

Managed Care

*Challenges for
Children and
Family Services*

Edited by
Leslie Scallet, J.D.
Cindy Brach, M.P.P.
Elizabeth Steel, M.S.W.

*Prepared by the Policy Resource Center
for the Annie E. Casey Foundation*

Additional copies of this report are available from:

The Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
410-547-6600
Fax: 410-547-6624
www.aecf.org

TABLE OF CONTENTS

Foreword <i>Patrick McCarthy</i>	i
Preface <i>Cindy Brach and Leslie Scallet</i>	iii
Introduction <i>Cindy Brach and Leslie Scallet</i>	1
Trends <i>Cindy Brach and Leslie Scallet</i>	3
Cross-Cutting Issues <i>Cindy Brach and Leslie Scallet</i>	10
Is Managed Care the Way to Go? Deciding Whether to Embark — Executive Summary <i>Suzanne Gelber</i>	17
Public Responsibilities in Managed Care <i>Cindy Brach and Donna Mauch</i>	19
Designing Managed Care Alternatives — Executive Summary <i>Susanna Ginsburg and Sharon Carothers</i>	25
The Role of Risk-Sharing Arrangements — Executive Summary <i>Anthony Broskowski</i>	28
Appendix A: Is Managed Care the Way to Go? Deciding Whether to Embark (Full Paper) <i>Suzanne Gelber</i>	33
Appendix B: Designing Managed Care Alternatives (Full Paper) <i>Susanna Ginsburg and Sharon Carothers</i>	45
Appendix C: The Role of Risk-Sharing Arrangements (Full Paper) <i>Anthony Broskowski</i>	69
About the Authors	90

FOREWORD

The migration of managed care tools to children and family services represents a change of potentially historic magnitude in how services are developed, managed, financed and delivered. The field is evolving very rapidly, with little theoretical or empirical clarity on what needs to be in place to avoid perverse incentives and ensure high quality, responsive, family focused and community based delivery systems.

Initial experiments in applying managed care strategies to social services suggest a number of opportunities for developing more rational, efficient and effective systems for delivering services to troubled children. In fact, the most promising models of managed care are quite consistent with the system reform efforts of initiatives such as the Federal Child and Adolescent Services System Program, Family Preservation and Family Support, and several initiatives of the Annie E. Casey Foundation. They create at least the possibility for integrated intake, diagnosis and assessment of children and youth with multiple problems; a unified network of agencies providing care for kids with serious problems; pooled resources across categorical budgets, permitting more flexible and holistic service plans; and incentives to develop less costly but effective community- and home-based services.

However, lessons learned from implementing managed care in the health care sector point toward significant risks as well:

- a limited focus on the cost containment potential of managed care often leads to precipitous implementation, without consideration of the elements necessary to ensure an effective service delivery system;
- models for determining the real costs of delivering services are difficult to construct; therefore, setting rates under managed care is difficult, often resulting in underfunding which leads in turn to incentives to shift costs to other systems;
- depending on how the target populations are defined, and how benefits are delineated,

incentives can develop to relabel the problems of children who need expensive interventions, so that the liability is shifted to other public systems;

- developing and maintaining adequate quality assurance systems is difficult;
- financing strategies can fail to provide incentives for prevention and early intervention, especially if the managed care entity will not profit from any costs avoided through reduced demand for services (for example, if the contract is short term, and the expected cost benefits are long term); and
- community residents may lose opportunities to participate in the design and management of the health and social services which affect their neighborhoods.

Because we believe it is critical that policymakers, public social service administrators, service providers, advocates and consumers understand these opportunities and risks, we asked the Policy Resource Center to commission the series of papers collected in this monograph. A companion paper, *Managed Care and Children and Family Services: A Guide for State and Local Officials*, offers a step-by-step process for (1) determining which, if any, managed care techniques can be adapted to fit a particular state or city's service systems and (2) developing a detailed design for a managed care system.

Our hope is that the ideas and perspectives contained in these two documents will contribute to the positive potential of managed care, and will help designers of managed care avoid mistakes that could be costly for the future of our children.

Patrick McCarthy, Senior Associate
The Annie E. Casey Foundation

PREFACE

This report is the second product of a project for the Annie E. Casey Foundation, *Managed Care: Implications for Children and Family Services*. The Annie E. Casey Foundation asked the Policy Resource Center to assist in developing a creative and constructive response to the challenges posed by the advancement of managed care techniques into systems serving children and families. A major goal of the project was to provide a bridge from the sectors where managed care is relatively more advanced, such as the health and mental health care systems, to those where managed care is beginning to make inroads. The project consisted of three parts:

- A meeting to draw upon the knowledge and experience of key experts in managed care, child health and mental health, child welfare, juvenile justice, and special education, and an overview paper that summarized the trends and issues discussed at the meeting and by other key informants;
- A set of commissioned papers by authors who could extrapolate managed care knowledge accumulated from the health and mental health fields to other child- and family-serving systems; and
- A managed care guide for state and local officials in child and family service systems.

The meeting and overview paper helped develop the basic topics and provide a common framework for the set of commissioned papers that are contained in this report. The papers were reviewed by Casey Project Officers and PRC Project Managers, revised, edited, and finally reviewed by experts in the field. Thanks are due to all who contributed to the process of producing this report. These include those who attended the meeting at the Policy Resource Center or who augmented the information collected at the meeting in telephone interviews:

- Kathy Barbell, Child Welfare League of America

- Julie Beckett, Child Health Specialty Clinics
- Steve Cohen, Jewish Board of Family and Children Services
- Robert Cole, Washington Business Group on Health
- Colette Croze, National Association of State Mental Health Program Directors
- Linda Glenn, Copeland Glenn Associates
- Judith Goodhand, Cuyahoga Children and Family Services
- Chris Koyanagi, Bazelon Center on Mental Health Law
- Debra Lipson, Alpha Center
- Ned Loughran, Council of Juvenile Correctional Administrators
- Ann Page, National Commission on Quality Assurance
- Jane Perkins, National Health Law Program
- Sheila Pires, Human Service Collaborative
- Pat Redmond, Philadelphia Citizens for Children and Youth
- Josie Romero, Santa Clara County Mental Health Department
- Sara Rosenbaum, Center for Health Policy Research
- Mark Sawyer, Open Minds
- Mark Soler, Youth Law Center
- Janet Stotland, Education Law Center
- Beth Stroul, Human Service Collaborative
- Dorothy Webman, National Resource Center for Permanency Planning
- Nora Wells, Family Voices
- Fred Wolczyn, Columbia University School of Social Work, Chapin Hall Center for Children

Preface

Special thanks also go to those who commented on a draft of the papers in this report:

- Julie Beckett, Child Health Specialty Clinics
- Tracy Feild, Human Service Collaborative
- Mareasa Issacs-Shockley, Human Service Collaborative
- Bernard Guyer, Johns Hopkins University School of Public Health
- Charlotte McCulloch, Child Welfare League of America
- Jane Perkins, National Health Law Program
- Sheila Pires, Human Service Collaborative
- Bob Schwartz, Juvenile Law Center
- Dorothy Webman, National Resource Center for Permanency Planning
- Fred Wulczyn, Columbia University School of Social Work, Chapin Hall Center for Children

While acknowledging the work of all who have contributed, the authors take sole responsibility for the content of this report. The views expressed do not necessarily reflect the position of the Annie E. Casey Foundation, the Policy Resource Center, or any of the contributors. As the managers of this project, we would like to thank the Casey Foundation — and our Project Officer, Patrick McCarthy, in particular — for the opportunity to address this topic that is at the cutting edge of delivery issues in the children and family service sectors.

Leslie J. Scallet, Executive Director
Policy Resource Center

Cindy Brach, Associate Director for Research
and Analysis
Policy Resource Center

INTRODUCTION

CINDY BRACH AND LESLIE SCALLET

Managed care has captured the imagination of the health and human services world. It has taken a firm hold in the health and mental health fields; its impact on other systems that serve children and families is growing. The term “managed care” refers to a variety of mechanisms designed to control utilization or costs of services. It does not define any particular model of service delivery. A managed care organization (MCO) may or may not provide direct care. Managed care’s defining characteristic is that it specializes in using certain techniques to manage the utilization of resources, for example:

- Preauthorization for care,
- Concurrent utilization review,
- Limitations on benefit packages,
- Selective contracting with negotiated discounts,
- Capitation or case rates,
- Case management,
- Provider profiling, and
- Practice guidelines.

The attraction of managed care lies in its potential to further goals long promoted by systems that work with children and families: reducing service fragmentation, increasing access to individualized care, establishing accountability, reducing costs, stimulating the development of more appropriate and less restrictive community services.

However, just as managed care has the potential to serve children and families more flexibly and holistically, experience in the health care sector underscores significant risks:

- Hurried implementation that may preclude adequate planning for the development or continuation of elements necessary for an effective service delivery system;

- Failure to blend funding streams and to integrate acute and extended care that may create a financial incentive for service providers to shift the costliest children and families from one system to another;
- Inadequate cost allocation models and capitation formulas, that may result in over- or underfunding;
- Rigid adherence to a medical model of care that works against the “psycho-social-behavioral” model of care embraced by children’s reform initiatives;
- Fiscal incentive to underserve combined with insufficient quality assurance mechanisms;
- Exclusion of providers (particularly indigenous community-based ones) that have expertise in children and families, and conversely, inclusion of providers whose technology and values are at odds with those of children’s reform initiatives; and
- Loss of opportunities for community residents to participate in the design and management of services that affect their neighborhoods and families.

There are lessons to be learned from the health and mental health experiences that can make managed care work better for children. Managed care initiatives require a great deal of sophistication on the part of both the public and the private sectors. The public sector must evaluate its own capacity and the capacity of the service system to adapt to a managed care environment. If done correctly, planning a managed care initiative is a time-consuming task, involving many different stakeholders. Any service system must contemplate managed care not as a discrete undertaking, but in the context of the full policy agenda.

The advent of managed care is demanding sweeping changes of both public and private sectors. Only thoughtful analysis of what has

gone before will allow those concerned with the welfare of children and their families to make the most of the opportunities managed care presents. While inter-system learning is essential, there is also the danger of extrapolating too broadly from what has transpired in one service sector to another. Analogies need to take into account the differences as well as the similarities between systems. This report, *Managed Care: Challenges for Children and Family Services*, provides a bridge from the sectors where managed care is relatively advanced to those where managed care is beginning to make inroads.

This report is the second written product of *Managed Care: Implications for Children and Family Services*, An Annie E. Casey Foundation Project. The Casey Foundation asked the Policy Resource Center (PRC) to assist in developing a creative and constructive response to the challenges posed by the advancement of managed care techniques into systems serving children and families. PRC has conducted a process of defining, writing, and editing a set of papers commissioned from authors who could extrapolate the managed care knowledge accumulated from the health and mental health fields to other child- and family-serving fields.

PRC's first step in this project was to draw upon the knowledge, experience and ideas of key experts in managed care, child mental health, child welfare, juvenile justice, and special education. A meeting of such experts, augmented by telephone interviews, was held to define the critical issues and select topics for the commissioned papers. Based on the information collected, PRC wrote *Managed Care's Implications for Children and Families: An Overview of Trends and Issues*. The third and final written product is a practical guide for state and community policy makers who are considering moving children and families into managed care.

The meeting helped to develop the basic topics and framework for this report. A series of issue and state case papers was then commissioned, reviewed by Casey Project Officers and PRC Project Managers, revised, edited, and finally reviewed by experts in the field. Executive summaries of the issue papers appear in the body

of this report. The complete text of the issue papers appear as appendices.

The report is comprised of the following papers:

Trends — reviews the history and implications of managed care in the health, mental health and substance abuse, education, child welfare, and juvenile justice systems.

Cross-Cutting Issues — addresses five cross-cutting issues that run through all the commissioned papers: the speed with which managed care is moving through the various systems that serve children and families, the emphasis that has been placed on outcomes, the involvement of consumers in the design and implementation of managed care policies and programs, the need for development of culturally competent systems of care, and the legal considerations that accompany managed care initiatives.

Is Managed Care the Way to Go? Deciding Whether to Embark — raises issues that policy-makers will want to consider when assessing whether they want to embark on managed care initiatives and provides guidance in how to assess a system's readiness for managed care.

Public Responsibilities in Managed Care — defines the public sector's objectives, details the core functions of government that cannot be delegated, and offers strategies to safeguard the public trust while implementing managed care.

Designing Managed Care Alternatives — examines the elements of the numerous alternative models of managed care. Design issues include defining and enrolling the eligible populations; defining the benefit package; designing the service system; deciding on an approach to financing; and deciding how to monitor access, quality and utilization.

The Role of Risk-Sharing Arrangements — discusses risk and risk-sharing arrangements as they apply to managed care approaches. The paper outlines determinants of risk, methods for estimating risk, contractual provisions that influence risk, and methods for reducing costs once risk is assumed.

TRENDS

CINDY BRACH AND LESLIE SCALLET

INTRODUCTION

Over a relatively short period of time, managed care has gone from being a minor player in the private health care industry, to becoming a major actor in the public systems that serve children and families. This paper sketches the movement of managed care, tracing its beginnings in health care and its rapid expansion to behavioral health and examining its influence on other systems that serve children and families. The interrelatedness of service systems has meant that managed care has affected systems neighboring those where it has been implemented. Additionally, managed care has proved contagious, frequently explored as a potential solution to system deficiencies in many sectors. It is in this context that public officials are making decisions about revamping their service systems.

MANAGED CARE IN HEALTH AND BEHAVIORAL HEALTH

Managed care's origins lie in the health care sector. Prepaid, predominantly nonprofit health care plans were first developed to improve access and continuity of care while controlling costs (Davis, Collins, and Morris 1994). Early staff- or group-model health maintenance organizations (HMOs) served primarily an employed population, and were developed primarily by groups of physicians or activists attempting to provide high-quality, comprehensive care to their communities (Morrison and Luft 1990). These precursors to today's HMOs had a long-term commitment to their patients and, therefore, found it cost effective to promote health through prevention and early intervention.

The federal government promoted the HMO model through the HMO Act of 1973, which provided start-up grants and loans and required large employers to offer HMO coverage when available. While HMO-style managed care gained a foothold, rapid expansion came only with the development of more flexible models. New

hybrid forms of managed care (such as individual practice associations, networks and, most recently, preferred provider organizations and point-of-service plans) depart significantly from the original model.

The expansion of the managed care industry also has involved a change in ownership. In the mid-1980s the industry's orientation had shifted from predominantly non-profit to largely for-profit. A consolidation of ownership of managed care plans has occurred, along with a trend toward ownership by insurance companies and investors, rather than hospitals and other health care providers. Simultaneously, specialty corporations have been formed to serve the niche market of mental health and substance abuse services, now referred to as "managed behavioral health care organizations." Mergers and take-overs are increasing market concentration in this industry as well.

Today's market environment produces incentives radically altered from the early prepaid plans. Increased competition among health plan alternatives now leads to rapid turnover of enrollees, as employers shift allegiance freely to the least costly plan. Managed care entities have less incentive to engage in preventive or developmental strategies that will pay off in the future, when the enrollee is likely to have moved to another plan. The stronger incentives may be to reap short-term profits or invest resources in market enlargement, rather than invest in expanded services or prevention.

In the last decade, managed care began to diffuse from the private sector to the public sector. States have searched for solutions to rising public health care costs. Managed care firms have sought out new markets. The number of Medicaid recipients subject to managed care has grown from 750,000 beneficiaries in 1983 — 3 percent of the Medicaid population — to 4.8 million in 1993 and 7.8 million in 1994 — fully 23 percent of the Medicaid population (Rowland et al. 1995). Primary care case management (PCCM) and

capitation (full-risk or limited-risk) are the two main forms of managed Medicaid, with the latter becoming increasingly dominant. Initially focused on the Aid to Families with Dependent Children (AFDC) population, Medicaid managed care is gradually incorporating disabled persons as managed care organizations (MCOs) continue their quest for new markets and states grapple with their highest cost populations.

The Kaiser Commission on the Future of Medicaid has summarized studies on Medicaid managed care's impact on access, costs, and quality, noting that most do not include elderly or disabled enrollees (Rowland et al. 1995):

- The effect of managed care on the number of physician visits is mixed, but PCCM program enrollees were more likely than those in capitated plans to have an increased number of visits.
- Referral rates to specialists appear to be lower in Medicaid managed care than under fee-for-service arrangements.
- Nonurgent use of emergency rooms appears to decline under Medicaid managed care.
- Medicaid managed care does not appear to affect use of preventive services, which remains low in both managed care and fee-for-service.
- While many Medicaid managed care programs appear to achieve cost savings, some claim to operate at costs similar or above those expected of traditional Medicaid programs. Costs savings are more likely to occur in capitated managed care programs than PCCM programs.
- Quality of care in Medicaid managed care plans appears to be about equal to that provided in fee-for-service Medicaid.
- Most enrollees in Medicaid managed care express overall satisfaction with their care, although some studies have shown satisfaction to be lower than those receiving fee-for-service Medicaid.

With few studies of managed Medicaid's effect on the disabled population, anecdotes of difficulty in accessing care cast a shadow on managed care's

reputation. For example, children with special needs have been reported to have difficulty obtaining access to pediatric specialists (Fox and McManus 1996). Some of the dissatisfaction with managed care in the public sector stems from the inability to fix problems that resisted solutions before the advent of managed care. Preventive services are a case in point. One study showed that where access to prenatal and preventive care was already inadequate, children enrolled in managed care programs showed no improvement, and some showed deterioration (Perkins and Rivera 1995). While some condemn managed care for failing to live up to its promise, others think managed care should be given a chance to tackle problems that have eluded the public sector for decades.

Whether for good or ill, managed care has made its mark on the public health and behavioral health care delivery systems. Providers who have traditionally served the Medicaid population increasingly find themselves operating under subcontracts with managed care organizations. For example, community health centers have felt compelled to enter into managed care arrangements when states implemented managed care programs because of the importance of the Medicaid program to health center revenues (GAO 1995). Not only have Medicaid recipients been a significant share of the clients served, but community health centers historically have relied on Medicaid funds to subsidize uninsured individuals for whom care is otherwise uncompensated.

Some community providers are developing alternatives to functioning as MCO subcontractors. Such models include formation of community provider networks that compete with MCOs; development of integrated provider networks that contract with MCOs (e.g., physician/hospital organizations, management services organizations); use of specialized MCOs, called administrative service organizations (ASOs), to handle functions such as provider selection and utilization review; and formation of jointly owned partnerships between MCOs and community providers whereby both partners bear risk and share profits. As these innovations proliferate, questions arise about how community providers can keep their values intact in the face

of financial pressures similar to those faced by for-profit corporations:

- Can they continue to place client needs first and fiscal concerns second?
- Will they learn how to ration care if the alternative is insolvency?
- How can they maintain the culture of their organizations and their workers' ideological commitment while becoming more efficient and business-like in their management?

Counties as well as community providers are experimenting with functioning as MCOs. In some areas of the country, programmatic responsibility has devolved, or is in the process of devolving, to the county level. As an alternative to contracting with private companies, counties can perform managed care tasks themselves. In the behavioral health field in particular, the concept of county-administered managed care is attracting attention as a way for public entities to maintain more control over managed care implementation.

SPILL-OVER INTO EDUCATIONAL AND OTHER SYSTEMS

Managed Medicaid affects the entire array of surrounding systems that serve children and families. "Systems of care" initiatives that organize services into a coordinated network have started up in a number of communities to combat the notorious fragmentation of services for children and families. Such systems rely on a patchwork of revenue streams, and often depend heavily on Medicaid — not only to fund services, but also to glue the system together. For example, there are at least six options for Medicaid financing of various care coordination activities for children with special health needs. Ironically, the success in blending funds and maximizing federal revenue that enabled the establishment of systems of care now means that these systems face disruption if managed care affects any critical funding stream. With the appearance of Medicaid managed care, they now risk the abrupt loss of essential revenue unless they become partners in managed care. The fate of such services as targeted case management under managed care is highly uncertain.

The education system has not been the target of managed care initiatives, but it is nonetheless affected by managed care. As the *universal* institution, schools may be expected to provide the venue of service integration efforts, although schools themselves do not have the resources to meet all the needs of children and families. For example, federal early intervention funds provided under the Individuals with Disabilities Education Act in 1986 (Part H—PL-99-457) was intended to serve as "glue" money rather than to fund actual service provision (Bane and Lusi 1991). Many states have arranged for Medicaid coverage of some early intervention or preschool special education services by designating school districts as allowable Medicaid providers, by adding a new Medicaid benefit specifically for Individual Family Services Plan-related services, or by authorizing discretionary treatment under the Medicaid pediatric treatment package — Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (Fox and Wicks 1990).

There is concern that Medicaid will not continue to be a source of funding for special education under managed care. MCOs have been known to attempt to shift costs onto the education system by denying services they consider to be the responsibility of the school district. Judicial opinions indicate that this activity is illegal, that MCOs cannot treat the education system as they would a private insurance company by invoking Medicaid's status as the payer of last resort. MCOs can be explicitly prohibited from such cost shifting, as in Tennessee's instructions to TennCare MCOs that they may not deny medically necessary services on the grounds that the services are the responsibility of a public agency.

The experience of school-based health clinics aptly illustrates the educational issues that may surface as managed care expands. School-based health clinics often serve large Medicaid-eligible populations, although they have had difficulty getting Medicaid reimbursement. According to the General Accounting Office (GAO 1994), the growth of Medicaid managed care complicates matters. MCOs are reluctant to incorporate school-based health clinics in which they do not control the type and quality of care provided. Additionally, MCOs lack the financial incentive to reimburse school centers; care that the centers

provide to Medicaid children in effect subsidizes the MCO.

School-based health clinics' attempts to make financial arrangements with Medicaid MCOs have met with mixed success. In rare cases, clinics have negotiated agreements for lump sum or fee-for-service reimbursement. For example, Baltimore school-based health clinics perform EPSDT examinations for a managed care plan (Brellocks and Fothergill 1995). Other school-based clinics have experienced flat denial or policies which inhibited reimbursement, such as not permitting students to designate a primary care physician independent of the one selected by their parents. Even before managed care, school-based health clinics' inability to maximize Medicaid revenue was attributed to a "culture gap" (School Based Health Care Program 1993). The fact that health center staff may not be sophisticated about business bodes poorly for school-based health clinics' continued funding under Medicaid managed care. Even when MCOs have happily paid for school services provided to their enrollees, there is concern about funding students who are not enrolled in managed care programs. Managed care, being individual-focused rather than institution-focused, comes in conflict with those who want to preserve existing systems. While schools see managed care as undermining their health care system, MCOs are in fact doing what managed care is designed to do — to make sure that funds follow the individual.

In addition to financial reimbursement issues, there is a general lack of communication between MCOs and school-based health clinics. Few formal or informal agreements exist in regard to sharing of information and coordination of services (DHHS Office of the Inspector General 1993). MCOs are not always sufficiently involved in the planning efforts for children with behavioral and emotional problems (Knitzer, Steinberg, and Fleisch 1990). Coordination is needed, such as transmitting school screening information to MCOs so they can follow-up with services. However, difficulties such as coordination and confidentiality predate managed care, which often is blamed for not solving thorny problems that have continually plagued service systems.

EXPLOSION IN CHILD WELFARE

Until recently, the child welfare system's exposure to managed care was limited, generally, to how it would be affected by Medicaid and other managed care programs. The physical and mental health services that child welfare workers have traditionally used have become increasingly subject to managed care. The child welfare workers' role has changed from being the authorizing agent to the more time-consuming role of being an advocate for services that are dispensed by managed care organizations.

A number of factors have now coalesced to create a "managed care explosion" in the child welfare field. First, a significant number of child welfare providers have seized an opportunity to diversify their funding streams. They have pursued the commercial business of MCOs by creating networks and marketing themselves to MCOs as a less expensive alternative to child and adolescent inpatient care. By offering MCOs a "step-down" alternative, these child welfare providers have captured new private clients and learned managed care skills that could be applied to the public sector.

