

## **Paper II**

### **US managed care models of children's foster care services**

In 1998, a number of states in the US had already, or since 1994, incorporated some of the principles of managed care into their family preservation, foster care, and adoption programmes<sup>1</sup>. In July 2000, a report was published<sup>2</sup> and the US General Accounting Office GAO gave testimony to the Congress on the progress made by states and localities as they developed new financing, service delivery, and accountability strategies for their child welfare programmes. This report focused on a) the financial and service-delivery changes states and localities had made in their managed care initiatives, b) how they were measuring the initiatives' outcomes, and c) what was known about the effect of these changes on children and families. The testimony was based on past and ongoing work in 27 state and local initiatives that had been in operation since January 1998 or earlier.

The report testifies that *states and localities are implementing managed care arrangements* in child welfare that *have two primary elements*:

1. The financing system in which states and localities are moving away from a traditional fee-for-service reimbursement approach. Instead they make prospective, fixed or capitated payments to one or more service providers.
2. Under this new payment method, a single entity is responsible for ensuring that children and families receive appropriate and quality services.

#### **The new financing system**

To increase service flexibility some of the states and localities were funding capitated payment arrangements by pooling individual state funding streams that support different services that children and families in the child welfare system need. By pooling and blending funds from various sources, in some cases also federal (foster care) funds, and by allocating a fixed level of funding – equivalent to a block grant, these states and localities were seeking to reduce service access problems associated with categorical programmes and thus increase flexibility in the use of funds.

While the potential to control costs attracted state and local child welfare agencies to managed care, their primary objective was not necessarily to reduce spending, but rather to reduce certain types of costs in order to use existing funds more efficiently on other services. In some of the initiatives, the overall spending had actually increased as a result of additional administrative costs associated with private entities assuming responsibility for managing clients' care and states and localities overseeing the contracts.

#### **The service delivery**

States and localities were trying to improve access to services for children and their families by charging a single entity with the responsibility of identifying and providing all appropriate services. In most of the 27 initiatives studied by GAO, states and localities had contracted with experienced private non-profit, community based providers – many of whom had had a long history of providing child welfare services for states and localities. As managed care entity operating under a capitated payment scheme, these providers take lead responsibility for co-ordinating specified child welfare services for a defined population of children and families. As a single point of entry to the service system, the managed care entity usually must provide, create, or purchase a wide range of services to meet the needs of children and families. If not providing services itself, this primary contractor may develop and subcontract with a network of service providers to make available the services referred clients need. States and localities had also shifted more case management responsibilities previously provided by public agency workers to private contractors as part of their new role as care coordinators. Most primary contractors used a team approach to manage caseloads of children and families, avoid the duplication, time delays and fragmentation by involving those providers who were regularly in direct contact with the child in the treatment planning and decision-making processes.

However, there were some variations in the way states and localities organised their managed care model<sup>34</sup>. The managed care arrangements generally fell into one of the four following managed care models:

**1. Public Model:**

A public model maintains the traditional management and service-delivery structure while the public agency incorporates managed care elements into its own practices and existing contracts with service providers. Illinois is an example here. Illinois began performance contracting in 1997, received an award from the Harvard Innovations in American Government programme in 2000, and has been pointed out as a very good example for other states to follow in designing outcome-based contracts<sup>5</sup>.

**2. Lead Agency Model:**

A public agency contracts with a private entity that is responsible for coordinating and providing all necessary services – either directly itself or by subcontracting with a network of service providers – for a defined population of children and families. Michigan and Kansas have adapted this model. Five contractors and 25 non-profit providers offer foster care services and programmes in Kansas (by Nov. 2003). The University of Kansas works with the Department of Social and Rehabilitation services to provide training and evaluation services from the private foster care agencies. Researchers at the Heartland Institute describe the privatization of foster care in Kansas as a great success (October 2003)<sup>6</sup>.

**3. Administrative Services Organisation Model:**

A public agency contracts with a private organisation for administrative services only, and direct services are structured as in the lead agency or public agency models. Massachusetts has combined this model with a lead agency model. Massachusetts took an incremental approach and did not introduce performance standards in the lead agencies' contract until the third year of operation, and sufficient information had been collected to establish a baseline from which to set standards. Massachusetts has reported increased overall costs of its initiative mainly due to increased administrative costs, but reported better outcomes since more children had moved from residential treatment to less restrictive settings.

**4. Managed care Organisation (MCO):**

A public agency contracts with a private organisation as in lead agency model, but the MCO arranges the delivery of all necessary services by subcontracting with other service providers and does not itself provide direct services. Indiana adapted this model but no reports on outcomes were provided in the GAO's study in 2000.

