system. If the only purpose of implementing managed care is to cut costs, there are easier ways for the system to accomplish that goal. Managed care is a significant enough system change that it should not be undertaken unless its underlying goal and intent is to achieve an overall improvement in the child welfare system. *PW*

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See page 32 for notes and references.

NOTES AND REFERENCES

Feild

1. The concern over the rate of growth in child welfare expenditures has been expressed to the Institute for Human Services Management by child welfare administrators throughout the country who note increasing legislative and gubernatorial pressure to control growth.

2. For a discussion of cost and service trends in foster care over time, see House Committee on Ways and Means, *1992 Green Book* (Washington, D.C., 1992), 899–932.

3. Although the mental health system traditionally has prioritized clients based on established criteria, the system's legal ability to do so changed for Medicaid-eligible children under the Omnibus Reconciliation Act of 1989 (OBRA 1989). This law required that all services deemed necessary for Medicaid-eligible children must be provided. This eliminated states' ability to refuse to serve clients or to place them on indefinite waiting lists for services. The requirements of OBRA 1989 have not been fully recognized and implemented in all states. Where they have been implemented, some states have restricted services by narrowly defining medical necessity. The status of these requirements is uncertain under the proposed Medicaid block grants.

4. This is also due to federal requirements for the development of Medicaid management information systems and to the availability of enhanced federal funding to pay for their development, which has been available in the Medicaid program for over a decade. Similar mandates for child welfare, along with enhanced federal funding, have only been made available within the last three years.

5. This is a true donation to the cost of care, supported by endowment and active fund-raising efforts, not merely a forgoing of profits that may occur among medical providers. Nor is this donation a Medicaid refinancing scheme, such as the provider tax imposed on medical providers in many states in the last several years but now forbidden by the Medicaid program. In many states, provider donations can be as much as 20 to 50 percent of the cost of care. Child welfare is one of the few fields in which there often is some expectation that providers contribute to the cost of the service they provide.

6. This observation is based on the author's conversations with administrators and supervisors over the years.

Goerge, Wulczyn, & Harden

1. This article is adapted from Robert M. Goerge, Fred H. Wulczyn, and Allen Harden, *Foster Care Dynamics, 1983–1992: A Report of the Multistate Foster Care Data Archive* (Chicago: Chapin Hall Center for Children, 1994).

2. The databases of Missouri and Florida already have been added. Comparative data on all seven states will be featured in forthcoming archive publications.

3. In addition to the variables that form the archive's core data, the archive retains all the other data contributed by the states, which can be used in a variety of research studies.

4. Except for California and Texas, data in this section of the article are taken directly from the archive for each year from 1983 to 1992. Data from Texas span the years 1985–1992, whereas the California data cover 1988–1992. For Texas and California, we drew year-end census counts from internal agency tallies for the years preceding archive data availability. These extended sources present one complete five-state time series for the full 10-year period. In subsequent tables and figures, only those data maintained as part of the archive are presented.

5. Our study probably underestimates the total effect of urban caseload growth because some urbanized areas—such as San Antonio, Texas, and California's San Francisco Bay area—are classified in "the balance of the state." We selected the chosen counties in consultation with our state collaborators to enable us to examine the issue of whether foster care trends are dominated by large cities and the counties in which they are located. Only in Texas was it clear that we had to choose two because of the impact they both had on the Texas foster care caseload.

6. In Texas, kinship placements are coded in the same manner as other licensed foster home placements. In Michigan, kinship placements often are identified, but no distinction is made between such placements arranged through the state child welfare system and others arranged through private agencies.

7. In part, the increase is attributable to the large number of children already living with relatives as foster children, who were not counted as part of New York City's foster care population. As a result of a legal challenge, the "preexisting" kinship caseload was formally recognized in 1987.

8. See Robert M. Goerge, "The Reunification Process in Substitute Care," *Social Service Review* 64 (September 1990): 422–457, and Paul D. Allison, *Event History Analysis: Regression for Longitudinal Event Data* (Newbury Park, Calif.: Sage Publications, 1984).

9. See Goerge et al., *Foster Care Dynamics*, 39–44, for a discussion of the results of an analysis using proportional hazards models.

Sullivan

1. According to the Administration for Children, Youth, and Families, U.S. Department of Health and Human Services, May 9, 1996.

2. According to the Indiana Family and Social Services Administration (FSSA), Bureau of Program Evaluation, January 8, 1996.

3. Governor Evan Bayh, [illegible] *[illegible] Personal R[illegible]* [illegible] State, January [illegible] 1996.

4. According to FSSA, Bureau [illegible] velopment, October 24, 1995.

5. According [illegible] FSSA, Office of Medicaid [illegible] ning, June 17, 1996.

6. Indiana Public Law 2[illegible] 1992, Sec. 2 [illegible] 8-1-1.

7. U.S. Department of Commerce, [illegible] of Labor Statistics, [illegible] ton, D.C., 1996).

8. Indiana Public Law [illegible] 1995, [illegible] 16-37-2-21.

9. Indiana Public Law [illegible]

10. Center for Law and Social Policy, "AFDC Caseload Declines: Implications for Block Grant Planning" (fact sheet [illegible]) Center for Law and Social Policy, Washington, D.C., October 2, 1995.

11. According to FSSA, Bureau of Program Evaluation, May 1996.

12. FSSA, Bureau of Program [illegible] Statewide Welfare Reform [illegible] vidual Statistics," May [illegible] 1996.

13. FSSA, "Number of Child Day Care Facilities," June 1996.

14. The Child Care Action Campaign [illegible] national, nonprofit coalition [illegible] and based in New York City [illegible] part, is to "increase the availab[illegible] affordable child care for the [illegible] dren, their families, and the [illegible] being of the nation." Child Care [illegible] Campaign and the Center for Policy [illegible] tives, *Investing in the Future: Child [illegible] ing Options for the Public and [illegible]* (New York: 1993).

15. Indiana Human Resource Investment Council, *A Statewide Assessment [illegible] Regional Welfare Reform [illegible]* (Indianapolis: February 27, 1996).

16. FSSA, "Every Family Counts in Indiana" (Step Ahead brochure, 1994).

Pearson & Thoennes

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1. Amara Bachu, "Fertility of American Women: June 1992," *Current Population Reports* P20-470 (Washington, D.C.: U.S. Census Bureau, 1993).

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