Second, the federal government has been promoting changes in the child welfare system that have some similarities to managed care. The child welfare system is in the process of trying to remake itself to overcome the deficiencies in the current system:

- Child welfare agencies have been unable to keep up with increased demands for their services, given constrained resources, high caseloads, and overburdened workers.
- Too many resources were focused on crisis intervention and not enough on prevention and treatment.
- There has been a shortage of services that fit the real needs of families.
- Child welfare systems have been isolated from other services needed by vulnerable families.

To address these problems the Family Preservation and Support Services Act was passed in 1993. It built upon existing efforts in the area

of family support and preservation that included the decategorization of funding, collaborative planning initiatives, and demonstrations of improved planning and child welfare service delivery supported by the Edna McConnell Clark Foundation, the Annie E. Casey Foundation, and the Kellogg Foundation. The Act promotes a particular vision of child and family services. In addition to assuring the safety of children and all family members and promoting healthy development and permanency, child and family services are to be focused on the family as a whole, flexible and coordinated, organized as a continuum, designed to achieve measurable outcomes, and intensive enough to meet family needs (whether they be preventive or crisis). Unfortunately, federal foster care funds are available only if a child is already in an out-of-home placement. A federal waiver is necessary to allow substitution between placement and in-home preventive services. Recognizing that to accomplish the goals of the Family Preservation and Support Services Act the array of services must be broadened and funds from out-of-home placements must be reallocated to preventive services, the federal government has invited states to apply for child welfare waiver demonstration projects. The waiver project provides needed flexibility to a service system where inflexible funding linked to specific services or service providers often has interfered with the provision of appropriate services. Several of the 14 proposals submitted by states and the District of Columbia have contained specific managed care approaches, such as using case rates, tying payments to specific outcomes, or use of utilization management techniques.

A third factor has contributed to managed care's attractiveness to child welfare systems — diminishing resources allocated to child and family services. Many states have made the decision to deal with financial pressures by cutting child and family services or keeping budgets constant in the face of increasing demands. Managed care is well suited to downsizing and cost containment. Managed care offers the opportunity to allocate money more efficiently by using more appropriate and effective services.

Fourth and finally, behavioral health MCOs have sought out child welfare business, continuing their quest for new markets. Just as in behavioral

health, where large amounts of money tied up in inpatient services have been moved to less intensive (and more appropriate) services, MCOs propose to increase preventive and rehabilitative services that offer some promise of containing growth in out-of-home placements and reducing lengths of stay. While foster care — child welfare's chief form of out-of-home placement — is much less expensive than inpatient mental health care, there is still a significant potential for savings from diversion because lengths of stay are currently so long.

The combination of these factors has led child welfare systems to gravitate toward managed care. The importation of managed care technologies into child welfare has been initiated by state offices of budget and policy, by behavioral health MCOs, or by the child welfare provider community that has already begun participating in managed care. However, only a few small demonstration projects are operational as yet, run by community providers and targeting expensive "deep end" children.

Varied models for instituting managed care child welfare services are being developed as states, MCOs, and providers position themselves. Some states are choosing a management-only model, under which the MCO contractor is prohibited from delivering services directly. In these states a national or regional MCO will manage care provided by subcontractors. Elsewhere, public-private partnerships have formed to develop new non-profit organizations that can function as the managed care entity. In still other states, officials are trying to adopt managed care technologies into their governmental functions without privatizing services.

The roles in child welfare managed care still are being sorted out. Initially eager to take full responsibility, MCOs are learning more about the needs of children in the child welfare system, and are exploring alternatives. Payers are concerned with including traditional service providers in managed care plans, not wanting to lose the private funds they raise and the expertise they have accumulated. Providers are in the process of assembling necessary capital, preparing themselves to enter into subcontracting or ASO arrangements with MCOs or to perform managed care functions on their own.

There has been concern that introducing managed care in child welfare, a system frequently described as underfunded, will result in funds leaving the system. Managed care has been used in the health and behavioral health fields to engineer or justify budget cuts. It has been argued that fee-for-service reimbursement and categorical funding streams distorted spending patterns and resulted in bloated budgets. However, advocates assert that the substantial cuts being made in Medicaid, such as dropping personal care services for people with special health care needs, is adversely affecting children and families. Because child welfare budgets are starting at a much smaller base than those of the health care system, reinvestment of managed care "savings" is all the more critical. Currently, many jurisdictions with limited funding underserve children and families, placing those eligible for child welfare services on waiting lists (Institute for Human Services Management 1996). Managed care can be used to address unmet needs.

Other concerns about the applicability of managed care to child welfare have been voiced (Institute for Human Services Management 1996). Child welfare services are more likely to be involuntary (imposed by courts or police), and families are more likely to resist services. There is more danger of underservice than in other systems that have implemented managed care, because child welfare clients are unlikely to advocate on their own behalf for services. Proponents of managed care argue, however, that managed care contractors have an incentive to press their clients to accept services since they hope to save money by averting out-of-home placements.

The child welfare system is also unique in its assumption of parental status. The state in *locus parentis* is held to a high standard of responsibility when caring for children in state custody. MCOs' experience with guardianship issues has pertained to the care of incompetent adults. Managed care initiatives that used MCOs would have to compensate for MCOs' inexperience in promoting the healthy development of children. Another question is whether managed care is the best vehicle for achieving the child welfare system's goals of becoming family-focused, building on family strengths, and linking to other community child

and family service delivery systems (e.g. mental health, education, housing, substance abuse) and the courts. Managed care has historically been more oriented toward adults, more pathology based, and more concentrated in a single service sector. Managed care would also have to learn how to mesh with existing efforts to reform child welfare systems. Many reforms aimed at coordinating care and encouraging the system to be more family-centered operate on the local level. While managed care techniques are not by their nature incompatible with these community-based initiatives, the approach to instituting managed care is often centralized, with state agencies imposing their plans on communities. Child welfare systems struggling to adopt the principles articulated by the Family Preservation and Support Services Act are still deciding whether and in what ways managed care can be of assistance.

JUVENILE JUSTICE BARELY TOUCHED

Managed care has not yet appeared on the juvenile justice scene, and administrators and advocates in the field are relatively unfamiliar with managed care. However, the juvenile justice system can expect to have increasing contact with MCOs as they continue to penetrate child and family service systems. As in education, there is a spill-over effect from other sectors employing managed care. For example, children coming into the juvenile justice system may have been receiving health and behavioral health care from MCOs. Managed care contractors, if not held at risk for the cost of services provided in the juvenile justice system, may have an incentive to move children in that direction. It will be vital for juvenile justice officials to expand their understanding of managed care systems in order to prevent children and costs from being shifted onto them inappropriately.

The danger of cost-shifting may exert pressure on the juvenile justice system to join in managed care initiatives. In addition, the managed care industry has displayed some interest in juvenile justice as a potential new market. In some areas of the country, children in the juvenile justice system are being drawn into managed care initiatives that were instigated in other service sectors. However, intimations that managed care was about to take off in the juvenile justice system appear to be

fading. For example, Massachusetts' governor has withdrawn his recent proposal to contract out management of all health and human services, including juvenile justice, to a single MCO. While a consolidation of five departments is still being proposed, managed care is no longer in the spotlight.

Some, discouraged by the chaotic state of the juvenile justice system, think that managed care could offer the juvenile justice system a way of ordering itself — forcing public discussion of the failures of the current system, clarifying its goals, improving case planning and accountability, and acting as a gatekeeper and preventing children from being dumped inappropriately into the juvenile justice system. However, introduction of managed care into juvenile justice using private organizations would likely raise the same concern that privately operated prisons have raised for the last 15 years — can nonpublic entities be held sufficiently accountable? The debate is beginning, but managed care has yet to make significant inroads into juvenile justice.

REFERENCES

- Bane, M.; Lusi, S. 1991. *The Federal Role in Improving Services*. Cambridge, MA: Malcolm Wiener Center for Social Policy, Harvard University.
- Brellocks, C.; Fothergill, K. 1995. *Ingredients for Success: Comprehensive School-Based Health Centers*. New York: School Health Policy Initiative.
- Davis, K.; Scott Collins, K.; Morris, C. 1994. Managed Care: Promise and Concerns. *Health Affairs* 13:4 (Fall) 178-185.
- Fox, H.; McManus, M. 1996. *Medicaid and Children with Disabilities*. Washington, DC: Fox Health Policy Consultants and McManus Health Policy Inc.
- Fox, H.; Wicks, L. 1990. *The Role of Medicaid and EPSDT in Financing Early Intervention and Preschool Special Education Services*. Washington, DC: Fox Health Policy Consultants.
- General Accounting Office (GAO). 1994. *Health Care: School-Based Health Centers Can Expand Access for Children*. Washington, DC.
- General Accounting Office (GAO). 1995. *Community Health Centers: Challenges in Transitioning to Prepaid Managed Care*. Washington, DC.
- Institute for Human Services Management. 1996. *Managed Care and Child Welfare: Are They Compatible?* Bethesda, MD.
- Knitzer, J.; Steinberg, Z.; Fleisch, B. 1990. *At the Schoolhouse Door: An Examination of Programs and Policies for Children with Behavioral and Emotional Problems*. New York: Bank Street College of Education.
- Morrison, E.; Luft, H. 1990. Health Maintenance Organization Environments in the 1980s and Beyond. *Health Care Financing Review* 12:1 (Fall) 81-90.
- Perkins, J.; Rivera, L. 1995. EPSDT and Managed Care: Do Plans Know What They Are Getting Into? *Clearinghouse Review* 28 (March) 1248-1260.
- Rowland, D.; et al. 1995. *Medicaid and Managed Care: Lessons from the Literature*. Menlo Park, CA: Kaiser Commission on the Future of Medicaid.
- School-Based Adolescent Health Care Program. 1993. *The Answer Is At School: Bringing Health Care to Our Students*. Washington, DC.
- U.S. Department of Health and Human Services, Office of the Inspector General. 1993. *School-Based Health Centers and Managed Care*. Washington, DC.

CROSS-CUTTING ISSUES

CINDY BRACH AND LESLIE SCALLET

INTRODUCTION

The papers in this report all address different aspects of the implications of managed care for children's services. Several cross-cutting issues have been identified that run through all the papers. This paper addresses five of those issues: the speed with which managed care is moving through the various systems that serve children and families, the emphasis that has been placed on outcomes, the participation of clients in the design and implementation of managed care policies and programs and the importance of assuring client protection, the need for the development of culturally competent systems of care, and the potpourri of legal considerations that accompany managed care initiatives. The treatment of each of these issues is not designed to be comprehensive. It is hoped that the discussion here will serve as a lens to focus the reader's attention on these issues as they appear in the remainder of the report.

SPEED OF CHANGE

The breakneck speed at which managed care is proliferating puts at risk the fragile progress to date in creating children and family systems and instituting quality improvements. Financial considerations and ideological beliefs about the superiority of the private for-profit sector have been the driving force in the creation of public managed care programs, and there is a fear that cost reduction goals are eclipsing quality improvement goals. For example, Medicaid capitation programs, with savings as their primary goal, have outpaced primary care case management programs, which are more likely to include improving accessibility as a primary goal.

With cost control as the impetus, fiscal administrators are making decisions about the structure of managed care programs, while administrators committed to systems of care frequently have not participated in planning managed care initiatives. The budget offices and

Medicaid agencies that have been the driving force are generally housed in separate departments from the agencies chiefly responsible for children and families. Managed care program designers have not adopted a client orientation and they are relatively inaccessible to advocacy groups. Only a few places have established a process allowing for substantial stakeholder input, but that number is growing as it becomes clear that any group that does not buy into a program may succeed in closing it down.

One important lesson from the implementation of managed care in the health care sector is that even though they want to "do right" by children and families, public officials often do not possess the skills needed to become "smart purchasers." The pace of change outstrips knowledge and resources. For example, the ability to accredit new organizations and providers lags behind a constantly shifting industry. Often public managed care initiatives rely on a few devoted public officials who, however tireless, cannot keep up with the range of capabilities they need to master.

The provider community also needs time to adjust. MCOs may have little experience in dealing with the needs of multi-problem individuals. They need adequate time for planning, obtaining client input, and developing quality assurance systems (Rowland et al. 1995). In the case of traditional providers, long-established approaches to delivering services must change. For example, current treatment planning and clinical skills in the child welfare industry may not meet the new demands imposed by managed care. Unless given time to learn, the provider community is likely to become unstable, creating vacuums in the service delivery system.

OUTCOMES

As government increasingly contracts with for-profit organizations, the ability to specify in advance the results expected becomes essential.

For-profit organizations cannot be expected to exceed the literal specifications of a contract (Donahue 1989). Increasingly, as they find themselves competing with for-profit organizations, non-profits cannot continue to do so either. No longer can contractors be relied upon to "do right" by their clients when the provisions of a contract are vague.

Contracts have been vague in the past, in part, because there is disagreement about what the outcomes should be. Lack of specificity has allowed programs to appear to be meeting all constituents' demands. If the outcomes for which contractors are being held accountable are spelled out, then difficult questions must be answered: Is the juvenile justice system trying to rehabilitate offenders, or is it chiefly punishing and incapacitating them? At what point should the child welfare system give up on family reunification and seek a permanent alternative? Managed care, with its emphasis on outcomes, may force policymakers to come to terms with competing agendas within their own systems.

In addition to surmounting the difficulty in defining desired outcomes, the technical hurdle of measuring outcomes must be met. Government needs to be able to hold contractors and subcontractors accountable for outcomes as the public sector stops dictating *how* programs are administered. Yet many outcome measures in use today often pertain to the individual child or family, and do not measure how an organization or system is functioning. There are other concerns about outcomes measurement. For example:

- Can client improvement and treatment effectiveness be quantified? What happens when the results of successful interventions appear in the long rather than the short term?
- Which outcome measures are appropriate for managed care? For example, if a contractor is in control of the decision to readmit a client to the hospital or to remove a child from his or her family after a reunification attempt, do recidivism rates measure contractor performance?
- Do outcome measures look at the typical experience at the expense of special needs children?

- Are existing measures appropriate for various cultural groups? The unique culture, situation, and life experiences of the client are integral to outcome and should be taken into account.

The state-of-the-art in outcome measurement varies among the different family- and child-serving systems. The health care sector has the most well-developed instruments, but even these tend to be geared toward measuring personal health status rather than the overall health care system. Attempts to address public sector concerns, such as development of a Medicaid adaptation of the Health Plan Employer Data and Information Set (HEDIS) by the National Committee for Quality Assurance, demonstrate the unevenness and gaps in measurement knowledge.

In the behavioral health field, there has been a flurry of outcome measurement activity. Several groups, including the American Managed Behavioral Healthcare Association and the Mental Health Statistics Improvement Program, have developed report cards — a set of indicators that reflect the performance of an organization or system. The proliferation of performance measures, however, has introduced some confusion into the field about the differences among the measures and provoked questions about which should be used. The U.S. Substance Abuse and Mental Health Services Administration has funded an effort led by the Institute of Medicine to bring together measurement-defining organizations to clarify the distinctions among the measurements, but securing consensus around a single set of outcome measures is considered unrealistic.

Outcome measurement is less developed in the child welfare field than in the health and behavioral health fields. The measures used, such as length of stay in out-of-home placements, have been criticized by some as being too coarse and creating incentives to return children to their families prematurely. Measurement of client satisfaction, widely used to guard against underservice in health and behavioral health programs, is a less dependable barometer of programmatic success in a system characterized by involuntary services and resistant clients. Those who would like to give managed care a

chance argue that perfect outcome measures are not necessary at this stage — once the child welfare system has mastered the primitive measurements currently available, the demand for better measures will emerge.

The impact of outcome measures depends on how incentives are structured to promote particular outcomes. Incentives can be structured to promote reductions in service, but they can also be structured to hold contractors accountable for the safety of children in their care by linking penalties to subsequent incidents of abuse and neglect. Resistance to outcome measurement is understandable because it pushes the child welfare system to face its limitations — admitting that there are failures (just as some sick children will die in the health care sector, some children in the child welfare system will die) and that scarce resources can be stretched only so far.

Concern for quality under managed care has given rise to a demand for accountability, but the emphasis on outcome measurement is not without its price. Pressure to produce credible outcomes has been placed on ill-prepared providers. All too quickly organizations are being asked to demonstrate that they can achieve results. Outcome measurement is sophisticated and expensive to implement, yet organizations have been made to feel that outcome measurement is the admission price to participating in managed care. Many of today's child and family service providers will need help building the infrastructure necessary to produce reliable information on outcomes.

CLIENT PARTICIPATION AND PROTECTION

Clients have fought long and hard to gain a measure of control over decisions made about their lives. Managed care threatens client gains by imposing a new decision-making process. Many decisions are made by someone who does not know the client, or by a provider whose incentives have changed because of the assumption of risk. As the roles of provider and insurer become increasingly integrated, clients cannot count on providers to be their advocates. Even when providers are not at financial risk, they may worry about jeopardizing their relationships with managed care organizations if they

repeatedly appeal denials. A provider, of course, has the option to continue to provide treatment even after a managed care organization has denied payment. Although there may be both a moral and legal duty to provide clients with appropriate treatment, requiring providers to deliver unlimited amounts of uncompensated care is not a sustainable public policy (Appelbaum 1993).

Managed care in the health and behavioral health sectors has also been associated with a loss of client choice. Restrictions are often placed on who can deliver care. The fact that such choice is relatively unknown in some of the other child- and family-serving sectors, where providers are routinely assigned, does not mean that choice is not an important value to be built into a managed care system. There are a variety of mechanisms that can preserve or create choice in managed care, such as making participation in a program voluntary, or contracting with more than one MCO. Both voluntary programs and creating competition among MCOs encourages quality, since dissatisfied enrollees can leave the program or go to another contractor.

Current managed care programs often lack client protections. For example, complaints about Medicaid managed care include:

- Continued use of generic drugs when name brands are prescribed;
- Failure to use appropriate specialists instead of generalists;
- Lack of grievance procedures; and
- Dearth of client education.

Evidence of managed care's deficiencies is not strictly anecdotal. For example, analysis of the Medicaid Competition Demonstrations indicates that the proportion of children with a visit to a specialist declined an average of 53 percent after enrollment in managed care (Newacheck 1994). Another study of 59 HMOs revealed that although most plans offered a liberal range of the types of ancillary services needed by children at developmental risk (e.g. home health care, mental health care, occupational therapy), access to the services was limited by discretionary decisions of plan administrators (Wehr and Jameson 1994).

The Federation of Families for Children's Mental Health has laid out principles for family involvement in the development and operation of managed health and mental health care systems for children and youth. This can serve as a checklist for ensuring a strong client voice.

- Family members must be part of the decision-making team responsible for managed care system development in both the public and private sectors.
- Families must receive the information and training to be empowered to advocate for themselves.
- Families must have a definitive role in the development of their child's care plan and service needs.
- Providers in the managed care system must be prepared to allow families to participate at whatever level they feel comfortable.
- Managed care systems must support the principles of wraparound and cover the non-traditional services designed and delivered through this approach.
- Managed care systems (both public and private) must have a comprehensive and easy-to-use appeals process for families.
- Money needs to be set aside by the managed care system to support and train family organizations as client-based entities that have a key role in monitoring the managed care system, as well as to be involved in complaint review and policy development.

Public involvement in managed care planning can begin at the earliest stages, with client and family participation in planning groups and advisory boards and providing opportunity for public comment on managed care plans. Public input needs to be ongoing. The Bazelon Center for Mental Health Law has recommended a number of mechanisms to achieve ongoing public involvement (Koyanagi et al. 1995):

- Set up a state-level client-oversight board to review implementation of state managed care.
- Require MCOs to establish client advisory boards.

- Require both MCOs and appropriate state agencies (e.g. Medicaid, mental health, child welfare) to conduct client-satisfaction surveys on a regularly scheduled basis.

Government officials also need to ensure that client rights, such as freedom from discrimination and the right to receive appropriate treatment even if other services have been refused, are protected under managed care. Grievance procedures with timeframes for dispute resolution must be installed and clients must be given information on how to file grievances. Protection against abuses, from marketing ploys designed to induce enrollment to disenrollment due to costly service utilization or difficult behavior, needs to be established.

CULTURAL COMPETENCE

The public sector has long struggled to develop appropriate programs for its culturally diverse populations. Efforts to develop culturally competent programs for children and families in public programs need to be maintained. Cultural competence refers to the ability to honor and respect the beliefs, interpersonal styles, attitudes, and behaviors both of clients and of the multicultural staff who are providing services (Roberts et al. 1990). Culturally competent systems of care acknowledge the importance of culture, assess cross-cultural relations, are alert to cultural differences and their repercussions, and adapt services to meet cultural needs (Cross et al. 1989).

Concern has emerged that managed care will lead to a "one size fits all" approach to service provision that ignores the complexity presented by America's wide range of ethnicities. Of special concern is the high out-of-home placement rate of minority children. While managed care has the flexibility to institute service adaptations to reunify families and/or provide home-based services, managed care programs must become sensitive to the meaning of behaviors in particular cultures and take the time to develop trust and productive communication with families.

To move toward cultural competence, experts agree there must be an organization-wide commitment. A clearly established policy to provide culturally competent services must be

accompanied by specific changes in practices in such areas as assessment, outreach, family involvement, staffing, use of translators, caseload, and training and support (Roberts et al. 1990). Pursuit of cultural competence cannot be put on a separate track, but must pervade all responsibilities and activities undertaken by an organization responsible for managing care. There must be a philosophical and policy commitment to cultural competency at all levels of the organization, from the very top management to the front lines. Tools for assessing organizations' cultural competency can be a useful departure point for cultural competency activities. However, they are not designed to be used in isolation but should be used as part of a broader effort to achieve cultural competency, and with the guidance of experienced cultural competency experts.

The first step to becoming culturally competent is the ability of individual providers to identify the culture and language of clients. This information should also feed into data systems that can support analysis of utilization patterns, outcomes, and client satisfaction to determine if there are differences among groups. Developing sensitivity to the varying needs and strengths of particular cultures is the next step. However, sensitivity must be followed by the acquisition of knowledge about the cultures of clients served, and the creation of skills to provide care based on that knowledge. For example, being aware of linguistic needs must lead to working effectively with interpreters, hiring of bilingual/bicultural staff, and taking the time to develop trusting and productive communication with clients. Similarly, having diverse staff members does not necessarily mean an organization is culturally competent. Cultural competence requires staff to be able, for example, to interpret the meaning of behaviors of individuals from different cultures, and to obtain cooperation with treatment plans or alter treatment plans to reflect the client's culture.

As MCOs continue expanding their business into the public sector, they will encounter more culturally diverse populations. As part of their process to become culturally competent, MCOs will have to share the scarce culturally competent resources among themselves. Traditional providers have been known to borrow staff from each other to meet a specialized need, such as for

a Spanish-speaking therapist with experience in childhood trauma. MCOs may have to broker such resources or risk not being able to provide culturally competent services. Care should be taken to preserve the culturally competent capacity already developed. As the trend in the provider community toward larger organizations continues, the viability of small community-based organizations that have developed specialization in cultural competency is threatened. These organizations are also threatened by managed care's reliance on educational standards and accreditation to assure quality, since staff with cultural expertise may lack professional qualifications.

MCOs can learn to become culturally competent. While they may not have the public sector's experience in serving culturally diverse populations, competitive forces can create the incentive to learn. In areas where managed care programs are voluntary or where multiple MCOs are competing for Medicaid enrollees, some MCOs have aggressively recruited culturally competent staff and increased their training activities. An example of an MCO's increasing its cultural competency is provided by California Kaiser Permanente. Kaiser pursues MediCal enrollment by advertising in multiple languages, developing services that meet the population's needs, relocating clinics to reduce access barriers, and contracting out for such services as visiting nurses when the in-house array is insufficient.