In every initiative the state or locality had continued to conduct all child protection functions related to investigating reports of child maltreatment and recommending to the courts whether a child needs to enter the child welfare system for protective or any other services. A child enters the managed care system on the basis of a referral from the state or locality to the managed care entity. In some initiatives the states and localities also maintained its presence by retaining the authority to approve contractors' decisions related to reducing a child's level of care.

**Performance-based and results-orientated approach to establish accountability**

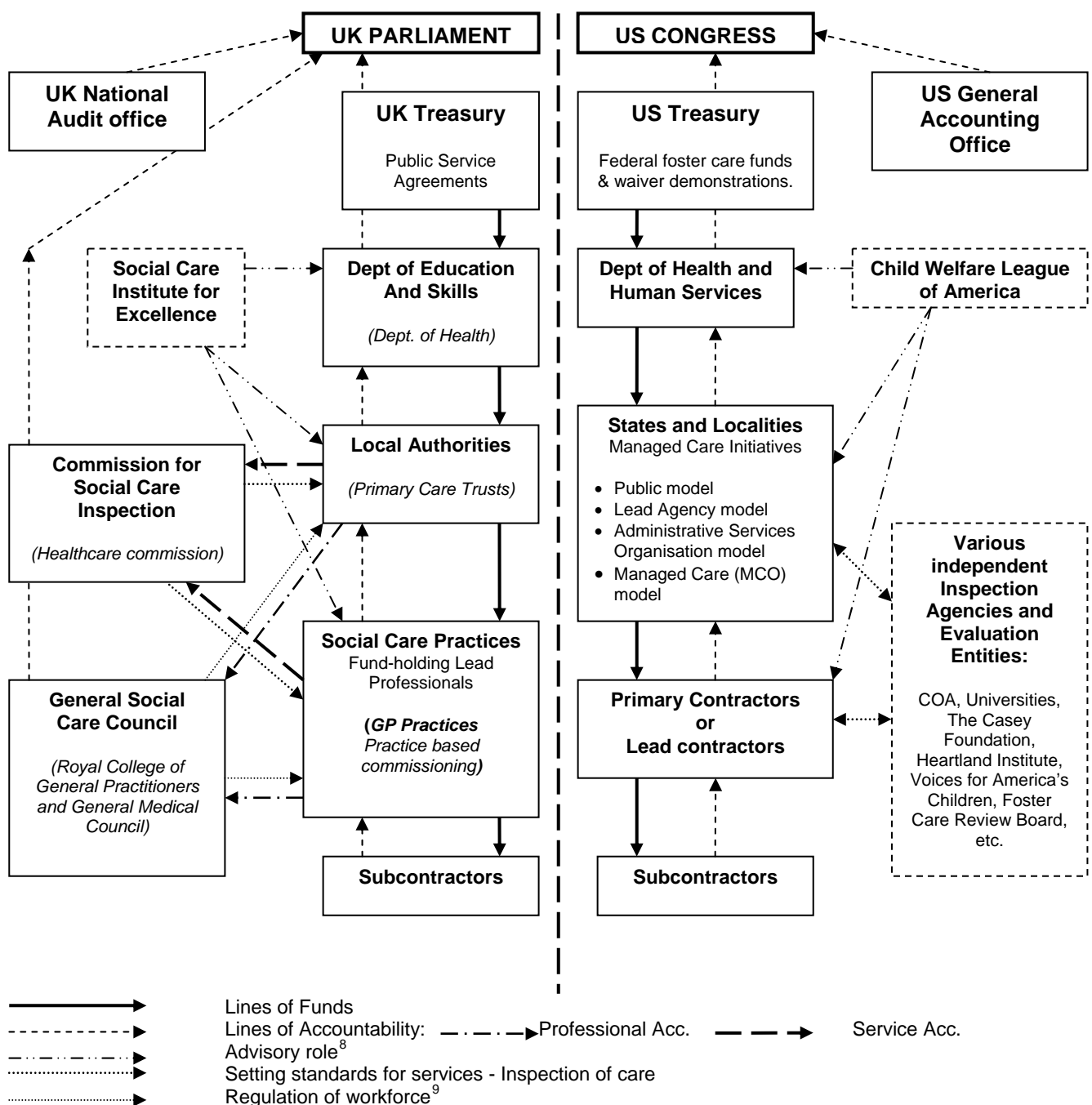
To more effectively monitor the progress of children and families and hold service providers accountable for their services, states and localities were taking steps towards a more performance-based and results-orientated approach. While moving from a process-monitoring environment to a performance-based approach, data systems have become the linchpin between a state or locality's efforts to identify and measure outcomes and thus fully implement such a performance-based, result orientated system.