Competitive forces, however, cannot be relied upon to achieve culturally competent systems of care. Public agencies issuing requests for proposals can specify standards for culturally competent care, such as documentation of linguistic appropriateness, staff training on cultural competency, and use of organizational policies and procedures that support competency practices. To date, cultural competency requirements have rarely been incorporated into contractual language, but California is one of the states developing standards and addressing these issues. For example, California's managed Medicaid program requires that MCOs use enrollees' preferred language when there are at least 3,000 persons eligible to enroll in the service area who prefer that language. Just as with outcome measurement, groups are forming to propose cultural competency standards for use in

managed care, such as the National Latino Behavioral Health Workgroup.

Outcome measurement can be employed to monitor an organization's cultural competency. Population profile data, such as language needs, utilization patterns, length of stay and client satisfaction, can be used by policymakers to flag areas needing attention. For example, *very* short lengths of stay for a particular cultural group might indicate an organization's inability to serve that group adequately. Furthermore, service outcomes for minorities can be compared among organizations. Culturally competent organizations would be expected to achieve better results because they have been able to communicate more effectively and develop more appropriate interventions.

In order to assure that adequate input from diverse clientele reaches MCOs, often located far from the site of service delivery, public sector payers can consider requiring community participation in an MCO's development of a managed care program. MCOs may be required to develop a staffing and program plan based on an analysis of the population profile.

The proportion of persons of color in this country is growing (by the year 2000, 33 percent of the population under 19 years of age is projected to comprise racial and ethnic minorities). Cultural competence will be an increasingly central part of any plan or system claiming to provide comprehensive care.

LEGAL ISSUES

Managed care brings with it a set of new legal considerations. Contract negotiation has become a highly prized skill, as public payers enter into contracts with MCOs and MCOs in turn contract with providers. There is a danger that parties entering into contracts may not realize the full ramifications of what they are obligating themselves to perform. When devising contracts both parties must learn how to take into account consent decrees, existing laws and regulations, as well as their own responsibility toward public populations.

Disparate power between negotiating parties can give rise to antitrust suits. For example, a group

of physicians has charged a company with violating antitrust laws by pressuring it to accept unconditionally the HMO's contract terms. In another antitrust case, doctors and hospitals have been accused of operating a monopoly that tried to keep out lower-priced managed care plans. Lawsuits alleging conflict of interest or improper procurement practices are also proliferating among states and would-be contractors as MCOs contest the award of contracts to competitors.

Managed care has also brought a new twist to malpractice lawsuits. Are providers liable for discontinuing treatment or failing to treat individuals when the MCO denies treatment? Court decisions predating managed care indicate that once a patient is accepted for treatment, health care providers have an obligation to furnish all necessary care; however, providers cannot be expected to provide unlimited amounts of uncompensated care (Appelbaum 1993). There may be a new form of defensive medicine, wherein providers appeal all denials of treatment by MCOs in an attempt to protect themselves from liability. When the provider and the MCO are one and the same, matters are further complicated. What is the liability of a provider, at risk for the cost of services, who reduces the amount of services provided in order to save money? States can retrieve money from MCOs for contract non-compliance, but are clients also entitled to enforce the contract under which services are being provided? Who is responsible for providing and paying for services ordered by a court, such as civil or community (outpatient) commitment?

Major legal changes must be made at all levels of government if managed care's full impact is to be felt. Federal waivers of the Medicaid, Child Welfare Services, and Foster Care and Adoption Assistance programs are necessary to free funding from its regulatory strictures. State and local agencies may find it necessary to streamline their procurement processes, which are often rigid and impede public organizations' ability to adapt to quickly changing circumstances. For example, some states are prohibited from entering into contracts for longer than one year, but contracts that short can lead to major disruptions in the service system and fail to provide incentives for contractors to make long-term investments.

Public agencies may also face a complete overhaul of their contract monitoring functions, as the complexities of managed care contracting and application of legal and contract provisions to subcontractors requires increasing sophistication. Personnel systems may also face fundamental restructuring, as managed care may involve increased privatization. To avoid costly delays and lawsuits, public officials proposing managed care initiatives that will replace publicly provided services with contracted services should engage labor leaders in discussions early in the planning process. A variety of strategies address the issue of displaced employees, such as: mandating employment of displaced employees by contractors, offering displaced employees first consideration for employment by contractors, reassignment to other public agencies, working within attrition rates, or retraining employees and/or assisting them with career planning (O'Leary and Eggers 1993).

The child welfare system, operating under a high level of legal mandates, introduces additional complexity. Courts have authority over child placement that is outside the managed care entity's control. The few operational child welfare managed care programs have been small enough to work closely with judges who have cooperated with pre-placement assessments and recommendations. These interventions, however, are being operated by traditional providers, rather than national managed care entities. Furthermore, some judges, even without managed care, make their own treatment and placement decisions without following recommendations of child welfare workers. Managed care providers could find themselves responsible for care planned and ordered without their input.

MCOs are learning to interact with court systems. For example, MCOs have been known to approach the court on behalf of an enrollee facing charges for driving while intoxicated, letting the judge know what alternative services could be provided through the MCO. Experience gained from the health care sector can be applied to other child- and family-serving sectors. For example, MCOs covering youths who become involved in the juvenile justice system could use presentencing assessments as a means of developing options for the courts. Incentives,

however, must be in place to motivate MCOs to divert children from detention.

REFERENCES

- Appelbaum, P. 1993. Legal Liability and Managed Care. *American Psychologist* 48:3 (March) 251-257.
- Cross, T.; et al. 1989. *Towards a Culturally Competent System of Care*. Washington, DC: CASSP Technical Assistance Center.
- Donahue, J. 1989. *The Privatization Decision: Public Ends, Private Needs*. New York: Basic Books.
- Federation of Families for Children's Mental Health. 1995. Principles of Family Involvement in the Development and Operation of Managed Health and Mental Health Care Systems for Children and Youth. *Claiming Children* (Summer).
- Koyanagi, C.; et al. 1995. Managing Managed Care for Publicly Financed Mental Health Services. Washington DC: Bazelon Center for Mental Health Law.
- Newacheck, P.; et al. 1994. Children with Chronic Illness and Medicaid Managed Care. *Pediatrics* 93:497-500.
- O'Leary, J.; Eggers, W. 1993. *Privatization and Public Employees: Guidelines for Fair Treatment*. Los Angeles: Reason Foundation.
- Roberts, R.; et al. 1990. *Developing Culturally Competent Programs for Families of Children With Special Needs*. Washington, DC: Georgetown University Child Development Center.
- Rowland, D.; et al. 1995. *Medicaid and Managed Care: Lessons from the Literature*. Menlo Park, CA: Kaiser Commission on the Future of Medicaid.
- Wehr, E.; Jameson, E. 1994. Beyond Benefits: The Importance of a Pediatric Standard in Private Insurance Contracts to Ensuring Health Access for Children. *The Future of Children* (Winter) 4:3 115-133.

IS MANAGED CARE THE WAY TO GO?

DECIDING WHETHER TO EMBARK

EXECUTIVE SUMMARY

SUZANNE GELBER

This paper delineates the steps policymakers should pursue to assess rationally whether their state, county, or community should embark on a managed care approach in systems that serve children and families — and if so, how quickly to proceed.

GOALS AND EXPECTATIONS

Unfortunately, an intent to embark upon a managed care initiative is too often declared before goals are discussed and stakeholders' divergent interests are resolved. Without careful planning and incorporation of stakeholders' perspectives and expectations, managed care systems can be badly designed, causing great harm to the vulnerable children and families they are supposed to serve, and/or creating problems for providers. If, in the rush to implement managed care before funds or political enthusiasm evaporates, policies on contentious issues are promulgated, litigation is likely to follow.

Policymakers — such as legislators, governors, or county commissioners — first must comprehend *why* things are done in a particular way and *how else* they might be done in order to determine effectively how they should be done in the future. Therefore, prior to beginning any effort to assess systems' readiness to convert to a managed care platform, policymakers must lay out certain essential factors:

- Their vision of an ideal system.
- The current care systems' objectives, current capabilities and weaknesses, and state and federal entitlements and requirements, if any.
- The key characteristics of the political and financial infrastructure supporting the categorical services.

- The costs of the services, and any existing cross-system financing capabilities or obstacles.
- The strengths and weaknesses of managed care techniques and systems.

ASSESSING READINESS

Steps to assess the readiness of the system include:

- **Gathering data** (e.g., the population being served or excluded, the providers who serve the populations under study as well as those who could serve them, the administrative managers who finance and monitor service provision, the funding streams and costs associated with the current system, patterns of service utilization) from formal management information systems as well as unpublished information sources at the national, regional, and local levels;
- **Mapping the system**, both its infrastructure and organizational components to tell the system's complete story;
- **Appraising internal capacity and using supplementary expertise**, prudently purchasing outside consulting or service delivery only after conducting an honest assessment of both internal government and existing provider network capacity;
- **Evaluating available financing**, considering consolidating and restructuring funding streams and service systems while assessing whether managed care techniques can be implemented adequately, given expected funding levels; and
- **Evaluating system resources**, including whether providers have and know how to use

a variety of systems important to implement managed care successfully (e.g., adequate network capacity, protocols for clinical decisionmaking, financial and administrative staff and systems to handle changes in financial mechanisms, credible audit and quality management systems and staff, culturally sensitive education and outreach systems, systems to train and evaluate managed care providers and practitioners, outcomes analysis, research, and management information systems).

If only some of the above prerequisites are present and adequate, policymakers must decide whether it makes sense to invest in bringing the inadequate components up to speed and in what period of time. Even if all other conditions for managed care readiness are met, resistance among stakeholders, such as clients, advocacy groups, and providers, can stymie a decision to move toward a managed system of care. Policymakers are therefore well advised to **involve stakeholders** in the process of assessing a system's readiness for managed care. Policymakers may want to make use of the **checklist** found in the full version of this paper to assure themselves that they have done a thorough job of considering the appropriateness, capacity, design, and implementation issues. It is easy to neglect or be unaware of design alternatives and it is very important to be as certain as possible that choices have been made with full knowledge of possible consequences and of alternatives.

MAKING THE DECISION

The system's state of readiness is not likely to be uniform and therefore the decision to embark on managed care is not a "yes or no" proposition. Decisionmakers may want to match the rate of managed care implementation to the system's level of readiness, allowing parts of the system or state that are more ready to proceed more quickly. A managed care initiative could begin as a pilot, or phased in by geographic region or by population. Managed care initiatives could also include special provisions (e.g., subsidized or free technical assistance, gradual transference of risk) to bring up to speed certain providers (e.g., those who have developed expertise in cultural competency, those who have expertise in serving

persons with AIDS) who are unready to participate fully at the outset.

If the difficult decisions discussed here are understood, made, and made well, and the result is a decision to proceed with a new managed care approach, the challenging task of planning, designing, and implementing the new system can begin. Understanding that managed care is not a monolithic system, but can be tailored to meet the idiosyncratic needs of each system is a step toward designing a system that can meet the needs of vulnerable children and families.

PUBLIC RESPONSIBILITIES IN MANAGED CARE

CINDY BRACH AND DONNA MAUCH

INTRODUCTION

At a time of decreasing public revenues, persisting social and economic problems, and intrigue with private sector solutions, the traditional American distrust of government flourishes. Politicians and citizens alike focus on the limitations of public policies implemented in the absence of true social and economic opportunity. The drumbeat for applying "tougher" and "more business like" methods has grown louder and threatens to drown out the range of opinions and facts key to a balanced debate on the legitimate role of government.

For over sixty years, government has taken responsibility for providing subsistence income, health care and housing to the destitute, for protecting victims of violence, and for rehabilitating troubled or disabled individuals. Recently, however, government has begun to limit or even withdraw from many of these roles, creating questions about what fundamental values our society still entrusts to government. The onset of managed care provides an opportunity for public sector officials to re-examine whether they are indeed living up to the values that the citizenry has charged government to uphold.

While "managed care" refers to a set of techniques used to manage the utilization of resources that can be employed by public agencies, the term has become associated with delegation to the private sector. The privatization of government functions is not a new phenomenon. Throughout the nation's history of meeting children and family's needs or preventing needs from arising, government has used a wide variety of tools to carry out governmental objectives: project and formula grants, social regulation, contracting out, tax expenditures, vouchers, government corporations, and many more (Salamon and Lund 1989). The proportion of human services delivered by non-governmental "third parties,"

first by non-profit and more recently by for-profit organizations, has been increasing as disenchantment with government has grown.

The boundary between the roles of government and the private sector has always been permeable and movable. The General Accounting Office (GAO 1991) investigated whether government contractors are performing inherently governmental functions. It found that the nation's acceptance of contractors in government service, which has evolved over time, has been primarily ideologically based. The advent of managed care comes at a time when the recognition of necessary governmental roles is at a low ebb, diminishing reluctance to transfer public decision-making functions into private hands. Nevertheless, concerns are voiced that in the rush to adopt managed care, public responsibilities may be inappropriately transferred to the private sector. Public officials must pause to consider whether managed care is appropriate for their system at all. (For more on making the decision to embark on managed care, see Gelber.)

Fear that government will "give away the store" seems particularly well-founded at a moment when some politicians question government's responsibility or capacity to provide for or guard the interests of our most unprotected citizens. A public trust in caring for vulnerable children and families is a fundamental function and the very heart of government, which may be misplaced in the private sector unless roles are carefully defined and private sector technologies are carefully evaluated for their fit with public sector functions. Before launching managed care initiatives, the public sector needs to be clear where its heart lies, as well as the formal responsibility for which it will be held accountable.

This paper poses the question: "What responsibilities must remain with the public

sector?" The response comes in three parts. First, the public sector's objectives in caring for vulnerable children and families are defined. Second, core functions of government that cannot be delegated are articulated. Third, strategies are offered for executing core functions and securing the public sector's objectives. Public sector officials who think through these issues and plan accordingly can remain in control while using the private sector effectively to accomplish public objectives.

OBJECTIVES

As the public sector strives to become a "smart purchaser" of managed care services, it must re-evaluate the objectives it seeks to achieve. What is government ultimately accountable for? Each service system has a different set of responsibilities, and will therefore conceive its role in different terms. In the interest of looking across the systems that serve children and families, we have developed a consolidated list of objectives that can serve as a basis for thinking about core functions and strategies should public officials proceed with managed care initiatives.¹

- To promote the safety and health of children, families, and communities.
- To provide leadership in partnership with all parts of the health care and human services system.
- To involve clients and advocates in planning, both at the client and policy levels.
- To provide a safety net for children and families, ensuring that they promptly get the full array of services they need.
- To provide vulnerable children and families an opportunity to achieve positive life outcomes.
- To assure quality and accountability.

¹ Using principles from the Child Welfare League of America's National Advisory Committee on Managed Care, these objectives have been adapted from a list of public interest principles that defined the most important roles of public mental health authorities in the context of health care reform (Folcarelli 1995).

- To promote access to community-based, integrated systems of care.
- To ensure that resources are being used efficiently.
- To promote innovation and best practices in services and systems.

CORE FUNCTIONS

Many of the tasks that must be completed to achieve governmental objectives can be assigned to other entities. However, some tasks — the core functions — must be reserved to government entities. Government must maintain sufficient in-house capability to be thoroughly in control of the policy and management functions of the agency (GAO 1991). Of course, this does not mean that government has to do everything itself. Rather, government must be able to make sure that activities to further public objectives are properly executed and that the government is in a position to step in should private undertakings fail. While there is not a one-to-one correlation between the objectives and the core functions, the latter grow from the former.

Structure the system. The public sector has a clear and distinct role in deciding what services and functions are necessary and what the system will look like. Which services will be integrated? Should managed care be instituted, and if so for what purposes and what services? Will managed care systems be directly operated or contracted out to public or private entities? How will contractors be selected? Will there be any competition among contractors, and what will be the criteria for selection? What reimbursement mechanisms will be utilized? While options can be generated by other actors in the system, such as clients or bidders, public officials must set up the decision-making process and act as the final arbiter. Responsibility for system design includes identifying potential problems and introducing features to remedy them.

Define target client populations, outcomes and coverage, along with overall population outcomes. The public sector must promote and protect the health and safety of all children, families, and communities. It must ensure that an acceptable level of services is available to

children and families in need, including particular defined populations. When defining who is covered by a managed care (or other) initiative and what services will be provided to those persons, the needs of vulnerable children and families must be identified and funded. Children with disabilities, as well as children in state custody (either for the protection of themselves or others), must be given the chance to maximize their human potential.

Finance the system. The government is responsible for making sure that resources necessary to fund care and support the system are gathered. These resources must be adequate to capitalize, operate and improve the system. Savings achieved through managed care or other mechanisms should be regarded, first, as a resource for remedying inadequacies in the system. Government officials have a role in promoting community, county, state, and federal sponsorship of services to individuals who have no other source of support. Funds must be used appropriately, by both allocating resources across service systems and ensuring that services procured are cost-efficient and cost-effective. Careful blending of resources from multiple sources can avoid duplication and promote integrated service delivery. The public sector must guard against inappropriate cost-shifting, both from the private sector to the public sector and among systems within the public sector.

Install effective mechanisms to assure client participation and protection. The public sector must ensure that the system is responsive to those it serves. All stakeholders, particularly clients and families, advocates, foster parents, providers, other child- and family-serving systems and the judiciary, must be integrally involved in a decision to pursue managed care and in the planning, implementation, and monitoring of any managed care initiative. Consumer protection and client-centered service principles should provide a framework for the design of any managed care project. The public sector should also establish a government-operated client protection and grievance system in addition to any contractor-operated process, and is required to do so whenever legal entitlements such as Medicaid are concerned.

Define the desired outcomes and evaluate performance. In order to hold contractors accountable, the public sector must have the capacity to implement and enforce quality assurance requirements. Public officials must establish criteria for effectiveness and monitor outcomes. Goals to be incorporated into outcome evaluations include: service access for all, including culturally diverse and geographically isolated populations; cost-effectiveness; consumer satisfaction; ensuring public education, prevention, and early intervention activities; and preserving continuity of care. The government must have the tools and the resources to enforce satisfactory performance and direct corrective action.

Make placement decisions. The public sector has a responsibility to the child, the family, and society. Youth offenders should be kept out of juvenile facilities when safe alternatives are available. Similarly, when abuse or neglect is involved, family preservation should be pursued, as both the least restrictive setting for treatment and the preferred home for a child. However, the public sector must be prepared to intervene in cycles of violence. When remaining with their families of origin is no longer an option, other permanent care arrangements must be made for children to allow them a sense of connectedness that meets their needs for a secure identity. Public officials must work in partnership with courts in making custody decisions. However, safeguards must protect children and families from unwarranted intervention.

Regulate. Despite the rise of provider credentialing and industry-sponsored quality improvement, preserving the public interest demands regulatory and monitoring capacity within the government. Government will need to set standards, license and/or certify providers, establish consumer protection and grievance procedures, and otherwise regulate the system. Client rights protections depends on government's responsible exercise of its legal authority.

Collect, manage and analyze data for the purpose of making policy decisions. Leadership cannot be exerted without essential data. There is a significant danger that unless government officials attend to this core function, the public sector will be bereft of the information it needs to

guide child- and family-serving systems. Even when data collection is delegated, the government must be the central repository of information that is key to planning and implementation, such as measurement of health status and the tracking of costs. Public officials need to guard against over-reliance on self-reported data, using independent means of verification to ensure that foxes are not left guarding the hen house.

Coordinate. The system of care for children and families must be comprehensive. This entails government agencies working together to foster communication and cooperation among service sectors and with providers to reduce service fragmentation.

Preserve rights. Government must promote basic constitutional rights and equal protection under federal, state, or local statutes. Not only must government refrain from violating rights and discriminating, it must protect against such infringements being perpetrated by others in the system.

Protect privacy. Failure to protect the privacy of children and families can result in stigmatization and can jeopardize personal, family, and job security. At the same time, coordination and efficiency often require the ability for multiple providers or systems to have access to information about shared clients. Public officials can employ strategies to serve both interests and overcome conflicts over confidentiality issues to meet the legitimate needs to share information.

Create and disseminate knowledge. The public sector must design and finance research and demonstration projects that further what we know about how to help people. Sharing knowledge among systems and providers can improve the quality of services provided.

STRATEGIES

Preserving the public sector's core functions while embarking on managed care initiatives can be difficult. As dissatisfaction with government increases, pressure grows to privatize more functions. Strategies to discharge public responsibilities effectively include:

Conduct needs assessment. Undertake or commission periodic studies of the need for service. Develop a socio-demographic, clinical and functional profile of currently covered clients, and analyze historic patterns of utilization and cost of care for defined geographic areas. Analysis of past utilization and cost data will have to be adjusted to take into account any previous underfunding of the system, and any philanthropic subsidization. Particular attention should go to assessing previously unmet needs and prevention/early intervention needs, to assure that pressures to contain or reduce costs do not institutionalize an inadequate system.

Reinvest savings. Managed care has the potential to reduce costs and save public funds, but all too often these savings disappear into the general fund, finance reductions in taxes, or become profit for private companies. Savings must be reinvested to preserve the service system's infrastructure, to address unmet needs, and to institute prevention and early intervention efforts.

Use incentives to promote public goals. Rewards and/or penalties can align attainment of public objectives with the self-interest of private contractors. Examples of such incentives include: rewards for improving access and quality, conducting outreach, coordinating services, high consumer satisfaction scores, initiating or expanding preventive services and early intervention, or improving population-based indices. Similarly, penalties can be established for not providing culturally and linguistically accessible services, placing children outside their communities, or failing to monitor children's progress in the school system.

Mandate communication with clients. Contractors can be required to institute advisory committees, hold public hearings, and otherwise actively seek input from clients and families. Clients and responsible government agencies should also receive information from contractors about how client input has been utilized and incorporated (or not). Beyond client participation in the design of a managed care program, clients must be educated about the program's existence, how to access services, what their rights and responsibilities are, and how to file grievances.

Institute information systems improvements. Managed care initiatives require the tracking of new kinds of service and fiscal information, as well as client and population data. Computer systems need to be developed, both for government and contractors, that will track the new data needed for proper management. Sufficient lead time and funds must be allocated for this purpose.

Make data public and mandate provision of data for research and policy use. Publishing data can be an effective means of attaining improvement. Additionally, independent review and analysis of data by qualified third parties, such as academics, can help identify the strengths and weaknesses of the system. Contracts can include requirements to make data available while taking proper precautions to preserve privacy.

Re-examine procurement operations. Public sector procurement regulations are often slow and cumbersome. Their inflexibility can impede a public organization's ability to adapt quickly to changing circumstances. Reform of the procurement process can improve the public sector's ability to direct managed care initiatives.

Set adequate rates. Underfunding will jeopardize quality of care. Prospective pricing avoids relying on historical data in sectors that have been historically underfunded. (For more on prospective pricing, see Broskowski.) For public services that have relied on subsidization from the voluntary sector, rates that reflect actual costs of care may have to be phased in over a period of time.

Award appropriate length contracts. Re-bidding contracts every year or two is disruptive to continuity of care and does not permit contractors to pursue longer-range strategies, particularly those for prevention and early intervention. Contracts that are too long, however, can lead to complacency and non-responsiveness by the contractor. A balance must be struck. At least four to five years may be required to provide incentives for population-based improvements.

Maintain adequate risk sharing. Shifting all risk to contractors gives contractors the greatest incentive to underserve. Installing some

protection, such as stop-losses or contingency funds, reduces contractors' exposure to financial losses. Adequately sized risk pools must also be established. Risk can be phased in over a period of time (including a no-risk period for contractors) to allow accurate data on costs and utilization to be captured and to give contractors time to adapt managed care techniques to the population they are serving. (For more on risk, see Broskowski.)

Set minimum qualifications. Contractors should have to meet minimum qualifications, such as licensure or credentialing by appropriate organizations. However, qualifications should take into account the differing norms of fields that have not been highly professionalized, such as substance abuse or alternative therapies of ethnic communities. In addition, financial viability of potential contractors must be established to guard against contractor insolvency disrupting care.

Protect traditional safety net capacity. Traditional safety net providers, who often cater to uninsured and/or minority populations that would otherwise go unserved, can be undermined by managed care initiatives. Government strategies to preserve traditional safety net capacity may include: limiting contractors to local non-profits, mandating (or providing incentives) that contractors include traditional safety net providers in their networks, requiring that contractors refer a specified proportion of clients to traditional safety net providers, and aiding safety net providers to adapt their programs and organizations to the managed care environment.

Address the needs of special populations. Contracts can set cultural and linguistic competency standards (e.g. guaranteed linguistic access, languages other than English to be spoken at key points of contact); provide financial incentives for serving particular groups; require adoption of practice protocols that consider the impact of culture, language, race, and ethnicity; mandate contractors' participation in training designed to increase sensitivity to special needs and competency in addressing them; encourage collaborations with community-based organizations that have a history of serving special populations effectively; install mechanisms for community input; require contractors to plan for meeting linguistic and

cultural needs; and require comparable outcomes for special populations as for others. Government can also provide assistance to organizations with experience and competence in serving particular cultural or linguistic groups to re-engineer themselves in response to managed care.

Define “socially necessary.” Conflict between government purchasers and managed care contractors has arisen because there is not a shared understanding of services to be provided. More inclusive alternatives to the term “medically necessary,” such as “clinically necessary” and “socially necessary,” are being developed to describe covered services. To achieve a meeting of the minds between government and its contractors, and avoid potential legal battles, the range of social supports to be provided and expected outcomes can be clearly articulated in contract language.

Place caps on profits and overhead. To prevent public funds from leaving the system or being diverted from service provision, a limit can be placed on the proportion of funds used for overhead or disbursed to investors. Such caps can promote reinvestment in services and reduce contractors’ incentive to underserve, if vigilance can prevent contractors from gaming the system.

Require evaluations and continuous quality improvement. Managed care is in its infancy in the child- and family-serving sectors. Constant self-examination by contractors about how they are performing and how they can improve will speed the field’s development. Learning obtained from this process can then be shared with others seeking to implement managed care initiatives.

Install privacy protections. The public sector can require contractors to obtain written releases signed by clients and families to authorize the sharing of sensitive information. Non-identifiable data should be used for such functions as planning, evaluation, and research. Appropriate security of information systems must be established. Staff should be trained to follow all confidentiality procedures.

Oversee development and implementation of practice protocols. The links among symptoms, diagnoses, interventions, and outcomes are often weak. Tools that could connect particular

problems to specific interventions to expected outcomes could standardize and improve service provision. Government must make sure that the public sector and expert providers have input into the development of practice protocols, and that contractors utilize them.

Encourage development of credibility with courts. In many areas of the child- and family-serving systems, judges and their agents are involved in decisions made regarding service delivery. Contractors can only manage care to the extent that they have legal authority to do so. Public officials need to help contractors establish the validity of their decision-making processes. Once contractors have earned the courts’ confidence, public officials can assist them in forming collaborative relationships with court systems.

CONCLUSION

The opportunities presented by managed care technology are touted as the solution to the disappointing results of current child and family policies. To realize that promise, public officials must clearly understand their responsibilities and their options. If managed care appears to be an appropriate tool, they must carefully structure the initiative and their own continuing role. The risk that managed care technology could be misapplied demands the institution of safeguards to ensure that the public trust is preserved. If managed care is to improve the quality of care, the public sector must articulate public objectives, retain core functions, and judiciously utilize the strategies available to protect vulnerable children and families.

REFERENCES

- General Accounting Office (GAO). 1991. *Government Contractors: Are Service Contractors Performing Inherently Governmental Functions?* Washington, DC.
- Folcarelli, C. 1995. *In the Public Interest: The Role of Public Mental Health Authorities in the Emerging Healthcare System.* Washington, DC: Policy Resource Center.
- Salamon, L.; Lund, M. 1989. *Beyond Privatization: The Tools of Government Action.* Washington DC: The Urban Institute Press.

DESIGNING MANAGED CARE ALTERNATIVES

EXECUTIVE SUMMARY

SUSANNA GINSBURG AND SHARON CAROTHERS

This paper considers issues of policy implementation, helping policymakers to determine which of numerous possible alternative courses of action may be most useful in designing their specific programs. Primary focus is on the period *following* a decision to adopt a managed care approach in a system that serves children and families. The intent is to help implementing officials to identify and explore the elements of each alternative that will facilitate the success of their programs. An array of managed care techniques has been applied in the public health and mental health arenas. With increasing interest in expanding the application of managed care techniques to a range of systems that provide human services for underserved and vulnerable populations, the approaches and techniques discussed below require evaluation for their utility in child welfare and other family-serving systems.

AFTER THE DECISION: HOW TO PROCEED (BROAD ISSUES)

Implementing officials must address a series of broad and interrelated questions — with no right or wrong answers. Each state's decisions must reflect its policy objectives, philosophy, and the existing capacity to both manage and deliver services. The transition to a new system is a complex process, and the success of the initiative may be strongly affected by the state's ability to invest its time, energy, and funds in adequate planning and infrastructure development.

Although managed care often entails delegation of tasks formerly performed by the public sector to the private sector, public entities still have substantial **roles and responsibilities**. Ultimately accountable for results, the public entity must be clear about its overall role as a decisionmaker, and must determine which specific functions it will perform, delegate to others, or contract out. Areas that will require decisions by public officials

include those related to determining program requirements, setting standards for achieving public objectives, setting payment rates, and determining how programs will be monitored.

A variety of *state agencies* (both service and finance) and *programs* will participate in planning and designing the new initiative. An array of agencies with no history of common endeavors may be called upon to work together. The state must determine how to bring all key agencies to the table, the nature of the relationships among them, and the contributions to be made by each player. In addition, other *stakeholders* (e.g., consumers, families, or current and potential contractors and providers) must provide input into the design and early implementation of a managed care initiative.

As they begin **taking stock** of their readiness for the new initiative, states must consider their current *administrative resources* and those that must be developed in order to plan, administer, and oversee a managed care initiative. These will include trained and experienced staff and highly sophisticated information systems. The *resources of the service system* must also be assessed. There must be sufficient program capacity, and services must be accessible and acceptable to the communities they will serve. Essential *financial resources* include money needed by the initiative in order to serve clients as well as an initial investment of capital necessary to start a large and complex program. The sources of those start-up funds as well as funds for ongoing operations must be identified.

Finally, an assessment must be made of *how quickly* a program can be implemented once it has been designed and approved. State officials must decide whether and how to phase in the effort, based on their assessment of existing capacity at both state and provider levels.

AFTER THE DECISION: HOW TO PROCEED (DESIGN ISSUES)

Certain critical factors must be addressed in designing balanced managed care alternatives. Many tools can help to manage care, risk, or both.

Eligible populations must be *defined* and *enrolled* in the new system. The nature and size of a population, its service needs, and its experience in service utilization must be estimated and the potential size and cost of the proposed effort projected. Decisions about eligibility will include an analysis of the situation through which the child or family comes to be seen as in need of service, as well as an assessment of the system's capacity to provide the necessary services. Once a population subset has been found to have specific service needs, and after individual and family eligibility has been determined, officials must choose whether and when to enroll them in the managed care initiative.

Issues related to enrollment of publicly supported populations differ from and often are more difficult than enrolling commercial populations in managed care. Eligible individuals must receive appropriate information in a location accessible to them so that they can make informed choices. For those who receive information but do not make a selection, state officials must establish a "default" process by which the person (or family) is assigned to a plan. Client grievance and appeals processes must be in place at the provider, plan, and state levels to provide opportunities for clients to have their concerns with either procedures or care addressed.

The **benefit package**, too, must be defined, and the **service system** designed based on the needs of the target population in the context of available resources. Mandated and optional services must be considered by the state, as planner and payer. The traditional health benefit plan would include "*medically necessary*" services and might include preventive interventions, treatment, and enabling services that facilitate members' compliance with medical recommendations. Flexible benefit plans that use a treatment plan approach to defining necessary service seem to yield satisfactory results in terms of cost control and patient satisfaction. States that plan to use a managed care approach for providing services to children

and families may find they must go well beyond the services currently included in many health benefit packages. Policymakers and advocates are beginning to think about how they might define "*social necessity*," as a basis for determining which specific services would be allowable and covered by a broad benefit plan.

State officials will wish to consider the extent to which they will contract out or retain *administrative services and direct services for enrollees*. The **role of the contractor** may be narrow or broad, depending on how much control the state wishes to retain. This is also a point at which the state will consider **how the service system will be structured and contractors will be selected**. For example, states will decide whether to work with one or multiple contractors.

Decisions about **how and by whom will services be provided** will depend heavily on whether the state wishes to be highly specific regarding providers or prefers to set standards and then allow many of the decisions regarding providers to be made at the MCO level. In general, a set of acceptable providers (a network) will be identified, and consumers will be restricted in their choice of providers. States may wish to make special provisions to protect "safety net" providers who are especially qualified to meet the needs of certain underserved populations. In addition, state planners will want to ensure that services are coordinated rather than duplicated, and that clients have access to the full array of the services they need.

Often the primary focus in designing managed care alternatives is the **approach to financing** that the state or program is proposing as part of its initiative. Traditional approaches that pay for services on a fee basis give little or no attention to managing the care that is provided. Managed care approaches use mechanisms that allocate risk and rewards for all stakeholders, generally offering incentives to limit the number of service units provided. State officials will need to *determine rates* and the payment type (usually case rates, per diem fees, or capitation). Alternative or hybrid approaches such as grants might be offered in specified categories of service, such as foster care or care of children with chronic conditions. *Risk can be apportioned* among various stakeholders so that profits (rewards) as well as losses can be

shared, encouraging coordinated, efficient, and effective service delivery.

The state must **monitor access, quality, and utilization** of the service system regardless of the role it plays in the actual design and implementation of the delivery system. All clients must be assured access to services that are culturally appropriate and acceptable to the target population, and providers must have incentives to provide the proper amount of services.

Monitoring activities may be designed and conducted by the state, by the managed care plans, or by outside evaluators. Measuring outcomes is complex and requires the development of *definitions and standards*. The methods for measuring and interpreting standards and outcomes are of particular concern in child-serving systems, since there are few practice protocols that include the standardized assessment and decision-making tools which are critical for ensuring that the needs of children and families in these systems will be addressed. In addition, there is a limited range of treatment modalities available at present, and treatment is often decided externally (as through court mandates). The *infrastructure for monitoring* must also be in place, ensuring that data and information about adherence to standards and results from interventions can be collected and managed. State officials will need to ensure that appropriate information systems are developed and maintained.

THE ROLE OF RISK-SHARING ARRANGEMENTS

EXECUTIVE SUMMARY

ANTHONY BROSKOWSKI

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, developing a managed care initiative provides an opportunity to build administrative and service-delivery structures that can have a positive effect on both the process of delivering services and the outcome of the services. 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. Balance is achieved among the interrelated service system factors of access, quality, satisfaction, and cost. Incentives for payers, populations of potential patients, actual patients, and various types of providers and their services are properly aligned. Managed care principles offer some insights into how this might be accomplished.

The appropriate allocation of risk requires understanding how to 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.

FRAMING THE DISCUSSION: TERMS AND CONCEPTS

This section serves to introduce the reader to the vocabulary of risk. It provides a basic framework to help policymakers and program developers in the complex process of conceptualizing their own new approaches to providing services. Five **stakeholders** are usually asked to share financial risks in the arena of health care:

- the employee/dependents (eligible users of services),

- the employer or government payer,
- the insurer or the managed care organization (MCO) that sets up and runs the system of services,
- the patient (the actual user of services), and
- the service provider.

Eligible and actual recipients of publicly funded services may not have enough income to participate financially in cost-sharing approaches to managing care.

This paper primarily deals with **financial** risk, which 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*. It is a challenge to measure the components of financial risk, but they indeed can be measured and the total risk can be distributed. **Nonfinancial** risks (the risk of a good or bad outcome) are harder to describe in measurable terms, take a long time to show results, and outcomes cannot as easily be teased out as the result of a given service.

Risks and rewards must be distributed proportionately if a system is to remain in balance. The potential for *financial reward* is one of the powerful **incentives** for achieving positive results. Providers also value having *control over resources*, which increases their ability to garner financial rewards.

At least two distinctive types of risks are shared. The **risk for utilization** asks how many persons will use care (i.e., how many "eligibles" will become "clients") and how much care will each client use? The **risk for cost or price** speaks to the uncertainty about what a unit of service will cost. *Cost* refers to the provider's actual expenses. *Price* is the amount that provider charges the payer, which includes cost and profit. Both utilization and cost are subject to *variation*. Services that are customized for individual users

raise the cost of the overall system. Therefore, health care systems strive to provide standardized treatments that have been demonstrated to be effective. Increased sensitivity to unique sub-population characteristics (e.g., language and culture) also means increased variation and its consequence, increased costs. However, responding to customer concerns may yield increased loyalty to the provider and better compliance with a treatment plan, possibly decreasing costs.

There are many **provider reimbursement mechanisms**, and managed care does not imply any particular method of reimbursing providers for their services. The continuum of payer and provider risk sharing may be visualized as a **risk ladder**. Just as the provider's risk increases with each step down the ladder, the state's increases with each step up. Both parties stand to gain when they find a point on this continuum where both feel comfortable with the balance of risk. The rungs of the ladder, which are defined and discussed in the full paper, include: *discounts off normal charges; fixed fees per service unit and global fees; case rates; capitation; and percent of premium*. However, the risk ladder was developed with health care in mind. Two additional rungs on the risk ladder (risk pools and high-risk client carve outs) may be useful in planning for more comprehensive managed care initiatives that will serve children and families.

SOME DETERMINANTS OF RISK

Whether historical data are used or prospective statistical models are constructed, risk estimates require that client, service cost, and plan factors be considered. **Client factors** relate to the *characteristics of the client population* (e.g., gender, age, marital status, education, employment) and their *patterns of service use*. **Service cost factors** relate to the *cost per unit* of service, *direct versus indirect costs*, and *fixed versus variable costs*. **Plan factors** that determine risk include: the *benefits plan* itself and the *enrollment of members*. The benefits plan controls risks by setting limits on the persons who will be covered, the number and types of services covered, the authorized providers, and the amount of money to be paid by the insurer and the member.

Benefits plans can be carved out to meet the needs of high-risk populations. However, the more the overall premium dollar and benefit package is split among separate provider organizations within the same community serving the same people, the more likely it is that some providers will try to shift risks to other providers. 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.

Membership and enrollment will have important effects on the level of risk in any service system. The overall *size of the membership* is the number of persons in the group whose care is to be managed, as well as the number of those 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 capitation and case rates are based and, therefore, the more reliable the estimate of risk.

Enrollment can be *voluntary* or *mandatory*. Voluntary enrollment carries with it the risk of *creaming*, selecting the most desirable members, and *adverse selection*, a term that refers to any process or circumstance that would result in more persons needing many services enrolling in your system.

Giving enrollees a choice among provider systems also creates potential for adverse selection and creaming. 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 balance among competing systems may be enforced by *assigning* members to a given provider network, either randomly or based on an algorithm to ensure initially a balanced enrollment of the various levels of severity among all competing provider networks.

SOME METHODS FOR ESTIMATING RISK

The **actuarial approach** and the use of **prospective risk simulation** are two basic methods for preparing 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 often flawed in that the historical data may not be complete and credible and the future service system is almost certain to differ from the one used in the past.

Prospective risk simulation uses statistical modeling techniques to make forecasts of the probabilities of future outcomes under various conditions. Given a set of inputs, computer software generates a model of possible outcomes and the probability that each will occur. By changing the size or content of input variables or the relationship among inputs and outputs, the decisionmaker can simulate the probable effects of making such a change. Modeling and simulation have many beneficial characteristics and are highly recommended for use by decisionmakers.

SOME CONTRACTUAL PROVISIONS THAT MITIGATE RISK

To prevent too much risk from being shifted to providers, contractual provisions can be installed to limit losses. **Adjustments in rates** may be necessary if utilization proves to be higher than expected, if the cost of providing service rises with inflation, or if changes in laws and regulations lead to increased costs.

Risk-limiting mechanisms may be used to address concerns that good contractors will lose money and drop out of the market or that risk-bearing contractors will make excessive profits at the client's or payer's expense. Contracts may establish *risk-reward corridors* that limit the provider's downside risks and upside profits. However, risk-reward corridors do not necessarily protect contractors against catastrophic losses, and *stop-loss protection* is used for that purpose. One type of stop-loss mechanism, a *risk pool*, may be in order when multiple providers serve a limited number of enrollees, and payer and contractors agree to spread some of the risk for excessive and unpredictable expenses over *all the providers*. Other stop-loss mechanisms include *negotiated agreements* between an individual provider and the payer that place limits on the provider's level of risk, and the *independent purchase of insurance* against catastrophic loss by an individual provider. Whatever arrangements are chosen, they must balance the interests of the payer and

the provider and the client. Reductions in cost must not come at the expense of necessary care and/or quality of care.

The length or **duration of contract** is important in that longer timeframes yield relatively greater stability. Although most risk calculations are based on annual utilization and cost information, much longer time periods should be considered, since risk will be lower as patterns of random fluctuations average out over the long term, and longer-term commitments encourage preventive services and foster long-term treatment relationships between client and provider.

The size of the **covered populations** must be considered as it is a major source of risk. The smaller the risk pool, the greater the uncertainty about utilization. Even when a large number of lives is covered, few may be enrolled with a given provider. 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

Some of the factors that may influence risk, 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. Contractors, having assumed a certain level of risk, should be able to implement cost-control measures that can influence and change historical patterns of utilization and administrative processes. Three main strategies for reducing costs are:

- **Reducing the rate of users/1000** — the best strategy is *primary and secondary prevention*. Prevention programs can improve the health status of many members (although certainly not all), thus reducing or eliminating their need to receive other services.
- **Reducing inappropriate use per user** — strategies include: activities designed to divert clients 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. Changing historic patterns of utilization depends on the availability of *effective additional or alternative services*. This may require the investment of funds for developing or purchasing services not already available.

- **Reducing the cost of providing a unit of care** — when a unit cost is too high, managers may take steps to reduce direct costs and reduce or reallocate indirect expenses, thus making a risk-sharing arrangement more acceptable for both the payer and the provider.

The trick, of course, is to achieve these goals without reducing access when it is needed, and without reducing quality and other positive outcomes. Therefore, the measurement of quality and outcome must go hand-in-hand with efforts to reduce costs by reducing utilization.

APPENDIX A

IS MANAGED CARE THE WAY TO GO? DECIDING WHETHER TO EMBARK

BY

SUZANNE GELBER

INTRODUCTION

More and more often, government officials and legislators are debating whether to use a managed care approach in health and human services systems directed either towards special populations or the general public. Managed care systems were originally developed for medical and behavioral health care, but they are expanding rapidly to child and family services, services for persons with disabilities such as retardation, for multi-problem clients, and even for juvenile justice clients. A survey by the Child Welfare League of America found that 82 percent of states are considering or planning to apply managed care principles to child welfare services, such as foster care and adoption. The goals of such approaches usually are to manage or reduce costs, to coordinate care using individually oriented service plans, to create an accountable group of organized delivery systems, to inject a mechanism for distinguishing excellence and inadequacy among providers, and to manage explicitly the quality of care and services provided for the dollars exchanged.

These are demanding objectives. Managed care is not necessarily a magic bullet that can instantly achieve these aims that have eluded public systems for years. Managed care is only one approach, one technology that is popular today. It was developed to better manage medical care. While it may be extended to human services such as child welfare, it may not produce the same results attributed to it in health care. Regardless, one knowledgeable commentator has described the momentum building to incorporate many human services under the umbrella of managed care as "an unstoppable steamroller." While a surge toward managed care and more competition among services *may* yield better outcomes, it may well leave some damage in its wake, particularly amongst our most vulnerable populations.

A variety of models characterize managed care implementation. For example, some states and/or counties have created their own managed human services networks using community mental health centers (CMHCs) or federally qualified health centers (FQHCs) as the fulcrum. Others have chosen to limit the public authorities' role to that of policymaker and quality reviewer. Some consciously adopt private sector purchasing

models, "outsourcing" management and purchasing functions to regional, public-private purchasing consortia selected by states, counties, and/or employers, and often building on earlier moves to privatize service delivery. The possibilities for enhancing coordination and improving accountability for performance have been addressed in many ways in the past. A new development, however, is the reexamination and reintegration of categorical agencies and the blending of their funds and provider networks. To some extent, states with Offices for Children (such as Massachusetts) tried this model years ago on a case management basis; now it is being linked to utilization review and network contracting.

This paper delineates the information and steps policymakers must pursue to assess rationally whether their state, county, or community should implement a managed care approach in systems that serve children and families—and if so, how quickly to proceed. It provides guidance as to how to assess readiness for managed care, including gathering information and mapping the system, appraising internal capacity and using supplementary expertise, and evaluating available financial and system resources. Finally, it poses a variety of alternatives to monolithic managed care implementation that can affect a system's decision to embark on managed care.

GOALS AND EXPECTATIONS

Unfortunately, an intent to embark upon a managed care initiative is too often declared before goals are discussed, stakeholders' divergent interests are resolved, and a set of policies regarding key, contentious issues have been promulgated. The magnitude of the changes involved, both policy and personal, often is not appreciated. The need to involve key stakeholders and participants is frequently ignored, only to surface after a crisis of confidence in governance has occurred. When this happens, often in a rush to implement before funds or political enthusiasm evaporate, the programs that result may be poorly conceived and contentious.

This phenomenon of rushing to change is not new to the public sector. A special challenge, however, lies in the possibility that poor decisions and poor systems may result in litigation. Badly

designed systems can cause great harm to the vulnerable children and families they are supposed to serve, or can create problems for providers, possibly leading to litigation. System users, advocates, or providers who feel that managed care approaches, systems, contractors and/or technologies have been imposed inappropriately and/or have caused them harm might be expected to retaliate by suing the public authorities whom they allege acted without sufficient due diligence.

Delays caused by litigation, whether brought appropriately or inappropriately, may result in delaying the delivery of enhanced services for children and families. Even if the suits themselves prove unsuccessful, they can bring (and have brought) promising managed care initiatives to a grinding halt. Successful suits impose a costly price on individuals and organizations found to be at fault; the required redesign and rebidding of contracts for the initiative is quite expensive as well. Even more important, great and even tragic harm for which no damages can compensate may have been done to vulnerable people. Managed care approaches can succeed only when they are carefully planned and appropriate attention is paid to comprehending and incorporating stakeholders' perspectives and expectations.

The goals of managed care initiatives are complex and not always explicit. The values, the economic stakes, and the political objectives of various stakeholders can be diverse and conflicting. Such ambiguity and complexity of objectives can make it difficult or impossible to tell whether managed care initiatives are succeeding. Policymakers must clearly articulate specific, measurable objectives so that all stakeholders, including the public and the entities selected to manage and monitor the new managed care system, understand how and to what purpose scarce resources will be used and what must be accomplished or avoided in order for performance to be considered satisfactory.

However, policymakers — such as legislators, governors, or county commissioners — first must comprehend *why* things are done in a particular way and *how else* they might be done in order to determine effectively how they should be done in the future. Therefore, we will begin by

identifying some factors that should be considered by policymakers as they set overall priorities and seek to address their many constituents' concerns.