Many agencies operating these initiatives were holding managed care contractors accountable for quality of care and desired results by using outcome measures to establish performance standards and link performance to financial incentives. For instance, contractors that incur expenses a specified rate

are liable for up to 3 percent of the excess costs; they may retain up to 3 percent of savings if costs are lower. Massachusetts' contractors can earn bonuses for successful outcomes, such as a child who is discharged from foster care and does not return within six months. Contracts used by the Illinois Dept. of Children and Family Services in 2004, specified that when private child placing agencies reunite foster children with families, the reunification must last for at least 12 continuous months if the agency is to claim a positive performance outcome. Thus the agency must work diligently to ensure the reunification process is successful<sup>7</sup>.

The diagram below shows The UK system of Social Care Practices (left) modelled along similar lines as existing organisation of GP practices in the UK (*italic*), and the US states managed care models (right). The map assumes that the existing accountability framework holds. The question is whether that will be the case or whether a different system of accountability should be proposed for the SCPs.

**Organisation of UK Social care practices and the US managed care initiatives in foster care.**



Examples of Child and Family outcome measures<sup>10</sup>

<b>CATEGORY:</b>	<b>OUTCOME:</b>	<b>MEASURE:</b>
<b>Safety</b>	Children are safe from maltreatment	Confirmed reports of abuse and neglect in the general population
		Recurrence of abuse or neglect while children are receiving in-home services
		Reports of abuse or neglect while children are in out-of-home care
		Recurrence of physical abuse, sexual abuse, or neglect after children have left care
<b>Permanency</b>	Children are placed in a permanent home in a timely manner	Children who are returned to their parents or relatives within a specific time
		Finalized adoptions
		Children who achieve permanency within a specific time.
		Average length of stay in out-of-home care
	Children maintain the permanent placement	Children who re-enter care within a specific time
<b>Well-being</b>	Children Function adequately in their families and communities	Children's emotional and behaviour crises that result in hospital use or police calls
		Children's behaviour related to sexual misconduct, running away, and suicide
		Children's scores on standardized tests of childhood functioning
		Children's movement to less restrictive placement settings
		Youths discharged from care who have completed high school, have obtained a general equivalency diploma, or are participating in an educational or job training programme
	Families function adequately in their communities	Families' adaptation to care giving
<b>Stability</b>	Children experience a minimum number of placements	Number of placements while in out-of-home care
	Children maintain contact with their family and community	Children placed with at least one sibling
		Children placed within their home or contiguous county
		Children placed out-of-state
<b>Satisfaction</b>	Clients are satisfied with services	Youths who reported satisfaction with services, as measured by the Client Satisfaction Survey
		Children who reported satisfaction with their foster care placement, based on an exit interview
		Families who reported that the initiative provided them with valuable service

**References and footnotes:**

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<sup>1</sup> U.S. General Accounting Office, "Child Welfare: Early Experiences Implementing a managed Care Approach", (GAO/HEHS-99-8, Oct.21, 1998).

<sup>2</sup> U.S. General Accounting Office, "Child Welfare: New Financing and Service Strategies Hold Promise but Effects Unknown," Washington D.C., July 20, 2000.

<sup>3</sup> U.S. General Accounting Office, "Child Welfare: Early Experiences Implementing a managed Care Approach", (GAO/HEHS-99-8, Oct.21, 1998), pp.5-6.

<sup>4</sup> U.S. General Accounting Office, "Child Welfare: New Financing and Service Strategies Hold Promise but Effects Unknown," Washington D.C., July 20, 2000, p.23.

<sup>5</sup> Texas State Comptroller (2004) "Forgotten Children": A Special Report on the Texas Foster Care System, April 2004, pp.260-263.

<sup>6</sup> Ibid. pp.263-264.

<sup>7</sup> Ibid. pp.30.

<sup>8</sup> Advisory role only. SCIE is a non-statutory body.

<sup>9</sup> Regulation of the workforce involves: a) Registration of individual employee, b) Accrediting and setting standards for training and education, c) Professional quality assurance, and d) Commitment to continuous improvements.

<sup>10</sup> U.S. General Accounting Office, "Child Welfare: New Financing and Service Strategies Hold Promise but Effects Unknown," Washington D.C., July 20, 2000, pp.7-8.