Policymakers trying to consider the “big picture” face many competing priorities. They would want to be sure, for example, that the “overriding goals of protection and permanency” remain the hallmark of the child welfare services system (Institute for Human Services Management 1996) and that the first responsibility of any such system, managed or not, is to ensure the safety of children. Placing a child in foster care or keeping a child at home while a family receives services are choices that must be available in any child welfare system. On the other hand, the choices may be different in the juvenile justice context. Since public safety is a primary goal in this system, intervention may be more oriented towards using a continuum of services, including out-of-home placement in secure programs when that is felt to be necessary for public protection. In a third example, mental health systems tend to feel that treating the child in the home or the community is the most critical goal for children with emotional disorders. These distinctions must be considered flexibly.

The goals and responsibilities of all of the individual systems currently in place will not vanish under managed care. Building a successful managed care initiative requires policymakers to decide how to construct an all-inclusive service system that can encompass them. Each system responds to federal, state, and local decisions and may even reflect court mandates to organize and deliver services in one particular way. Deciding to change such systems simultaneously or sequentially involves reinstalling their objectives in a new way that neither violates legal or ethical responsibilities nor changes their text or interpretation.

Beyond such global concerns, decisionmakers must examine managed care approaches for state and local systems of care for children and families in light of many different objectives:

- Holding down cost increases or absolute spending levels through the use of negotiation, competition, and capitation or performance-based risk sharing.

- Creating a system of continuous care and preventive services that cuts across categorical boundaries and creates multi-source pooled funding for a designated population.
- Improving monitoring of and intervention in the quality of care and services.
- Expanding access to linked services, the ability to link vendor and/or provider performance with compensation, and increasing the appropriateness and utility of services.

Everyone does not subscribe to all of these goals and many would include others on the list, such as protecting consumers' rights more proactively or saving service workers' jobs. Somehow, all of these priorities must be built into any managed care system that seeks to combine and manage each or all of these systems for children and families.

Therefore, prior to beginning any effort to assess systems' readiness to convert to a managed care platform, policymakers must lay out certain essential factors:

- Their vision of an ideal system.
- The current care systems' objectives, current capabilities and weaknesses, and state and federal entitlements and requirements, if any.
- The key characteristics of the political and financial infrastructure supporting the categorical services.
- The costs of the services, and any existing cross-system financing capabilities or obstacles.
- The strengths and weaknesses of managed care techniques and systems.

Policymakers must think through what changing to managed care will mean, theoretically and concretely. Decisionmakers must come to understand how managed care systems work, and how they can fail. They must appreciate what they can and cannot accomplish using managed care approaches and how quickly results reasonably can be expected. If there is a preliminary match between system redesign needs and managed care capabilities, planning a new system can begin. The planning process takes

time but it can facilitate convergence of dramatically different goals and objectives, allowing all parties the space to negotiate and truly buy in to the new system.

For example, an evaluation might determine that the primary problem of a system is that consumers are dissatisfied because the street level staff with whom they come in contact are perceived as rude or ineffective in meeting their needs. This may result from poor training, lack of motivation, or disinterest in or disdain for consumer concerns. Addressing this primary problem may have little to do with applying managed care techniques; on the other hand, if consumer feedback mechanisms are built into managed care from the outset, that might contribute to resolving the problem. However, if the same assessment concludes that the primary problem is a lack of accountability and uneven provider performance, managed care mechanisms such as performance-based reporting and compensation might be very effective in ushering in positive change.

All public agency contracts with private or internal managed care networks should include measurable outcomes (with variables and scoring defined in advance) such as those put forward by the Substance Abuse and Mental Health Services Administration (including its White Paper on Performance Measures and the Center for Mental Health Services Report Card). Both interim (process) measures and longer term client and systems outcomes measures should be included. Grievance and appeal procedures should conform to state guidelines and be comprehensible in reading level and language. All contracts should have a "best practices" focus and reference, updated annually.

ASSESSING READINESS

The political will to initiate managed care usually precedes system readiness. No readiness assessment can succeed without an understanding of the steps involved and the intelligent use of valid data. The steps proceed as follows:

- 1) Identifying, cleaning, and consolidating data on system resources, weaknesses and utilization.

- 2) Clarifying the limitations of data in measuring actual readiness; for example, the age or comprehensiveness of the data may preclude accurate information on which providers are currently in place and which have closed or even died.
- 3) Mapping the infrastructure and organizational components of the current system, including the current system's geographic catchment area.
- 4) Assessing the knowledge base, ability, and capacity of current staff to develop the plan for a new managed care system.
- 5) Identifying personnel, new contractors or entities, technologies, and financial resources that will be needed to implement the new system.
- 6) Evaluating the financial resources available to implement a new system that fills gaps in services, and the sophistication of providers who would participate in the new managed care system.
- 7) Examining the willingness or obstruction to be expected regarding managed care from key stakeholders, and determining whether objections can be neutralized or overcome within the time specified.
- 8) Evaluating legal frameworks (e.g., procurement, federal guidelines, confidentiality, provider agreements).

The information gathering and analytic phase of an appropriateness assessment is both inescapable and expensive. This process of accumulating and digesting data enables the state or county to be informed by an accurate and current understanding of the existing needs and systems and how they interact and are organized. Since human services and health care data are notoriously difficult to collect and interpret, expert assistance is often required to decide what kinds of data are available and valid enough to use, and then to determine what the data mean.

Gathering Information and Mapping the System

The data gathered should give policymakers access to information (minimally) about:

- The population being served (or excluded).
- The providers who serve the populations under study (e.g., claims data), as well as those who could serve them (e.g., who are licensed).
- The administrative managers who finance and monitor service provision.
- The funding stream(s) and cost(s) associated with the current systems.
- Patterns of service utilization.

The long-term starvation budgets affecting most human and health services in the public sector have taken their greatest toll on the most capital intensive investments: management information systems (MIS) and other sophisticated technology. Utilization data may exist only at the facility or program level, rather than for the system as a whole. Information about staff capacity and capabilities requires assessing current data on workloads and examining credentials that may be out of date. Discovering potential contractors, improving MIS capacity, and exploring alternative plan designs and their implications involves gathering information from often unpublished or informal sources at the national, regional, and local levels. It is critical to understand where the pockets of information are and to weave them together to tell the system's complete story. It is also critical to be open to and engage in interagency cooperation rather than competition — for example, to share data, expertise, staff, and/or financing.

For example, looking only at easily available hospital data such as average lengths of stay, admission rates or cost per admission tells a partial story. Policymakers need to understand existing referral and use patterns in the area, to what extent hospital admissions occur because of a lack of residential or outpatient programs, and how often admissions occur after or during outpatient care. But answering the latter question, while it sheds light on how and why providers are used, involves determining a common but confidential client identifier that can track episodes of care by client, or finding another way to link data across systems, manually if necessary. This capability is not built into many information systems.

Similarly, there can be extensive problems with the routine data that are collected: confusion in coding the diagnosis for a discharge is common, making it difficult to separate psychiatric and substance abuse admissions. The extent to which medical admissions need to be analyzed is often not obvious either, and the problems involved in integrating multiple data sets by user or user cohort are not easy to solve.

Many states and counties have data on the same person in multiple health care and human services systems, but they lack the ability or willingness to match episodes of use by client name. The data systems themselves are not user friendly; many are cumbersome, categorical, antiquated, and subject to strict confidentiality provisions. Expecting them to yield useful and usable information sufficient for a complete and unbiased description of current system functioning may be unreasonable, or may require significant allocation of priority and time.

In light of these endemic problems, decisionmakers must provide adequate funding and time for this step. At least they must proceed far enough to decide whether the necessary data exist and simply need to be organized, or whether it is really hopeless to rely on existing data systems. In the latter case, the decision process will be far more speculative, begging for a pilot-site approach that includes gathering information on which to base future decisions. In some places the problem is not insufficient MIS capacity; the capacity may be there but people may not be using it or may not understand it. Building the capacity to utilize information is as important as building information systems.

State and county decisionmakers must determine whether the available staff can address their data and information needs, or whether they must hire additional staff or look to an outside contractor to find, interpret and report the information needed to describe the system. Such a contract, too, must be well thought through.

In one recent state government managed care project, the state determined after much debate and a change in political parties that managed care could introduce positive change in the Medicaid system. A bidding process ensued to identify a

consultant to assist with this profound change. However, the winner proposed such a small consulting budget that it was entirely consumed by the tremendous effort required simply to put together an accurate system description from more than 20 separate sources of data. Once that effort neared completion, the state had to go out to bid again for additional consulting services and a new consultant. The entire process cost more than twice the original estimate and also led to an unplanned 15-month delay that forced postponement of savings and considerable opportunity costs.

Had the state spent more time initially in assessing and preparing its data set, the whole process could have proceeded far more efficiently and swiftly. Consulting fees could have been reserved for the far more challenging project of helping the state to plan a well-engineered service system.

Appraising Internal Capacity and Using Supplementary Expertise

The next questions involve the degree to which internal administrative and technical resources suffice for the tasks to be accomplished. It will be critical to assess skill levels honestly and realistically; failure to do so will lead to excess costs and disruption. Do available staff have the skills needed to implement and manage the type of managed care system under consideration for children and families? Are there sufficient staff internally or through interagency staff sharing who are skilled in designing and negotiating vendor services contracts, managing information systems, or monitoring and evaluating outcomes? Then, to what extent could current staff be trained for new roles in a short period of time, and for which functions does it make more sense to hire new staff or contract for expert assistance and/or technology? Do the public or private providers have the capacity to do multi-year budgeting that would take into account the cost of converting the system, including the cost of retraining workers, converting management information systems, contracting for some services, and putting new services in place?

Many states and counties answer these questions without conducting any assessment, relying on

unsupported assumptions about whether or not they can function as managed care entities or should seek an outside vendor for particular services. However, even a hint that the public sector assumes it cannot perform certain managed care functions internally serves to signal vendors that the time is ripe for seeking business from the state. Vendor staff may besiege startled bureaucrats and decisionmakers with unanticipated proposals, barely veiled inducements, reams of marketing materials and offers to provide "free" consulting services. It is possible that these offers will serve as helpful guideposts in a wilderness of choices. However, there is also the chance that they will lead the state to make choices that benefit mainly or only the vendors.

The decision to bring in consulting assistance should be made only after assessing the capacity of internal staff. The amount of influence a consultant will have, the tasks to be assumed, and the time and money to be spent on consulting services all must be carefully considered and articulated. Failure to do so will result in confused responsibilities, neglected timeframes, inadequate deliverables, and other undesirable consequences.

Prudence in purchasing is always the safest and surest position. In hiring any type of contractor (e.g., as consultants, analysts, or vendors), decisionmakers must ensure that the processes put in place to identify potential external resources lead to the selection of individuals who are truly expert, competent, available and ethical. Designating consultants is particularly sensitive. The supply of consultants with expert knowledge of managed care decisions and methods and children and families is extremely limited, and the group of such experts who also understand governmental operations, resources, and funding streams (and will work for government) is even smaller. State policymakers risk lawsuits if they yield to political pressure to hire "favorite consultants," unless such individuals or firms turn out to be acceptable after an objective assessment of available alternatives.

Evaluating Available Financial and System Resources

Financial resources must also be carefully considered but in such a way that sufficient thought is given to innovative combinations of funding. Historically, service systems have used "silos" of categorical funds that are further divided by purpose into demonstration, research, and block grants; state or county general revenues; and foundation support. Attention must be given to consolidating and restructuring funding streams and service systems. However, sufficient money to meet the needs of clients and systems has rarely been available in the past, and the present and future are equally, if not more, questionable. Koyanagi (1996) and others have raised grave concerns regarding whether governmental appropriations (federal, state and local) will be sufficient even to come close to supporting systems of care for persons in need, regardless of whether they involve managed care.

The amounts of money states and counties can count on is one concern. Another is the permissible uses of funds. Different funding sources currently place different requirements on the use of funds. For example, grant funds distributed through the mental health system may require that systems use them only for in-home services for children with serious emotional disorders. Juvenile justice funds may be earmarked only for residential treatment, whether that is what children need clinically or not. AFDC-eligible children can be supported through Medicaid funds but in some places non-AFDC children may only qualify for such funding if they are placed outside their homes. Needless to say, such restrictions are not common in managed health care systems that function on rational criteria.

State procurement laws may require contracts to go to the lowest qualified bidder or the least expensive of several "equally" qualified bidders. However, there may be subtle but important differences that may be particularly salient for certain stakeholders. For example, one contractor

may be more “client friendly,” while another has a more proficient data system and superior implementation plans.

It is not clear that managed care can be as effective as many assume if these requirements are left in place rather than waived because they contradict notions of “clinically necessary care” that are the basis of managed care protocols. If, as seems likely, federal mandates are restrained and resources migrate eventually to block grants, some (but by no means all) of these restrictions may ease. However, planners will still need to decide how to organize, authorize, and distribute funds. Policymakers will need to assess how much funding they expect and whether managed care techniques can be implemented adequately, given expected funding levels. This is a major issue that has derailed many hasty managed care initiatives.

The capacity of the service system to meet the needs of clients must be considered in relation to the funds that will be available to pay for those services. There is no point in planning an elegantly designed system if the providers who must offer newly linked services lack sufficient resources or sufficient understanding of managed care techniques to ensure their willingness and ability to participate. Any thorough assessment of readiness and appropriateness of managed care, therefore, must include an objective analysis of the strengths and weaknesses of care providers, many of whom may be unrealistically positive or negative about their ability to change their historical operating patterns.

This dispassionate assessment should address whether providers have the following systems in place and know how to use them:

- Adequate network capacity to assure clinically appropriate levels of care and timely referrals;
- Protocols for clinical and service level decisionmaking (few of the latter have been developed or standardized);
- Financial and administrative systems and personnel to handle capitation, risk sharing, claims preauthorization and/or payment, and performance standard reporting;

- Credible audit and quality management systems and staff;
- Culturally sensitive education and outreach systems to assure that consumers understand the services and how to access them;
- Systems to train and evaluate managed care providers and practitioners; and
- Outcomes analysis, research, and management information systems (MIS).

If only some of the above prerequisites are present and adequate, policymakers must decide whether it makes sense to invest in bringing the inadequate components up to speed and in what period of time. The providers themselves cannot be relied upon to make such a decision, as it represents a conflict of interest. This kind of assessment may also require outside consulting analysis and should be integrated into any consulting proposal.

Involving Stakeholders

Even if all other conditions for managed care readiness are met, resistance among stakeholders, such as clients, advocacy groups, and providers, can stymie a decision to move toward a managed system of care. Policymakers are, therefore, well advised to involve stakeholders in the process of assessing a system’s readiness for managed care. Numerous ways of obtaining stakeholder participation in managed care readiness assessments can be employed, such as:

- Representation of stakeholders on bodies charged with assessing the system’s readiness.
- Holding public hearings throughout the state, inviting testimony on the system’s/clients’ readiness.
- Surveying key stakeholders on their assessment of the system’s readiness.
- Having stakeholders review and contribute to proposed RFP or contract language.

Soliciting stakeholders’ opinions about the system’s readiness will not only provide valuable insight into what obstacles must be overcome if a successful managed care system is to be implemented, but it will also identify areas of potential conflict. Unhappy stakeholders have

been known to pursue legal means of fundamentally changing or delaying managed care initiatives. Policymakers aware of areas of contention at an early stage can plan to work with stakeholders to satisfy their concerns, whether or not managed care is ultimately pursued.

A Checklist for Overall Readiness

Policymakers may want to make use of the checklist below to assure themselves that they have done a thorough job of considering the appropriateness, capacity, design, and implementation issues. It is easy to neglect or be unaware of design alternatives and it is very important to be as certain as possible that choices have been made with full knowledge of possible consequences and of alternatives. Policymakers need to be able to make most, if not all, of the assertions on the checklist in order to have a reasonable chance of success in restructuring their system. Insufficient information to make an assertion suggests the need to postpone a decision about managed care until that shortage can be remedied.

While many of the checklist's statements relate to issues of managed care implementation, policymakers will need to think through these issues as part of the process of deciding whether to embark on a managed care system. Only by pondering what implementation requires can policymakers truly assess if their system is ready for managed care. This checklist is designed to expose policymakers to the complexity of managed care initiatives *before* a decision is made. (Each statement on the checklist is a simplification of the depth of examination required. Following the checklist, an example is provided.)

- ☒ We have determined through careful data collection and analysis that the weaknesses and configuration of the current service system for children and families can be improved through using managed care approaches.
- ☒ We have considered a range of managed care approaches and designs with the best available knowledge of their financial, political, clinical, and administrative

implications and have decided that a given managed care approach or set of approaches will work best in our particular circumstances.

- ☒ We have made all of our decisions using the best possible expert advice/oversight from individuals with the knowledge and experience to steer us appropriately and ethically.

- ☒ We have specified how and to what extent consumers, family, and community groups will be involved in deciding on, managing, and implementing the managed care restructuring we are undertaking.

- ☒ We have determined with whom sponsorship of and authority/liability for the new system will rest and how that entity will be accountable to the public, both on an individual and system-wide basis.

- ☒ We have agreement on the population(s) to which managed care techniques will be applied.

- ☒ We have decided which techniques will be applied to which population(s).

- ☒ We have agreement amongst all agencies (including purchasing offices) and funding streams involved that the system changes we are planning are appropriate, feasible in the timeframe elected, and that all possible negative consequences have been anticipated and planned for to the extent possible.

- ☒ We have determined that existing or expected financial resources are at least adequate to carry out the scope of changes that is planned or that we have contingency plans to limit scope through the use of demonstration and pilot sites if resources are inadequate.

- ☒ We know who will pay for the system, how much is due, and with what mechanisms and frequency payments will be made. Our MIS is capable of monitoring the flow of funds.

- ✓ We have decided how clinical and financial risk will be handled (i.e., reinsurance, capitation, performance standards, grievance mechanisms, and so forth).
- ✓ We have a reasonable assessment of what we will spend and what we will save.
- ✓ We have determined that we either have, can build quickly, or can contract for the vendor capacity to manage and monitor a managed care system combined with likely restructuring of services and funding.
- ✓ We have decided who will administer and who will evaluate the system.
- ✓ We have criteria in place to evaluate and guide implementation.
- ✓ We have communicated beforehand clear evaluation criteria that we are capable of measuring at predetermined points during implementation and operations.
- ✓ We have determined how, by whom, and using what competitive processes managed care will be purchased (i.e., through a purchasing sponsor, a state agency, or a consortium of funders).
- ✓ We have considered how to identify potential bidders and how to conduct a fair and open bidding process that will withstand court challenge. We have determined upon what basis entities will be eligible to bid, whether or not they are existing state agencies. We know how we will select the winning bid and how we will conduct financial and operational negotiations and we have staff or consultants in place to help us.
- ✓ We have demarcated the timeframe for this change and determined whether or not it will be phased in, at first applying to just a few regions.
- ✓ We have assurances from all parties involved that the timeframe proposed is at least feasible, even if challenging.

- ✓ We have adequate contingency plans to deal with obstacles.

An Example: Evaluation. Consideration of each question may entail exploring multiple levels and decisions. An example follows, to illustrate the complicated nature of deciding upon and designing a managed care system, even when the team of policymakers is well prepared. The more specific the questions asked in addressing each issue, the more likely that the state or county as purchaser will be able to determine appropriate and feasible responses. Decisions to embark that are based on data and clearly specified objectives are both defensible and most likely to yield positive results in the short and longer terms.

The complexities of determining who will evaluate the managed care program and under what circumstances can serve as a good example of the levels of decisions often involved. General issues come first. Policymakers will need to decide who will be responsible for undertaking and managing the evaluation and what assistance will be available to help the evaluators to understand the project and to properly couch their findings. This first decision takes policymakers back to goals and objectives. If the evaluation is to serve as the basis for deciding on performance based risk sharing, for example, it is especially critical to decide if in-house staff, external consultants, or a task force combining the two, will attempt the analysis. Findings that are negative may well be disputed, requiring arbitration mechanisms. The evaluators must be extremely skilled and accurate in their observations and conclusions because of the likelihood of challenges. The evaluators will need access to timely and reliable information, program staff, and the perceptions of participants. Access will depend heavily on the respect accorded to them as unbiased experts.

Evaluators may be chosen through competitive bidding. In this case, criteria for their selection must be available beforehand, in addition to the criteria they will be expected to use in their study. Timeframes must be clearly specified so that results are timely enough to be of use in program enhancement and refinement. Funders may expect that they will have the ability to influence the way in which the evaluation is conducted, who conducts it, who interprets it, and what

consequences it has. The scope and limits of such influence must be clearly understood.

Process questions must also be addressed or delegated. For example, what will the methodological approach be? What instruments or data sources will be used? How will data be analyzed and by whom? How will confidentiality be assured? How will valid and reliable surveys or audits be conducted or integrated into the evaluation? Answers must be found also for the extent to which consumers/families will be involved in designing, implementing, participating in, interpreting and disseminating the results of the evaluation.

Probably the most difficult questions will involve decisions to be made ahead of results, such as what rules will apply if results are ambiguous, contested or exceedingly negative or positive, particularly if financial rewards or penalties are at stake. Exactly what type and level of negative findings will trigger program change, reconsideration, or even discontinuation? Clearly, if the evaluation has such serious consequences, there may be pressures to come up with positive findings. (A decision may be made to treat evaluations as advisory only.)

In the case of one large managed care initiative undertaken by a non-profit insurance carrier, evaluation was the cornerstone of very substantial financial incentives. Results were often ambiguous and the consequence was audits that had to be repeated three times until challenges were satisfied. Decisions about who the final arbiter would be shifted constantly and caused repetitive rounds of reanalysis that cost the carrier a great deal of money, delayed payment of bonuses to the contractor, and ultimately resulted in changing the contractor, who is suing the carrier for abrogating the contract and drawing all of those involved into a tedious lawsuit.

MAKING THE DECISION

Ultimately, deciding whether or not managed care is the right or wrong choice is the most critical decision to be made. For managed care to be the "right" choice, some minimum standards must be met. Baseline assessments must have shown that managed care can redress system weaknesses and that resources are either relatively sufficient or

can be enhanced adequately within the timeframe proposed. Policymakers must have determined that the managed care techniques to be applied can be carried out appropriately and will not produce untoward and unforeseen consequences such as suicide attempts and/or embarrassing litigation. Realistic, staged performance expectations must have been established and systems must be in place to measure their achievement.

The system's state of readiness is not likely to be uniform. Therefore, the managed care decision need not be a "yes or no" proposition. There are options that can match managed care implementation to the system's level of readiness, allowing parts of the system or state that are more ready to proceed more quickly. Decisionmakers will want to consider questions about phasing in managed care, such as:

- Should the managed care initiative be implemented as a pilot, a series of comparable demonstrations, or system-wide? If system-wide, can it be phased in by region?
- Is one part of the state or county more prepared than others, having a full complement of providers who can function along managed care lines?
- Should certain regions or populations be covered with special pilots or demonstrations, phased in consecutively, or entered into the equation all at once?
- Should implementation wait until all desired locations or populations are ready to participate or should it begin in the most well-prepared sites or populations first?
- Should certain providers be mandated or given special participation consideration even if they are unready because they comprehend and have experience with a particularly difficult subpopulation or because they are the most culturally appropriate? If not, what will happen to these providers? Will they be given a timetable to meet in developing managed care capabilities and will the entire system await their entry?
- Should subsidized or free technical assistance be given to designated community-based providers in order to bring them to the point

where they can participate fully? How much help should be made available and for how long? At what point does the probation/preparation period end and how should this be factored into the financial risk sharing embedded in the system?

- Should risk sharing precede full-risk capitation so that providers and MCOs have a chance to learn how to work together?

CONCLUSION

The adoption of a managed care approach to services for children and families may in the end be the right decision. However, without rational and valid consideration of the purposes it is to serve and whether or not managed care is the right course to follow, the results are more likely to be equivocal or problematic than to be positive. The processes and issues described in this paper require a significant investment of time and energy. However, failure to confront them may cause delay, dissatisfaction, and even tragedy as the project is implemented. Success depends on an initial decision set that delineates specific and measurable objectives through data-based planning and feasibility analyses.

It is troubling that the rush to managed care often has literally been a rush, with some programs covering large and complex-need populations (such as Medicaid) being converted to managed care by fiat, or "outsourced" to an eager private vendor in six months or less. Little consideration may have been given to the impact of such a comprehensive change, to whether or not managed care is the appropriate vehicle to carry out certain kinds of changes and reforms, or whether there really is a good match between the problems identified and the solution proposed. Especially because the populations involved are so vulnerable and because certain kinds of decisions entail potential conflicts of interest both ethically and financially, this hastiness carries grave risks.

If the difficult decisions discussed here are understood, made, and made well, and the result is a decision to proceed with a new managed care approach, the challenging task of planning, designing, and implementing the new system can begin. Understanding that managed care is not a

monolithic system, but can be tailored to meet the idiosyncratic needs of each system is a step toward designing a system that can meet the needs of vulnerable children and families.

REFERENCES

Child Welfare League of America Managed Care Institute. 1996. *Survey on Managed Care and Child Welfare: Preliminary Draft*. Washington, DC.

Institute for Human Services Management. 1996. *Managed Care and Child Welfare: Are They Compatible? Conceptual Issues in Managed Care for Child Welfare*. Bethesda, MD.

Koyanagi, C. 1995. Remarks to the Partnership for Change Conference, Washington, DC.

Pires, S.; et al. 1995. *Health Care Reform Tracking Project: Tracking State Health Care Reforms as They Affect Children and Adolescents with Emotional Disorders and Their Families*. Washington, DC: Human Service Collaborative, National Technical Assistance Center for Children's Mental Health; Tampa, FL: Florida Mental Health Institute.

APPENDIX B

**DESIGNING MANAGED CARE
ALTERNATIVES**

BY

SUSANNA GINSBURG AND SHARON CAROTHERS

INTRODUCTION

It is one thing to decide to use a managed care approach to the financing and delivery of services but quite another to determine which of numerous possible alternatives should be used in developing and implementing an actual program. The elements of a number of alternatives are delineated and discussed, with the primary focus placed on the period that *follows* a decision by policymakers that a managed care approach will be used in a system that serves children and families. The intent is to help the officials who will implement that policy decision to identify and explore the aspects of each alternative that will facilitate the success of their programs. Examples are drawn from the experiences of public programs, primarily those providing for the physical and behavioral health needs of Medicaid-eligible populations. The summary checklist provided at the end of the paper summarizes the issues discussed and may be a useful reference while reading the paper.

As discussed in the introduction to this report, "managed care" is a term with many definitions. In health and mental health service systems, the term usually indicates the use of any of an array of techniques intended to meet the broad policy goals of improving service delivery to an identified population in a cost-effective manner. When managed care initiatives are developed for more inclusive child- and family-serving systems, the additional policy goals of providing children with safe and permanent homes, as well as protecting the community, must also be addressed. This is of particular importance when the state, serving in *locus parentis*, is operating in a strict framework of legal and moral obligations.

Many public initiatives began in the health and mental health arenas reflecting states' perceived need to reduce (or at least contain) costs. Those managed care initiatives have often been part of a larger health care reform strategy. At present, there is an increasing interest in expanding the application of managed care techniques to a range of systems that provide human services for underserved and vulnerable populations. Consequently, the approaches and techniques discussed below need to be evaluated for their utility in child welfare and other family-serving systems.

States have developed a variety of approaches to meet their goals, including redesigning the financial aspects of existing programs; redefining the eligible populations and the services they are eligible to receive; developing new relationships with providers and delivery systems; and employing managed care organizations (MCOs) to handle many functions that were once performed by the public sector. Much of the experience of both states and MCOs has been gained in projects conducted under Medicaid waiver authorities. Waivers have allowed states to alter their usual way of doing business. At least thirty-nine states and the District of Columbia have used them to assign more than three million Medicaid-eligible people to primary care case managers. Twenty-four states have placed more than three million people in managed care programs that may entail capitation payments and shifting of risk away from the states (IHPP 1995). The discussions which follow often reflect states' experiences in this area and only raise the implications or issues for child welfare. Efforts have been made to identify child welfare related experiences to the extent that such information was available.

AFTER THE DECISION: HOW TO PROCEED (BROAD ISSUES)

Once the basic decision has been made that a managed care approach will be designed for a publicly funded program, state agency officials must address a series of broad (and interrelated) questions that have no right or wrong answers. Rather, each state's decisions will need to reflect its policy objectives, philosophy, and the existing capacity to both manage and deliver services. The transition to a new system is a complex process, and the costs and time involved in transitioning to managed care are often underestimated (GAO 1995). The success of the initiative may be strongly affected by the state's ability to invest its time, energy, and funds in adequate planning and infrastructure development.

Roles and Responsibilities

What is the role of the public entity? Other papers in this report have addressed the responsibilities of the public sector and the issues officials will want to consider in deciding to embark on a managed care initiative. Now, in the design phase of the initiative, the public entity

must be clear about its overall role as a decisionmaker, and it must determine which specific functions it will perform, delegate to others, or contract out. No matter what managed care model is selected, and regardless of which functions are contracted, the public sector will be held accountable for results. Therefore, certain ultimate responsibilities will remain with public officials. These include:

- setting program requirements, such as deciding who is eligible to receive services and what services to include in the system of care;
- setting standards and developing criteria that help to ensure that public objectives are achieved (e.g., provision of culturally competent services, emphasis on prevention);
- assuring adherence to population-specific entitlements;
- setting payment rates for services rendered and/or outcomes achieved;
- deciding how quality will be assured; and
- determining how programs will be monitored and what data will be collected to ensure the adequacy of the service system and the proper use of public resources.

Which state agencies and programs should be involved, and how will this be accomplished?

Two sets of state agencies (service and finance) are likely to be involved in the early stages of program design. The service agencies may not have a history of common endeavors, and it is likely that the service and finance agencies have not done extensive design work jointly. Agencies that deal with finance and budget will determine which funds will be used, and perhaps whether money will be targeted toward particular populations and issues through the development of specialized systems (e.g., carve outs for behavioral health care). Since children and families vary in their service needs, an array of service agencies may be called upon to contribute ideas and information. Depending upon the specific client populations and their specific service needs, an initiative may bring together agencies responsible for mental health, substance abuse, public health, maternal and child health, child welfare, juvenile justice, and education, and

perhaps other agencies as well. However, given the current level of fragmentation among children and family service systems, this level of collaboration presents significant challenges.

The state must determine how to bring all key agencies to the table, the nature of the relationships among them, and the contributions to be made by each player. Pooling, or "decategorizing," funds by placing money from a variety of child-serving agencies into a common pot is being pursued by a small number of states, and it may be a critical issue as states increasingly explore the applicability of managed care to child welfare and other child-serving systems. Decategorization may be a useful tool for reducing overlap and duplication of services, and may even allow the flexibility to pay for services that are an authorized use of funds from one source but a prohibited use of money under the rules of another. However, these very differences may be related to divergent agencies' responsibilities and authorities that must also be considered in designing a program.

How are stakeholders involved in the process?

States will need to consider carefully how to obtain input into the design and early implementation of a managed care initiative from consumers, families, and current and potential contractors and providers. A variety of approaches can and have been used by states including focus groups, surveys, public hearings and forums, and developing task forces or committees with broad representation. While experiences to date do not provide sufficient evidence of best practices, what is clear is that stakeholder inputs and interests are critical to the successful implementation of a program.

The actual approaches used may vary depending upon the particular state's environment and relationships with and among stakeholders as well as approaches to involving specific stakeholders. For example, the Pennsylvania Family Service System Reform Initiative established county-wide collaboration boards to ensure broad input. These mandated boards are made up of consumers of human services (e.g., parents, grandparents, extended family, children), representatives of community groups (e.g., churches, volunteer organizations, grassroots services agencies), and representatives of public agencies (e.g., school

districts, municipal health departments, juvenile courts). The board must guide the development and monitor the responsiveness of the local program.

In some cases, key issues involve the need to work closely with providers and related agencies to ensure that they have a seat at the table and are able to participate adequately in the planning and implementation process. Providers will undergo significant changes in conceptualizing their roles in the "new" system, which will also mean changes for their clinical, fiscal, and administrative operations. Recognition of this impact on providers may be important to ensure that there is an appropriate and adequate service delivery system for the managed care initiative. The state of Vermont experienced considerable delays in implementation when it was unable to find a managed care entity with which to contract for its 1115 waiver program. In several states, the initial Medicaid RFP for managed care organizations had to be rewritten because the state did not involve managed care organizations and providers in its development. In Pennsylvania, this actually resulted in a lawsuit by hospitals and consumer advocates.

Such consideration must take into account the potential and actual changes that may be occurring in the provider community. Proposed shifts to managed care may create opportunities for new partnerships among provider entities and may also stimulate dialogues within the provider and consumer communities as well as new strategic alliances. The state should examine its policy objectives and the anticipated impact on the nature of the delivery system as it designs its programs.

In the child welfare world, this may require significant efforts on the part of public purchasers of care to help stimulate the development of integrated systems of care. For instance, they may wish to support and partner with non-profit community-based agencies that are interested in developing relationships to ensure seamless systems of care for the children and families they serve. Such efforts have been encouraged in the health sector by the Federal government and its Bureau of Primary Health Care grants for Integrated Service Networks. The funds available through these grants were designed to assist

community health centers to develop the appropriate networks to ensure adequate services for enrollees in Medicaid managed care programs.

Taking Stock

What are the administrative resources and resource needs? A shift to managed care can often strain limited administrative resources and infrastructure. Public officials will need to assess and perhaps enhance internal resources to ensure that they are sufficient to plan, administer, and oversee a managed care initiative. Experienced staff must be put in place at all levels, including skillful contract negotiators, project managers, utilization reviewers, alternative dispute resolution specialists, and information specialists. These staff may be even scarcer for child welfare or juvenile justice than for health or mental health agencies. If highly sophisticated information systems are not already available, they must be developed to assure that the new system is properly designed to meet public policy objectives and that it can be monitored to ensure that it achieves acceptable outcomes.

Some states have experienced major problems when programs were initiated before the necessary infrastructure was in place. For example, one state launched its statewide Medicaid effort without ensuring that it had adequate staff and without having an information system in place. As a result, determining whether the project is meeting its objectives in regard to cost containment and access to care has been difficult. In the absence of necessary data, the state has not been able to provide its MCOs and providers with feedback that could lead to improvements in policies and procedures. Other states report similar experiences. Infrastructure issues include development of: adequate information systems (software, hardware, data collection); appropriate linkages across state agencies and with provider entities and MCOs; regulatory systems for such areas as licensure, grievances, monitoring and enforcement of standards; and adequate trained personnel to implement and administer all the requirements.

Experience with public managed care initiatives has highlighted the gaps between public agencies and managed care entities with regard to information systems development. While not all

MCOs — especially new organizations developed in response to public managed care initiatives — have well-developed information systems, the private organizations have generally been far ahead of public agencies in the information technology arena. There is a need for states to critically examine their information systems, including new developments in both child welfare and mental health¹ to determine what is needed and how to ensure that development of such systems can be funded and put in place in a timely fashion. For example, by the end of the first year of implementation of Hawaii QUEST, its 1115 waiver program, the state was still in the design phase of its data system. Limited information was available for decision-making at the state level or even at the plan level, raising significant issues for the management of the program.

What are the service system's resources and resource needs? The state must assess external aspects of readiness, as well as its own internal capabilities. Attention should also be paid to the possible strain involved in staffing oversight functions (as well as start-up functions) as new programs are phased in. Is there sufficient program capacity, or must capacity be developed? Is computer capacity adequate? Are programs and services accessible and acceptable to the communities they will serve? What incentives can be built in that will lead to expansion of programs and services as they are needed? Who are the current providers of service, and how can they be included in the revised system? How are programs and services financed now, and how can a variety of funding streams be organized or combined to meet the objectives of the new policy? Will more money be needed to provide or adjust payment rates for increased services that will now become available to historically underserved clients (CWLA 1996)? What training and technical assistance is needed to help providers (especially publicly supported "safety net" providers) and other stakeholders, including the government, make the shift to the new way of doing business?

Public officials addressing these questions may find it helpful to draw on the knowledge and expertise of a variety of collaborative initiatives that are already underway in many communities. For example, the decategorization project in Linn County, Iowa, has used pooled funds to educate

the community about the "decat" vision, to provide grants for prevention and early intervention services, to fund new services such as an intensive supervision program to track and monitor high users of services, and to begin a performance management system.

What financial resources will be utilized? Two separate issues are included for consideration here: the resources needed to prepare for a managed care initiative, and the resources that the managed care initiative will need in order to serve its clients. Although managed care approaches may help to contain the costs of providing services, starting such a large and complex program will require an initial investment of capital. The public agency's in-house needs have already been discussed in regard to enhancing current systems and preparing staff. The Child Welfare League of America (1996) also identifies capital to reengineer services as a start-up investment need. Agency endowments, if available or attainable, may be utilized in addition to public dollars. Start-up funds may be drawn from general tax revenues or other sources identified by public officials, although this is not occurring widely at this time.

Once these initial investment needs have been addressed, officials must turn to the funding of the new programs. Managed care techniques are just beginning to be applied in child welfare systems and other systems that serve large numbers of children and families who have a variety of urgent and persistent needs. Since many agencies participate in addressing the needs of children and families, various funding streams may be considered by state officials as they look for ways to finance a managed care initiative. It has been suggested that no financial strategy can work for children and families in the absence of decategorization. One such effort, the Iowa decategorization initiative mentioned above, brings together nine sources of funds into one pot of money that can be redistributed to meet the specific service needs of an individual youngster or family. Iowa's program combines money from group and family foster care, day care, and juvenile justice services into a single pool of funds for child welfare services. Incentives are built into the system to use unspent dollars to expand and enhance services. Another example of the blending of funds is the Family and Children First

(FCF) program in Hamilton County, Ohio, which intends to use multiple funding sources to serve youth over the age of eight in the least restrictive settings possible. FCF is a collaborative project of six public entities and the United Way, and it is set up as a private, not-for-profit MCO. The county's Department of Human Services provided start-up funds, and collaborating agencies will contribute the cost of the services provided to their own clients once that dollar amount has been determined.

Current state experiences with managed care highlight the considerable need for investments in the system in order to adequately implement and administer managed care initiatives. The public sector faces many challenges in addressing the investment issues involved in ensuring adequate infrastructure as well as potential service expansions. The basic business dimensions of investments, risk taking, profits and losses are not easily translated from the private to the public sector. States have generally operated their programs on a state budgeted and federal or private grant basis. Consequently, the state must review the implications presented by the risk-taking approach of managed care, both for the public entities involved as well as for the traditionally non-profit provider communities. Critical issues will include: determining whether and how public entities are involved in risk arrangements; identifying the potential sources for investment; determining the nature of relationships between public and for-profit entities; defining contract arrangements with public and private entities that define how "profits" can be used and "losses" covered. Legal, regulatory, and political issues in these areas may be highly complicated and will vary from state to state.

How quickly can a managed care program be put into place? Once a program has been designed and approved, state implementing officials must determine when and how to put it to use. Whether to phase in an effort by geographic areas, by population groups, or by sets of benefits should be based on the assessment of existing capacity at both state and provider levels. Some states have found it easier to start a fully capitated risk program under Medicaid waiver for a well-defined population in an area where managed care capacity is already established. Other population

groups are accepted later. This has been the case with children's services, typically added in year two or three of a demonstration, which helps to explain the delay in these issues reaching the public agenda. In other cases, states have begun with relatively minor changes, such as primary care case management (PCCM), in order to gain experience in managing care. After a while, they find they are comfortable with moving into capitation, which requires more extensive managed care expertise.

One example of step-by-step change is Pennsylvania, which established a statewide PCCM model of managed health care under a Medicaid waiver. This Family Care Network serves 340,000 children in 60 counties, and most children who are eligible for medical assistance are included in the program. The state's new HealthChoices model is intended to provide *all* needy children with both health and behavioral health services through separate managed care programs, which will be capitated. North Carolina's Carolina Alternatives is another example of a Medicaid program that is moving slowly into the management of behavioral care, beginning by conducting utilization review to reduce inappropriate placements. Section 1915(b) waiver authority will then be used to establish a more comprehensive managed care effort.

AFTER THE DECISION: HOW TO PROCEED (DESIGN ISSUES)

Many tools are used to manage care, risk, or both. As Exhibit 1 illustrates, risk management and care management must themselves be balanced with care if a program is to succeed (Ginsburg 1995). A number of critical factors must be addressed in designing managed care alternatives. Although much experience has been gained in programs that address physical and behavioral health care, specific issues for systems that serve children and families will also be identified (CWLA 1996). The balance between managing risk and managing care is a difficult one, as demonstrated in the number of activities that address these objectives. In the earlier stages of managed care, the "balance" tends to be focused on managing costs, since this is often the primary policy objective driving the initiative. As managed care systems mature, more attention begins to focus on managing the care, and thus the scales may tip in

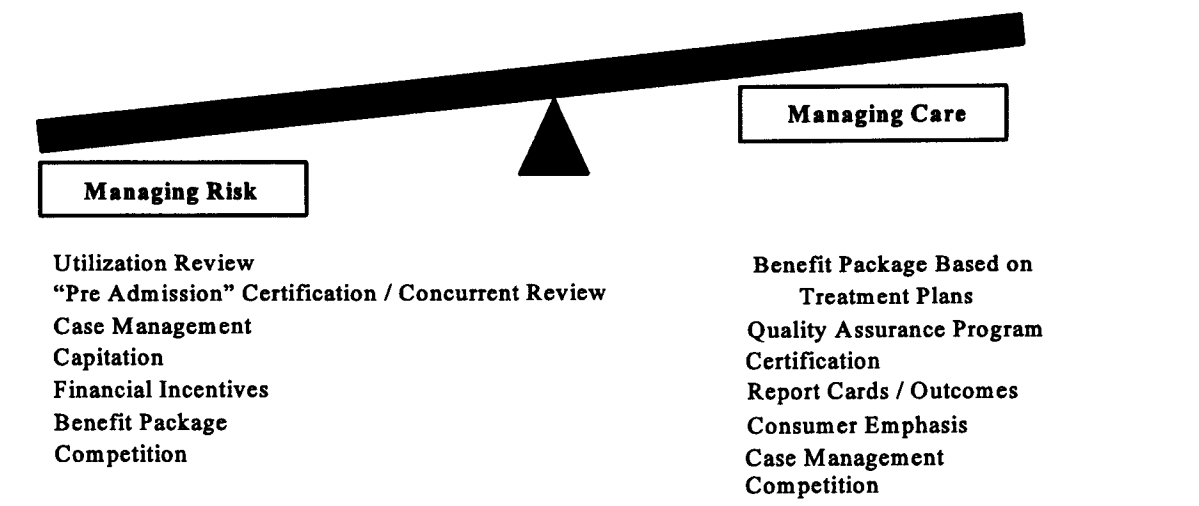
that direction. The discussion which follows reviews many of the design issues that are involved in the development of a managed care initiative. The dual objectives of managing care and managing costs underlie the decisions involved in selecting among the choices and should be dealt with explicitly by policy makers and program developers so that unintended consequences are minimized.

Defining and Enrolling the Eligible Populations

Program designers must pay careful attention to the population that will be targeted for inclusion in a managed care initiative. The nature and size of a population, its service needs, and its experience in service utilization must be estimated

as accurately as possible so that the potential size and cost of the proposed effort can be projected. States can use this type of information to determine which groups to include or exclude in a particular initiative, as well as to ensure that any program that is designed will be culturally competent and structured to meet the needs of its clients. They can also tailor the enrollment process to address characteristics and issues related to distinct populations. Issues in defining the eligible groups and phasing of enrollments include development of risk pools (Broskowski 1996) and the determination of the benefit package, discussed in the next section. Special issues and service requirements for the child welfare population may have to be considered in determining whether to separate such groups of eligibles as foster children or court-ordered adolescents.

Exhibit 1: The Balancing of Managing Risk and Managing Care (Ginsburg 1995)



Who will be included? States and localities have taken various approaches to determining who is eligible to enroll in their managed care programs. Most states involved in Medicaid managed care initiatives examine who is currently eligible for Medicaid and determine whether to expand the eligibility criteria and whether to limit the managed care initiative to a subset of the eligibles. For child welfare, however, the decision focuses more on an analysis of the situation through which the child or family comes to be seen as needing service, and on an assessment of the system's capacity to provide the necessary services.

The first analysis, therefore, looks at the child within the context of the family, and requires that the state determine what constitutes a "family" for purposes of the managed care initiative. An important element of this determination may be the way in which a child is brought to the attention of providers. Was the child's "eligibility" based on specific illnesses or conditions they may have? Was it the result of their behavior? Was it a consequence of things done to them, such as abuse and abandonment? Eligibility may be highly complicated and require an array of resources to determine not only an individual child's eligibility, but also that of the family. Eligibility determinations may also affect the nature of the services included. For example, the inclusion of children with dual diagnoses, such as mental health and developmental disabilities or physical illnesses and mental health problems, has major service and benefit implications.

When assessing whether a system will enroll a particular child, it will be noted that some systems, such as child welfare, already attempt to work with the entire family. Where this goal is realized in practice, parents may receive services in this type of family-focused system, although the child may be the individual whose problem brought the family to the attention of the agency. Other systems, such as some school health clinics, may identify the child as the patient and have no interaction with the parents.

Once determinations about eligibility have been made, officials still must choose whether to permit all eligible persons to enroll

immediately, or whether to omit some of them from initial enrollment but allow them to enter on a phased basis over time. Or they may decide to exclude them from the overall program while developing separate approaches to meeting their needs (such as through carve outs for children with special health care needs or people with AIDS).

Differing approaches to meeting the needs of a challenging population are illustrated by some examples related to children in foster care. Many foster children have chronic and serious health and mental health problems, as well as high levels of social service needs. They and their foster families are often highly mobile, and providers are often reluctant to take on the paperwork and potential involvement in adjudication proceedings that may be encountered when working with foster children (Halfon and Klee 1987). Pennsylvania has approached this in its PCCM-model Family Care Network by excluding foster children and paying for their health care on a fee-for-service basis. Its HealthChoices program, however, will begin to accept foster children after an initial period of exclusion. In 1976, Baltimore, Maryland established a separate health maintenance organization (HMO) for children in foster care. This approach was successful for a time due to strong support and cooperation among health care providers and social service agencies (Halfon and Klee 1991). North Carolina's capitated program in Mecklenburg County includes foster children at the option of the DSS and the family; decisions are made on a case-by-case basis.

How will they be enrolled? Issues related to enrollment of publicly supported populations are different from and often more difficult than enrolling commercial populations in managed care. Enrollment may require providing eligible individuals with appropriate information so that they can make choices where such choices are available. Approaches used by existing public programs have varied from contracting out with private entities (enrollment brokers) to conducting all activities "in house" under the aegis of the state. Some states have allowed the MCOs themselves to conduct outreach (marketing) and enrollment. The physical location of eligibility workers must also be

considered in examining enrollment issues. Can they be “out-stationed” at key provider sites or in other areas that are accessible to the population?

These issues are important and need to be considered in terms of both resource availability and the characteristics of the target population. People must have access to sufficient enrollment information that they find acceptable, as well as to workers trained in the enrollment process. A problem arose in one state when its 1115 waiver program expanded Medicaid eligibility to new groups, but no specific new resources had been developed to handle the increased number of applications from people wishing to enroll. As a consequence, enrollment, and therefore receipt of benefits, was considerably delayed.

The target population’s needs and the service system’s capacity are key issues that must be reflected in the enrollment process and marketing information. Translating materials into various languages and using non-written approaches, such as presentation at community events and use of outreach workers, need to be considered. Literacy and readability are also important issues. A significant percentage of the population has difficulty reading written materials, and this group is more likely to be poor, less educated, and less healthy (JAMA 1995). States may wish to develop specific regulations regarding the nature of permissible marketing activities for MCOs. In addition to providing some specific guidelines on marketing activities, such as whether or not sign-up incentives are permitted, some states have actually prohibited any direct marketing by the MCOs. In those cases, the state or its enrollment broker provides the enrollee with marketing materials on all the available plans. Unanticipated issues, however, have occurred when public program marketing is highly restricted. For instance, MCOs that also have commercial plans are able to market their commercial products and achieve some name recognition among the public program eligibles at the same time. This is often seen as an unfair advantage for these MCOs.

Some clients receive information about the plans or providers they may choose but do not

make a selection. In that case, there is usually a “default” process by which the person (or family) is assigned to a plan. Different approaches to the assignment process may be taken, such as the use of a rotation list or assignment to the least costly plan.

Arrangements for consumers to change providers or plans, or to disenroll altogether (if that is an option), also need to be built into the assignment process. Generally, provisions are made to restrict the number of changes that can be made without justification. Client grievance and appeals processes must be set in place at the MCO and state levels to provide opportunities for clients to have their concerns with either procedures or care addressed.

Reports from states with implementation experience indicate that there is a need to more adequately address the issues of provider and consumer education. This is particularly critical because success of a managed care initiative is dependent upon appropriate changes in the behavior of both providers and consumers. Providers need information on the program requirements and adequate feedback, while consumers need information on how to use the system. Effective education involves multiple approaches to providing information, a variety of formats, and frequent opportunities to reinforce desired behaviors — such as an emphasis on prevention and compliance with treatment/service regimens. Procedures to ensure feedback from both consumers and providers are also needed, including opportunities for suggestions and opinions as well as grievances. Satisfaction surveys by providers, plans, and the state, as well as review and analysis of reasons for plan and provider switching, are useful mechanisms for feedback. Grievance procedures provide a more formal mechanism and need to be developed at the provider, plan, and state levels.

Defining the Benefit Package and Designing the Service System

Developing a benefit package is a complex and potentially explosive activity. It was a notable problem area in the Clinton Administration’s national health care reform effort, and it has been a major issue in states as well. Consumers and providers have great interest in what will or

will not be included in a benefit package. Clearly, the basic underlying principle for determining the scope of the benefit package should be the needs of the target population in the context of the available resources. The services that are required to address the identified needs can be considered for inclusion in the benefit package, and those services that are excluded from the package will need to be addressed in other ways.

What services will be provided, and how will need for them be determined? The state, as planner and payer and recipient of federal funds, has a major role in determining which services will be included in a benefit package. If certain services are required by law or regulation, the managed care initiative is certain to include them. Other, optional services may also be made available to the extent that there are resources to fund them. In the case of managed care services for children, it is important to remember that EPSDT or the courts may mandate that certain services be provided without regard to the contractual arrangements made between a state and an MCO. The amount, duration, and scope of services need to be defined clearly in public managed care programs, because public coverage rules (e.g., Medicaid) will differ from private rules, for example referring to habilitation rather than rehabilitation services.

■ **Traditional Benefit Plans**

Health and behavioral health MCOs generally provide a selection of services from which payers can construct a benefit package. These may include preventive interventions as well as treatment services. Many managed care health programs also have added non-medical, "enabling" services such as case management, transportation, outreach, education, and translation services to their benefit packages. Such services are intended to make it easier for members to gain access to core services that are culturally competent and acceptable to the consumers, and to facilitate the members' compliance with prescribed treatment regimens. EPSDT generally requires all of these services for covered children; the issue will be determining who has the responsibility to provide them.

The key tool for determining which health care procedures, supplies, and services of the array available within the plan will be covered for the individual patient has been found in the term "medical necessity." The exact definition of medical necessity varies across insurance plans, but its basic elements have not changed significantly in the past thirty years (Bergthold 1995).

Traditionally, the determination of whether an expenditure of resources was to be deemed "medically necessary," "appropriate," and "cost-effective" was left to the physician. For low-income children, the federal EPSDT definition of medical necessity applies. More recently, payers and purchasers of health insurance have played a greater role in making decisions about the nature of benefits and the amount of services covered.

The type of service that may be prescribed is being defined more flexibly in a growing number of private insurance managed care initiatives, which have begun to use a treatment plan approach to defining necessary services. This has even allowed them to move beyond listing the covered benefits to offering services determined on the basis of individual needs. Early evidence from these efforts suggests that their enrollees do get the services they need (including some that may not have been otherwise available, such as residential treatment), and that the employers who fund these plans have realized savings in their overall benefit costs. In the public sector, with more limited experience, this approach also appears to be satisfactory. For example, Wisconsin's "Katie Beckett" program is designed to meet the needs of children with long-term medical and disabling conditions by providing services that help them remain in their own homes. Eligibility is based on an assessment conducted by a team of nurses and reflects the needs of the patient and the cost-effectiveness of providing community-based rather than institutional care.

Cost control and resource allocation are important issues and, in a managed health or behavioral health system, designers may set priorities and determine whether costs can be controlled by limiting benefits for certain conditions or encouraging physicians to

prescribe generic drugs or less costly procedures. The plan may try to control long-term treatment costs by supporting prevention efforts, such as offering health screenings and risk assessments and providing individual and group health education services. In addition, the type, intensity, and duration of treatment made available to an *individual member* per episode of illness will be related to the availability of resources. For example, there may be limits placed on the number of hospital days allowed or the number of psychotherapy sessions that will be covered. However, such limits may be illegal for children covered under EPSDT.

■ **Further Benefits Needed by Children and Families**

States that plan to use a managed care approach for providing services to children and families may find they must go well beyond the services that are currently included in many health benefit packages. The issues related to identifying an appropriate benefit package are quite complex, since the needs of the eligible population and the nature of the services they may require are both very broad.

"Medical necessity" is a term that cannot be easily applied to the array of non-medical services involved in serving children and families. By their nature, non-medical services and procedures do not lend themselves to categorization as mutually exclusive, nor can they generally be expressed in terms of "best practices," two hallmarks of the medical necessity designation. As an increasing number of states give thought to creating some type of managed care program for child welfare services, policymakers and advocates are beginning to think about how they might define "social necessity." Social necessity could address a myriad of systems and individuals (i.e., children, families, and community members) and provide a basis for determining which specific services would be allowable and covered by the benefit plan. Currently, social necessity criteria are being developed by the Child Welfare League of America's Children's Services Managed Care Institute and by the National Resource Center for Permanency Planning in collaboration with the Partnership for Children and Families.

The Institute for Human Services Management suggests a minimum benefit package for child welfare programs. It includes 24-hour emergency intake, evaluation and placement capabilities; home based services such as crisis intervention, home management education, parenting education, behavioral management, respite care, outpatient therapy, and drug and alcohol services; out-of-home care services, such as group home care, residential treatment, inpatient services, and residential drug and alcohol services; case management services, including ongoing protective services, foster placement and follow-up services, adoptive placement and follow-up services; preparation for and participation in child custody and delinquency judicial proceedings; and working with parents or other family members for return or placement of children who have been in out-of-home care (IHSM 1996). The breadth of these service requirements points to the need to link or integrate a variety of systems to ensure that a full range of services is available.

Cost control and resource allocation are complicated issues that the state must consider in designing a managed care initiative that will include the range of systems that serve children and families. Long-term savings may flow from prevention programs and strategies, and lower costs may result from providing community-based rather than institutional services. However, it is difficult to limit the individual child or family to receiving only a specific amount of service during a particular span of time.

What is the role of the contractor? This section covers two major types of roles that can be played by contractors: *administrative services* and *direct services for enrollees*. State officials will wish to consider the extent to which they will contract out for either or both of these types of services and the extent to which they will retain certain functions in house. In any case, contract specificity will be essential, particularly in governing the content of subcontracts with providers.

- *Administrative contracts:* Some states may choose to retain most administrative responsibilities in the public domain, whereas others may choose to contract with MCOs,

specialized Administrative Service Organizations (ASOs), or even with provider groups to perform those functions. Using a hybrid approach, some states have selected to retain some administrative functions but to contract for others. Pennsylvania has chosen two different approaches:

- The Family Care Network, a statewide Primary Care Case Management program, uses a contractor only for provider training, administrative services, and enrollment of clients.
- The new HealthChoices behavioral carve-out program will offer county mental health and drug and alcohol authorities the “right of first refusal” to manage behavioral health services on a full-risk capitated basis. Philadelphia has indicated that it will develop an in-house administrative MCO which will continue the current practice of purchasing contract services from providers.

■ *Service contracts:* A number of questions will affect the state’s decision in regard to service delivery, and state officials will need to answer them during the process of planning their managed care initiatives. To what extent does the state wish to define specific aspects of the delivery system? What degree of control does the state wish to have in both initial decisions and during ongoing implementation? Are there some aspects of services and some service providers that require special protections? To the extent that services are provided directly by the state, what role do the public agencies have in the overall managed care effort? These questions reflect a very basic consideration of the extent to which the state will define the program or allow it to be defined by the MCOs and providers. Fundamental decisions in this arena are necessary in order to design an approach that is cohesive and can achieve the state’s objectives.

How will the service system be structured and contractor(s) be selected? This is a point at which states will consider whether they wish to work with one or multiple contractors. There are many possible models from which to choose, three examples of which are drawn from

initiatives in Massachusetts, Utah, and Connecticut:

- Massachusetts has contracted with a single behavioral managed care organization to oversee mental health and substance abuse benefits for Medicaid recipients state-wide. The contractor, prohibited from providing services directly, subcontracts with a network of providers.
- Utah uses several contractors to provide Medicaid mental health services. Each contractor is charged with serving all Medicaid recipients in a particular geographic region, and contractors do not compete with each other for enrollees.
- Connecticut contracts with 11 health plans for Medicaid medical, mental health, and substance abuse treatment services. Medicaid recipients can choose to enroll in any plan available within their geographic area.

For both administrative and provider contracts, some states may find that they prefer to limit their direct participation to working with one highly qualified contractor organization. That primary contractor would most likely develop multiple subcontracts with specialty providers to ensure that the full spectrum of services is made available. On the other hand, some states might prefer to develop contractual relationships with many provider organizations. This might be a mechanism for protecting non-traditional providers who have established relationships with member populations but who might not meet the credentialing or capitalization requirements to qualify for a subcontract. Finally, some states have carved out certain sets of services or certain populations to be served through specialized contracts or to continue to be served by public agencies.

The process by which contractors are selected may also vary according to the needs and interests of the state. In most cases, states have planned their managed care initiatives and then selected one or more MCOs through a competitive bidding process. However, some states have responded to proposals developed in the private sector and offered to the government. Recently, for-profit organizations

have shown interest in managing child welfare services, seeing this area as a new source of revenue and a logical next step from managing behavioral health services. At least one organization has been formed to compete with traditional public and non-profit child welfare agencies in addressing foster care and other child welfare services. Generally, many of the specific decisions will be reflected in an RFP that is issued in order to identify the organization or organizations with which the state will contract to manage the delivery of services.

How and by whom will services be provided?

Decisions about who should be included in the provider network(s) have been addressed in a variety of ways. As is true of many other decisions, the state may wish to be highly specific regarding providers, or it may allow many of the decisions regarding providers to be made at the MCO level, once MCO standards are defined.

In general, the development of managed care health programs includes identifying a set of acceptable providers (a network) for each managed care plan. It places restrictions on the "freedom of choice" that consumers have in selecting their provider in order to hold costs down. These restrictions have been challenged, however, and some have been addressed through laws that mandate payments to "any willing provider." States must determine who will be included in their networks, and may seek providers whose qualifications go beyond professional credentials and address their ability to meet the needs of underserved populations. Thus, the state may wish to mandate that "safety net" providers be retained, or that organizations which have expertise in working with specific cultural or ethnic groups be included, or that enrollees be permitted to maintain previously established relationships with providers. Alternatively, the state may require that contractors and subcontractors show they can meet the needs of these populations.

A special issue that requires the state's attention is that certain providers who traditionally work with underserved populations may be reluctant (or financially unable) to participate in a program that requires them to take on risk.

They may already suffer from adverse selection, in that they receive a disproportionate share of higher need/higher cost referrals. Those who provide specialized enabling services, such as transportation or translation, may fear an influx of new clients with high levels of need. States must consider how payments can be adjusted to encourage traditional providers to continue to participate in the service network and to reflect the cost of providing specialized, intensive, and extended service.

Issues related to safety net providers have been addressed by a number of states in the development of their public managed care programs. A major consideration in Medicaid programs has been the special role played by federally qualified health centers (FQHCs). FQHCs have special status in the Medicaid program, which specifies the set of services they must provide and the cost-based reimbursement they will receive. When states have been allowed to waive these service and payment provisions, concern has been raised as to the ability of these FQHCs to participate in managed care arrangements. In a number of cases, the FQHCs have formed their own MCOs to help them compete by ensuring their involvement in critical decisions regarding the rates and incentives for primary care and participation in the potential savings.

For example, in Oregon, the Multnomah County Health Department (an FQHC), the Oregon Health Science Center, and other FQHCs formed CareOregon to contract with the state. Prior experience with managed care programs by Multnomah County gave it a jump start in planning and developing the MCO, which is financially supported by the county and housed within the county structure. The approach, however, raised issues about the ability and appropriateness of risk taking by county government. In contrast, AlohaCare in Hawaii was established by the FQHCs who chose to contract out for the management of the plan because of a lack of prior experience with managed care. Both MCOs have developed capitated methodologies that support an emphasis on primary care and prevention (Lewin 1995-6).

Another provider-related issue that must be considered in designing managed care initiatives that include a range of service systems and providers is the possibility that the children and families who are to be enrolled may be receiving services from multiple providers and provider organizations. State planners will want to ensure that services are coordinated rather than duplicated, and that clients have access to the full array of the services they need. At the same time, some duplication may be valuable in assuring a competitive marketplace. Some communities have made considerable efforts to develop systems of care for children with mental health or child welfare needs. State planners will want to support the highly coordinated systems that are already in place and develop incentives to reduce fragmentation in the less developed systems. Thus, implementing officials must address the preservation of current systems of care, the retention of current provider groups, and the continued delivery of certain services by "in-house" staff.

Deciding on an Approach to Financing

Often the primary focus in designing managed care alternatives is the financial approach that the state or program is proposing as part of its initiative. The overall issue that must be addressed is the extent to which the system will shift away from traditional approaches that pay for services on a fee basis, giving little or no attention to managing the care that is provided. Fee-for-service systems in public programs have usually been based on a specific fee schedule which reimburses the approved provider for specific services that are included in the program's benefit package. Under such a payment system, there are few incentives to limit the number of service units provided.

Managed care approaches are designed to change the incentive structure by using mechanisms that allocate risk and facilitate reward for all stakeholders. These are discussed extensively in the paper by Broskowski, elsewhere in this report. State officials responsible for implementing a transition to using managed care in systems that serve children and families should consider a number

of issues as they develop their implementation plans.

How will rates be determined? A type of payment must be selected, and the basis for making payments must be determined. The chosen approach should reflect the objectives and specific outcomes that the state's policy is intended to achieve. Three broad categories of payment types are often used:

- **Case (or global) rate:** a specific amount is paid for each case for a defined period of time; this has been applied to specific episodes of care that are fairly easy to delineate, such as pregnancy (including prenatal, delivery, and postpartum services); it is the basis for payments based on diagnostic related groups (DRGs).
- **Per diem fees:** a specific amount is paid for any and all services provided during a day of treatment; this is usually applied to inpatient services (e.g., hospitalization)
- **Capitation:** a specific amount is paid for each enrollee, whether or not services are provided; this is often referred to as a per member per month rate (PMPM). Capitation may cover the full range of benefits, or a subcapitation (partial capitation) may be used to cover some defined set of services within a benefit package.

Capitation is the most widely used technique for financing managed care initiatives. From a policy perspective, a purchaser (e.g., a state) may wish to fully capitate services. However, there may be insufficient information on which to base a reasonable initial capitation rate. Even when enough good data are available, the state may determine that rates would have to be set extremely high to meet the needs of the eligible population or to account for the cost of interventions over which the provider has limited control (IHSM 1996).

If the state does decide to take a capitation approach, it is critically important to base initial rates on the best information available, and it is equally important to monitor and make adjustments based on experience. Capitation may prove to be inappropriate for a particular

system, and *alternative or hybrid approaches* to payment should be considered. For example, grant or case-rate approaches might be used in offering a flat fee based on a total caseload in specified categories of service, such as child welfare (family in home, foster care, special placements), juvenile corrections (intensive home based, placement), and mental health services (home based, some institutional care, moderate residential), as well as a rate for children with chronic conditions (chronic mental illness, developmental disabilities).

How will risk be apportioned? Risk can be handled in a number of ways. The state can assume all risk, shift all risk to the MCOs (full risk arrangements), or place the MCOs at partial risk (shared risk arrangements). Further risk-sharing occurs if the MCO passes some degree of risk on to providers. Risk-sharing arrangements are intended to provide the potential for sharing profits (rewards) as well losses, which is expected to encourage coordinated, efficient, and effective service delivery.

Risk arrangements are an important element of program design and can be used to address major policy objectives. For example, Carolina Alternatives is a Medicaid waiver program providing behavioral health services on a capitated basis for a population of children up to 17 years of age through area agencies and consortia. Because the major policy objectives were to reduce inappropriate hospitalizations and increase the use of community-based services, the area contractors were placed at full risk for inpatient services from the onset of the program. Full risk for outpatient services is a goal once these services are developed. Initially, a partial risk arrangement was developed, under which the MCO is only at risk when actual costs are less than capitation and it must refund the difference. When costs exceed capitation, quarterly settlements are made. Initial experience with the pilot health sites has found that inpatient costs were below capitation, and the savings were used to enhance programs that would further reduce inpatient services over time. However, providers have complained they were paid less than promised, causing expansion to halt, and there have also been complaints of difficulty in getting needed inpatient care. Most

state child welfare agencies and provider networks would have difficulty affording this type of risk.

Deciding How to Monitor Access, Quality, and Utilization

The state maintains responsibility for assuring that there is access to the system, that services are of appropriate quality, and that the proper amount of service is provided, regardless of the role the state may play in the actual design and implementation of the delivery system. All clients must be assured access to services that are culturally appropriate and acceptable to the target population. This may require funding the services of native healers or indigenous outreach workers or individuals whose credentials are far different from those of traditional service providers, or for kincare arrangements or equipment costs for after-school services participation or bail for a child in trouble. It also requires guarding against underutilization. What are the incentives for providers to ensure that there are no barriers to receiving services and that clients receive the appropriate amount of high quality services? Payment approaches and appropriate structuring of risk arrangements can play some role. Potential use of "outcome-based" contracts may address some of these issues, along with other managed care mechanisms such as utilization review, rate incentives and rewards, and quality monitoring. Monitoring activities may be designed and conducted by the state, by the MCO, and by outside evaluators.

Definitions and standards: The state has the responsibility for determining the standards or minimum requirements that must be met by managed care organizations and providers. It may also use benchmarks to "evaluate" the job that particular contractors are doing and provide them with grades, and/or use the evaluations of other outside groups for this purpose. The efforts of such groups as the National Committee for Quality Assurance (NCQA) in developing the HEDIS (Health Plan Employer Data and Information Set) and similar report cards are proliferating in the general health arena as managed care penetration proceeds. States will need to determine the nature and emphasis of their efforts to assure that minimum

standards are met, as well as the degree to which they will actually evaluate performance. In both cases, issues concerning how the information will be used and the extent to which it will be made public must be considered.

Monitoring functions include monitoring the overall system, as well as individual health plans or providers, in terms of access to care and quality of the services provided. For example, standards of access are often incorporated into contracts with managed care plans and may include the time it takes to get to a service, the length of time it takes to get an appointment, and the availability of certain services and providers. A parallel access standard for the overall system might be that no enrollee is more than thirty minutes from a primary care provider. Quality may be measured in terms of the effectiveness of services that are delivered, as well as the process of service delivery and the actual services provided. Quality can be assessed based on "objective" professional standards as well as from the satisfaction of various stakeholders.

Measurement issues are complex and require the development of definitions and standards. For example, what constitutes a medically or socially necessary service? Criteria must be established for admissions and discharges, and for determining the necessary level of care. Which enabling services must be available to facilitate appropriate use of the service system? Standards must be set to ensure easy and timely movement between different levels of care. It is important to determine how standards will be interpreted and success measured in light of differences among communities or groups of recipients. For example, the range of services available in rural settings may be different from that in urban locales, or the needs of Hmong immigrants in one part of a state may differ from those of African-Americans in another.

Particular concerns arise in devising measures that permit us to monitor child-serving systems. At present, there are few practice protocols that include the standardized assessment and decision-making tools which are critical for ensuring that the needs of children and families in these systems will be addressed. In addition,

there is a limited range of treatment modalities available at present, and external influences on the service delivery system (such as court mandates) make it difficult to identify reasonable indicators of success in managed care approaches serving the target populations. Disabilities and chronic conditions make measurement more difficult because the small numbers preclude statistical reliability.

However, monitoring quality *requires* the development of meaningful outcome measures. The recent emergence of "report cards" reflects the need to establish clear outcomes for which MCOs can be held accountable. States can build in requirements that reflect national standards, such as those based on the NCQA's HEDIS, or the Mental Health Statistics Improvement Program (MHSIP) consumer report card, or the American Managed Behavioral Healthcare Association (AMBHA) report card. They can also use other data sources to develop their own standards, since existing measures may not cover all concerns relevant to the new initiatives. Measures have been proposed to evaluate the process by which permanency planning for children is enhanced, to look at rates of reunification, independence, and adoption; and to determine outcomes related to child safety, family connectedness, and child and family well-being and functioning (CWLA 1996).

These measures have inherent problems because they take a long time before results are firm; more typically, managed care outcomes focus on short-term measurements. In addition, measures of relapse and recidivism that can track efforts across multiple agencies and service systems must be determined. Measuring client and provider satisfaction is also important, and some current approaches use patient satisfaction surveys as well as reviews of complaints and grievances for this purpose. In a broader service system, the perspectives of payers, providers, and the courts might also be monitored. In addition, the cost of outcome measurement must be considered; public agency budgets have not included funds for this purpose, while for-profit MCOs typically devote significant resources.

Developing the infrastructure for monitoring: The issue of developing standards and outcome measures is an important requisite for monitoring systems. It is equally important to ensure that data and information about adherence to the standards and the results of interventions can be collected and managed. State officials must ensure that information systems are developed and maintained, and this may require a significant investment in hiring or training expert staff, developing and testing information systems, and perhaps purchasing or designing computer equipment and software suitable for the evaluations they wish to have conducted.

The systems required for monitoring are complex and require serious investments. Often investments focus on *development* of monitoring systems and do not place adequate emphasis on the far more complicated issues of *implementation* of an effective system. A variety of questions must be addressed in designing such efforts. How will information be collected and used? Will information be provided to consumers? In what form? What education and other supports are needed so that consumers can make effective use of the information? Will performance contracting be used, or are there other mechanisms for assuring compliance with standards and tools to ensure necessary improvements are made?

These issues are highly complex and require a great deal of deliberation and planning — as well as resources — to implement. Experience with such approaches as publicizing mortality rates for specific hospitals have taught us valuable lessons. Collection and provision of such information is insufficient by itself to educate a consumer and may, in the absence of a more comprehensive approach, create confusion.

IN CONCLUSION

Managed care alternatives in the public sector are currently expanding at a rapid pace. Information is available, albeit on a piecemeal basis, to inform decisionmakers about the various alternatives and tools for managing care or managing risk. This paper is structured to help public officials think through the many

facets of managed care that must be addressed in developing an approach that will use managed care techniques in systems that serve vulnerable and disadvantaged children and families. Examples have been drawn from managed care initiatives that are under way or under consideration for implementation. Ultimately, however, each new program will represent a pioneering effort, and adequate feedback and evaluation mechanisms should be structured to build a broader base of knowledge about the choices that will be made. It is hoped that states will document and share their experiences so they can assist others who are moving toward managing a variety of child-serving systems.

ENDNOTES

1. States should take advantage of systems developed through the child welfare information modernization program (SACWIS) and the Mental Health Statistics Improvement Program (MHSIP), while recognizing that these were not specifically designed for a managed care system.

REFERENCES

Bergthold, L. 1995. Medical Necessity: Do We Need It? *Health Affairs* 14:4 180-190.

Brokowski, A. 1996. The Role of Risk-Sharing Arrangements. In *Managed Care: Challenges for Children and Family Services*. Annie E. Casey Foundation: Baltimore, MD.

Child Welfare League of America (CWLA). 1996. *Developing a Managed Care Approach to Child Welfare: Essential Tools and Critical Investments*. Washington, DC.

General Accounting Office (GAO). 1995. *Medicaid: Spending Pressures Drive States Toward Program Reinvention*. Washington, DC.

Ginsburg, S. 1995. *Managing Risk or Managing Care*. Presentation at the National Association of Psychiatric Treatment Centers for Children, April 1995.

Designing Managed Care Alternatives

Halfon, N.; Klee, L. 1987. Health Services for California's Foster Children: Current Practices and Policy Recommendations. *Pediatrics* 80:2 183-191.

Halfon, N.; Klee, L. 1991. Health and Development Services for Children with Multiple Needs: The Child in Foster Care. *Yale Law and Policy Review* 9:71-95.

Institute for Human Services Management. 1996. *Managed Care and Child Welfare: Are They Compatible? Conceptual Issues in Managed Care for Child Welfare*. Bethesda, MD.

Institute for Human Service Management. 1995. The State of Bliss: Request for Proposals. In *Unraveling the Mysteries of Managed Care*. Child Welfare League of America: Washington, DC.

Intergovernmental Health Policy Project. 1995. *Fifty State Profiles: Health Care Reform*. Washington, DC.

The Lewin Group. 1995-6. *Evaluation of the Impact of Medicaid Waivers on Federally Qualified Health Centers*. Case studies prepared for the Bureau of Primary Health Care, Health Resources and Services Administration, Vienna, VA.

Williams, M.; et al. 1995. Inadequate Functional Health Literacy Among Patients at Two Public Hospitals. *JAMA* 274:21 (December 6) 1677-1682.

SUMMARY CHECKLIST

After the Decision to Use Managed Care in a Public System That Serves Children and Families Has Been Made: Broad Issues to be Addressed...

What is the role of the public entity?

- Setting program requirements.
- Setting standards.
- Assuring adherence to population-specific entitlements.
- Setting payment rates for services rendered and/or outcomes achieved.
- Deciding how quality will be assured.
- Determining how programs will be monitored and what data will be collected to ensure the adequacy of the service system and the proper use of public resources.

Which state agencies and programs would be involved, and how will this be accomplished?

- Service and finance agencies are likely to be involved in the early stages of program design.
- Depending upon the specific client populations and their specific service needs, mental health, substance abuse, public health, maternal and child health, child welfare, juvenile justice, education, and others may be involved.
- Determine how to bring all key agencies to the table, the nature of the relationships among them, and the contributions to be made by each player.

How could stakeholders be involved in the process?

- Consider obtaining input from consumers, families, and current and potential contractors and providers.
- System coordination and integration initiatives have often approached the consideration of stakeholders through focus groups, surveys, public hearings and forums, and task force mechanisms.

What are the administrative resources and resource needs?

- Assess internal resources to ensure that they are sufficient to plan, administer, and oversee a managed care initiative.
- Experienced staff must be put in place at all levels including: skillful contract negotiators, project managers, utilization reviewers, alternative dispute resolution specialists, and information specialists.

Designing Managed Care Alternatives

- The presence of sophisticated information systems will assure that the system is properly designed to meet public policy objectives and that it can be monitored to ensure that it achieves acceptable outcomes.

What are the service system's resources and resource needs?

- Assess external and internal readiness and capabilities.
- Ensure that there is sufficient program and computer capacity and that programs and services are accessible and acceptable to the communities they will serve.

What financial resources will be utilized?

- It is imperative to consider resources needed to prepare for a managed care initiative and the resources that the managed care initiative will need in order to serve its clients.
- Starting a new program requires an initial investment of capital.
- New funding ideas are beginning to be applied to managed care systems that serve children and families (e.g., decategorization).

How quickly can a managed care program be put into place?

- Assess existing capacity at both state and provider levels to determine a phase in effort by geographic areas, population groups, or sets of benefits.
- Experience has shown that it may be easier to start a fully capitated risk program under a Medicaid waiver for a well-defined population in an area where managed care capacity is already established.
- Other experience has demonstrated that some states have begun with relatively minor changes, such as primary care case management, in order to gain experience in managing care.

How to Design the Program: Questions to be Answered...

In defining and enrolling the eligible populations, who will be included?

- Analyze the situation through which the child or family comes to be seen as in need of service, and assess the system's capacity to provide the necessary services.
- Determine a population subset that has specific service needs.
- Define the eligible individual and family and choose whether:
 - to permit all eligible persons to enroll immediately,
 - to omit some of the eligible persons from initial enrollment but allow them to enter on a "phased in" basis over time, or
 - to exclude the eligible persons from the overall program while developing separate approaches to meeting their needs (e.g., carve out for persons with AIDS).

How will they be enrolled?

- Issues related to enrollment of publicly supported populations are different from, and often more difficult than, enrolling commercial populations in managed care
- Approaches to providing eligible individuals with appropriate information so that they can make choices (where such choices are available) have varied from contracting out with private entities to conducting all activities “in house” under the aegis of the state.
- Some enrollment issues to consider:
 - the physical location of eligibility workers.
 - target population’s needs and the service system’s capacity.
 - translating materials into various languages and using non-written approaches such as presentation at community events and use of outreach workers.
 - literacy and readability of written materials.
- Some clients receive information about the plans or providers they may choose, but they do not make a selection. They are usually assigned to a plan, a process that can take different approaches.
- Arrangements for consumers to change providers or plans or to disenroll altogether (if that is an option) also need to be built into the assignment process.
- Client grievance and appeals processes must be set in place to provide opportunities for clients to have their concerns addressed.

In defining the benefit package and designing the service system, what services will be provided and how will need for them be determined?

- The basic underlying principle for determining the scope of the benefit package should be the needs of the target population in the context of the available resources. The services that are required to address the identified needs can be considered for inclusion in the benefit package, and those services that are excluded from the package will need to be addressed in other ways.

Traditional Benefit Issues

- The state has a major role in determining which services will be included in a benefit package.
- The amount, duration, and scope of services need to be defined clearly in public managed care programs because public coverage rules (e.g., Medicaid) will differ from private rules.
- “Medical necessity” is the key tool for determining which health care procedures, supplies, and services of the array available within the plan will be covered for the individual patient.
- A growing number of private insurance managed care initiatives, which have begun to use a treatment plan approach to defining necessary services, are more flexibly defining the type of service that may be prescribed.
- Cost control and resource allocation are important issues. In a managed care system designers may set priorities and determine whether costs can be controlled by limiting benefits for certain conditions or by encouraging physicians to prescribe generic drugs or order less costly procedures.

Further Benefits Needed by Children and Families

- Since the needs of the eligible population and the nature of the services they may require are both very broad, the issues related to identifying an appropriate benefit package are quite complex.
- The term “medical necessity” cannot be easily applied to the array of non-medical services involved in serving children and families. Policymakers and advocates are beginning to think about a definition of “social necessity” — addressing a myriad of systems and individuals.
- The state must consider the complicated issues of cost control and resource allocation in designing a managed care initiative that will include the range of systems serving children and families.

What is the role of the contractor?

- Two major roles can be played by contractors: ***administrative services and direct services for enrollees.***
- ***Administrative contracts:*** some states may choose to retain most administrative responsibilities in the public domain, and others may choose to contract with MCOs, specialized Administrative Service Organizations (ASOs), or even with provider groups to perform those functions.
- ***Service contracts:*** a number of questions will affect the state’s decision in regard to service delivery, and state officials will need to answer them during the process of planning their managed care initiatives (e.g., to what extent does the state wish to define specific aspects of the delivery system?).
- Fundamental decisions in this arena are necessary in order to design an approach that is cohesive and can achieve the state’s objectives.

How will the service system be structured and contractor(s) be selected?

- In considering whether to work with one or multiple contractors, states have many possible models to choose from:
 - for both administrative and provider contracts, limit their direct participation to working with one highly qualified contractor organization.
 - develop contractual relationships with many provider organizations.
 - carve out certain sets of services or certain populations to be served by specialized contractors or by public agencies.
- The process by which contractors are selected may also vary according to the needs and interests of the state. Generally, many of the specific decisions will be reflected in an RFP that is issued in order to identify the organization or organizations with which the state will contract to manage the delivery of services.
- Some states have taken different approaches:
 - planned their managed care initiatives and then selected one or more MCOs through a competitive bidding process.
 - responded to proposals developed in the private sector and offered to the government.

How and by whom will services be provided?

- Decisions about who should be included in the provider network(s) have been addressed in a variety of ways:
 - The development of managed care health programs includes identifying a set of acceptable providers (a network) for each managed care plan (e.g., including safety net providers that have expertise in working with specific cultural groups to be enrolled).
 - Certain providers who traditionally work with underserved populations may be reluctant (or financially unable) to participate in a program that requires them to take on risk.
 - States need to consider issues related to safety net providers, especially those that have unique capabilities/inabilities. In addition, children and families who are to be enrolled in a plan may be receiving services from multiple providers and provider organizations. These may present service duplication and service coordination challenges.

Deciding on an approach to financing, how will rates be determined?

- A type of payment must be selected and the basis for making payments must be determined. A decided approach should reflect the objectives and specific outcomes that the state's policy is intended to achieve.
- Three broad categories of payment types are often used:
 - case rate — a specific amount is paid for each case for a defined period of time.
 - per diem fees — a specific amount is paid for any and all service provided during a day of treatment.
 - capitation — a specific amount is paid for each enrollee, whether or not services are provided.
- Capitation is the most widely used technique for financing managed care initiatives. If a state does decide to take a capitation approach it is critically important to base initial rates on the best information available, and it is equally important to monitor and make adjustments based on experience.
- Alternative or hybrid approaches to payment can be considered if capitation is not an option (e.g., grant or case rate approaches used in offering a flat fee based on a total caseload in specific categories of service, such as child welfare).

How will risk be apportioned?

- Risk can be handled in a number of ways:
 - state can assume risk.
 - state can shift all risk to the MCO (full risk arrangements).
 - state can place the MCOs at partial risk (partial risk arrangements).
- Risk-sharing arrangements are intended to provide the potential for sharing profits as well as losses, to encourage coordinated, efficient and effective service delivery, and to address major policy objectives.

**Deciding how to monitor access, quality and utilization:
a look at definitions and standards**

- Regardless of the role that the state may play in the actual design and implementation of the delivery system, the state maintains responsibility for assuring that there is access to the system, that services are of appropriate quality, and that the proper amount of service is provided.
- Outcome-based contracts, utilization reviews, rate incentives and rewards, and quality monitoring are examples of monitoring activities. These can be designed and conducted by the state, MCO and outside evaluators.
- Standards must be set to ensure easy and timely movement between different levels of care.
- Concerns arise in devising measures that permit monitoring of child-serving systems:
 - Few practice protocols include the standardized assessment and decision-making tools which are critical for ensuring that the needs of children and families in these systems will be addressed.
 - A limited range of treatment modalities are available at present.
 - External influences on the service delivery system make it difficult to identify reasonable indicators of success in managed care approaches serving the target populations.
 - Disabilities and chronic conditions make measurement more difficult because the small numbers preclude statistical reliability.
- Monitoring quality requires the development of meaningful outcome measures. Measures have been proposed to evaluate the process by which permanency planning for children is enhanced; to look at rates of reunification, independence, and adoption; and to determine outcomes related to child safety, family connectedness, and child and family well-being and functioning.
- These measures are problematic because of the length of time it takes before results are firm. Managed care outcomes often focus on short-term measurements, although it is important to assess "longer" term measurements.
- The cost of outcome measurement is a major concern because public agency budgets do not have funds for this purpose, while for-profit MCOs typically devote significant resources.

Developing the infrastructure for monitoring: the issues

- States must ensure that information systems are developed and maintained in order to develop measures, collect data, and conduct monitoring activities.
- This assurance may require a significant investment in hiring or training expert staff, developing and testing information systems, and purchasing or designing computer equipment and software suitable for the evaluations they wish to conduct.

APPENDIX C

**THE ROLE OF RISK-SHARING
ARRANGEMENTS**

BY

ANTHONY BROSKOWSKI

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 timeframe 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 timeframe 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:

$$\text{Total Risk} = (\text{Number of Users}/1000) \times (\text{Units per User}) \times (\text{Price per Unit})$$

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 health care 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-cost 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 timeframe.

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 timeframe 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 *down* the ladder; the state’s increases with each step *up*. 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 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.

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

■ **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 in the population*, 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 Commonworks 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 "**carve out**" 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 risk pools 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 of clients who reappear for services (i.e., increased recidivism).

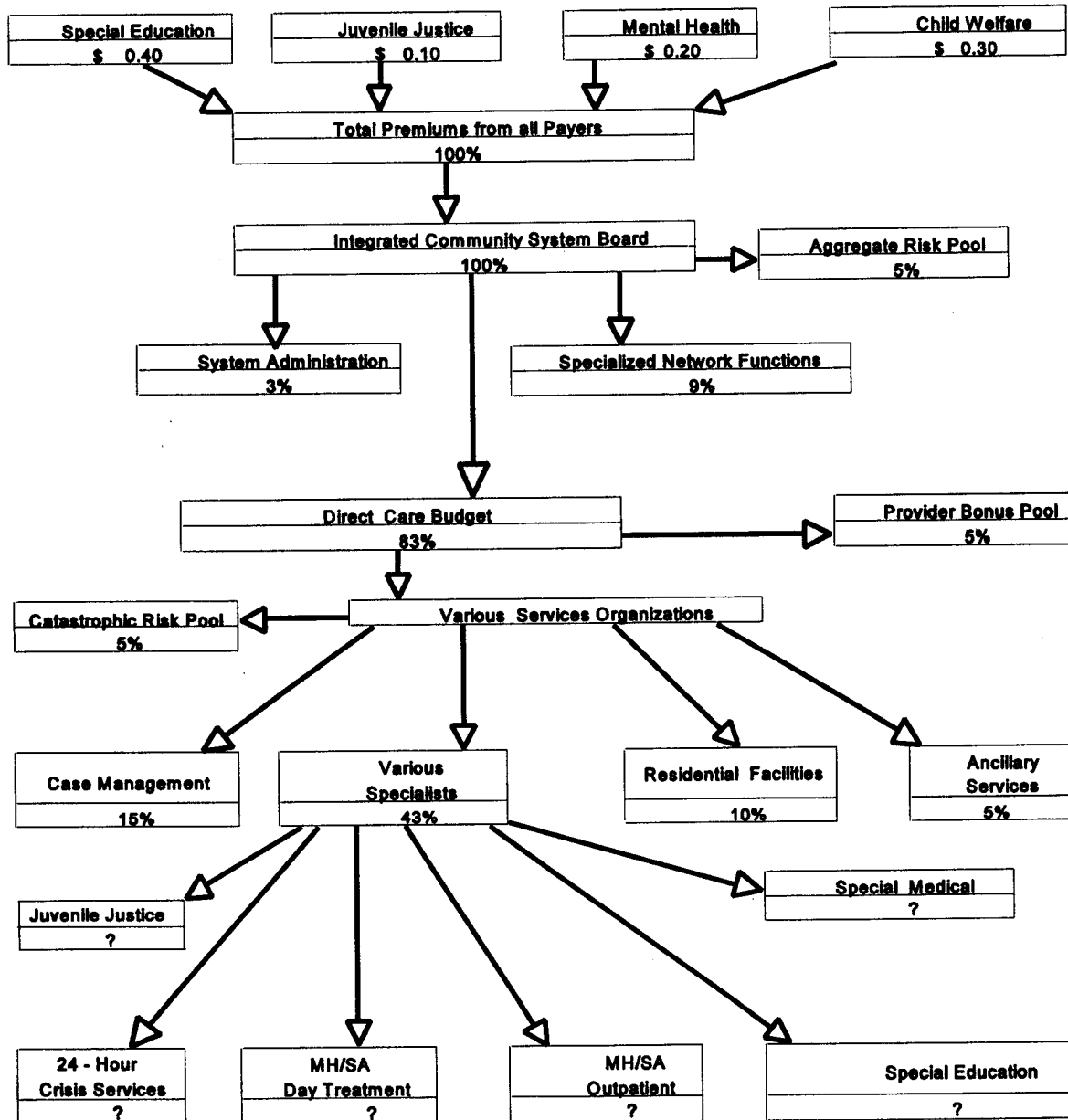
Figure 2 does not illustrate how the dollars might be paid, but there are many possible combinations that might be considered, based on a system's particular characteristics. For example, a Community Systems Board could accept risk on a capitation basis (per member per month for a large population of 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 carve out**, 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

Figure 2

An Illustration of a Premium Allocation Formula and Risk Distribution System



group, the lower the variability and the lower the chances a single patient can influence the average.

Secondly, in a high-risk carve out, 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 copayments 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 analogous

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 carve outs**, 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 carve-out plan. A mental health/substance abuse (MH/SA) carve out 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, decisionmakers 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 decisionmaker 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 loan 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 timeframe. 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 outcomes 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 timeframe 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 “carve outs” 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 carve outs, 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.

ABOUT THE AUTHORS

Cindy Brach was Associate Director for Research and Analysis of the Policy Resource Center (PRC), where she directed mental health and health policy research projects, with an emphasis on managed care. She prepared a Managed Care Guide for public officials on capitating substance abuse and mental health care, analyzed the options for privatizing a county mental health agency in anticipation of a Medicaid managed care initiative, and functioned as Issue Editor for PRC's periodical on managed care, supported housing, and cultural competency. Ms. Brach's decade of health and human services experience includes serving as a welfare reform consultant and technical assistance provider, an administrator of a housing subsidy program for homeless families for the Commonwealth of Massachusetts, and a policy analyst for the City of New York. She currently works for the Agency of Health Care Policy and Research's Center for Organization and Delivery Studies. Ms. Brach has a Master of Public Policy degree from the University of California, Berkeley, where she is a Ph.D. candidate.

Anthony Broskowski is President of Managed Care Solutions, a firm that specializes in computer modeling of risk-sharing arrangements, disease management, and the design of integrated health care delivery systems. Previously, he served as Director of Health Care Information for Prudential Insurance Co. and as Senior Vice President and Senior Analyst at Preferred Health Care, Ltd. (now Value Behavioral Health). Between 1977 and 1986, he was Executive Director of Northside Centers in Tampa, Florida, where he developed a comprehensive and innovative system of alternative mental health programs for children and adults. Dr. Broskowski has published extensively on topics that include mental health program administration and systems of managed care, computer information systems, and program evaluation and management of risks, and he provides consultation to major corporations, federal and state governments, and non-profit human service agencies. He received his Ph.D. in Clinical Psychology from Indiana University and has held faculty appointments at the University of Pittsburgh and Harvard University.

Sharon Carothers is a Senior Associate at the Lewin Group, focusing on health care issues of women, children, and vulnerable populations. She has particular expertise in the delivery of primary and behavioral health care services to pregnant and parenting low-income women and their children. Her experience includes the development of training materials, workshops, and reports for the National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs. Ms. Carothers received her M.S.W. in Policy, Management, and Planning from Boston University.

Suzanne Gelber, a Senior Research Fellow at the Institute for Health Policy at the Florence Heller School of Brandeis University, also serves as President of SGR Health, Wilton, Connecticut. Dr. Gelber works with public and private sector organizations to plan, evaluate, implement, and improve managed care programs, particularly in the area of behavioral health. Her research focuses on managed care and its impact on enrollees, providers, service systems and governmental organizations. Her clients include the Substance Abuse and Mental Health Services Administration, the National Committee for Quality Assurance, several Fortune 100 employers, academic medical centers and community mental health centers, and selected managed care companies, insurance carriers and foundations. Dr. Gelber serves on several Hastings Center task forces, is a contributing editor and reviewer for several national journals, and also serves on a number of expert panels. She received her Ph.D. in Sociology and her M.S.W. from the University of Michigan.

Susanna Ginsburg, a Vice President of the Lewin Group, received her M.S.W. in Administration from the University of Michigan and has completed doctoral course work in Social Policy at the Florence Heller School, Brandeis University. She has over 25 years of experience with public health programs at local, state, and national levels, and she has conducted studies on issues such as maternal and child health, substance abuse, and primary care. Currently, Ms. Ginsburg holds responsibility for two of her firm's contracts with the federal Department of

Health and Human Services, and she recently served as developer and senior advisor for a federal center on perinatal substance abuse. She has also been involved in projects related to a range of subjects (such as managed care, access to treatment, and family planning for low-income women) for the Institute of Medicine, the City of New York, and the Delaware Department of Public Health, among others.

Donna Mauch is the President and Chief Operating Officer of Magellan Public Solutions. She has held positions as Director of Mental Health for the State of Rhode Island and Assistant Commissioner of Mental Health for Massachusetts, and she is presently Special Master for the United States' District Court of the District of Columbia, evaluating the implementation of reforms in the D.C. public mental health system. Dr. Mauch has served on the National Advisory Board of the U.S. Center for Mental Health Services, and she co-chaired a health care reform task force on behavioral health for the U.S. Senate's Labor and Human Resources Committee. She has been Principal Investigator for research and demonstration projects funded by foundations and the federal government. Dr. Mauch received her Ph.D. in Social Policy, Planning, and Administration from Brandeis University.

Leslie Scallet founded the Policy Resource Center and was primarily responsible for its design and development from 1987 to 1996. She has 25 years of experience directing and working on national, state and local policy issues affecting mental health and health. Ms. Scallet's particular interests involve the relationship of mental health with the numerous social issues and service systems. Among these are substance abuse, health, education, child abuse and protection, juvenile justice, criminal justice, aging and long-term care, employment and workplace, and income support. Ms. Scallet has published extensively in many areas, including health care reform, managed care, policy information, protection and advocacy, nursing home care, and financing of services. Her service on numerous boards includes the Carter Center Mental Health Task Force, the Editorial Board of *Health Affairs*, the National Committee for Quality Assurance's Behavioral Healthcare Task Force, Chairmanship of the Mental Health Liaison Group (1990-1993), and the Board of Trustees of the Consumer Health

Foundation. Her earlier professional positions included directing the policy advocacy program at the Mental Health Law Project (now the Bazelon Center for Mental Health Law), a public interest advocacy group, and serving as a Special Assistant in the Office of the Director at the National Institute of Mental Health. Ms. Scallet is now a Vice President of the Lewin Group. She received her J.D. from the University of Pennsylvania.

Elizabeth Steel has more than 25 years of experience in health and human services activities, including program and policy development and management, as well as the evaluation of health and mental health programs and systems, with a particular focus on rural populations and children with serious emotional disorders. She developed the community liaison programs (1986-1994) and served as Deputy Coordinator of AIDS research (1989-1994) at the National Institute on Drug Abuse. Currently, she is a consultant to health and mental health organizations, providing technical assistance related to service coordination, developing evaluation protocols, and preparing and presenting reports. Ms. Steel received her M.S.W. from Catholic University School of Social Service, returning to teach graduate courses in health, mental health, and social welfare policy.



The Annie E. Casey Foundation