

**MANAGED CARE AND CHILDREN AND
FAMILY SERVICES:
A GUIDE FOR STATE AND LOCAL OFFICIALS**

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FOREWORD

This guide is the final 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 the child- and family-serving system; 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. This guide integrates and translates those papers for policy audiences. Acknowledgement is due to both the experts who have contributed as well as the authors of papers listed below (see Appendix A).

- *Trends and Cross-Cutting Issues* by Cindy Brach and Leslie J. Scallet.
- *Is Managed Care the Way to Go? Deciding To Embark*, by Suzanne Gelber.
- *Public Responsibilities in Managed Care*, by Cindy Brach and Danna Mauch.
- *Designing Managed Care Alternatives*, by Susanna Ginsberg and Sharon Carothers.
- *The Role of Risk-Sharing Arrangements*, by Anthony Broskowski.

The papers were reviewed by Casey Project Officers and PRC Project Managers, revised, edited, and finally reviewed by experts in the field. While acknowledging the work of all who have contributed, the author takes sole responsibility for the content of this guide. 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 undertake such timely and important work.

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INTRODUCTION

This is a new era for the publicly supported child and family service system (CFSS) — that extensive network of government and private non-profit and for-profit organizations and individuals dedicated to protecting and enhancing the lives of vulnerable children and their families. While the CFSS also includes child and family health and mental health systems, this guide uses the term CFSS to refer to those systems that have had relatively little experience with managed care, such as child welfare, juvenile justice, and special education. Nevertheless, this guide should prove useful to all persons involved in providing services to children and families who are struggling with managed care concepts and transformations to the delivery system.

For decades, the CFSS has fulfilled an increasingly complex mandate in caring for abused, neglected, misbehaving, ill, or endangered children and families in our communities. The system has been funded by a complex mix of welfare, social services, education, judicial, and public medical assistance funds, supplemented by specially dedicated categorical funding, grants, and private donations. Regrettably, resources have invariably been insufficient to meet demands. The result is an overworked system operating with a patchwork of legislative mandates and funding sources, insufficient administrative systems, inadequately trained and overburdened staff, and increasingly dated or obsolete practices.

Now a breath of fresh air is blowing through the entire human services industry, fueled by enthusiastic adoption of new managed care practices in the organization and delivery of health care services. The privately insured health care system is coalescing into new organizational structures; similarly, Medicaid and Medicare services are moving towards consolidation into organized delivery systems.

The rapid adoption of managed care is dramatically affecting the operations and structuring of other human services. However, service methods, clinical and professional procedures, and funding principles appropriate to the health care system may not be directly transferable to child and family services, which require a blend of medical and social services. It is increasingly evident that options for assisting CFSS families may be tied to organizational and operational decisions outside the traditional network of CFSS agencies. As more for-profit organizations take over CFSS functions formerly provided by governmental or non-profit organizations, it is inevitable that practices and motivations within the service community will change.

Managed care places a dual charge on CFSS administrators. First, they must decide how to respond to penetration of managed care in other service systems. Second, they must consider whether, and to what extent, managed care might be appropriate for adoption by the CFSS. Ideally, managed care would produce both cost savings and improved services. However, instituting managed care practices in the CFSS would entail significant changes that could lead to negative consequences for clients. CFSS administrators are therefore challenged to determine which measures are reasonable and appropriate to accomplish both fiscal and quality goals.

While this period is fraught with uncertainties, it is an opportunity for CFSS personnel and system advocates to participate in an era of exciting innovation. The tasks include helping to redefine the boundaries between public and private sector functions, redefining the domains of non-profit and for profit, and introducing new approaches to serving vulnerable people never before achievable under more restrictive administrative environments. It is critically important that this movement towards human services innovation is managed carefully and responsibly. Sufficient protections

and monitoring must be built in to assure that private aspirations do not deteriorate into irresponsible and reprehensible practices that forever destroy the fabric of compassionate care across the face of America.

If the CFSS is to continue meeting its objectives and still maintain some freedom to take effective and innovative action to preserve vulnerable families and children, public CFSS officials must face the challenges presented by managed care, including:

- Assuring that vulnerable children and families requiring CFSS services receive adequate health services under existing or proposed public managed health care initiatives,
- Determining the adaptability of managed care principles and methods to achieve improvement and innovation in CFSS,
- Establishing an orderly process for planning and introducing appropriate managed care practices to the CFSS system,
- Monitoring and continually adapting the system to assure adherence to public policy mandates, and
- Assuring continued input and feedback from the public.

This guide presents a broad overview of managed care concepts and suggests some of the myriad challenges it raises for CFSS administrators and advocates. It is intended to assist state and local government officials in conducting a careful review of the existing system of services for children and families — especially those who are ill or otherwise vulnerable. The guide outlines how a systematic review of the service system could be conducted and identifies some key issues to be considered and questions that need exploration. The focus encourages planners to recognize that there may be differences in applicability of some managed care practices between health systems and other human services.

The sequence of steps in this guide reflect the recognition that a fundamental responsibility of government is to provide leadership in shared planning for community service requirements. The rapid changes affecting public responsibilities for services for vulnerable families and children require a major and ongoing rethinking of the system and an openness to introducing new methods or adopting innovative technologies. The report begins in Part I with a review of managed care from a child and family service system perspective. Part II calls for the establishment of a managed care planning process. This process, laid out in concrete tasks in Parts III through V, entails analyzing the roles and future expectations of public agencies, assuring public input to the planning process, and evaluating current system performance — including a realistic assessment of provider capabilities, system funding, management information system capabilities, staff capabilities, and performance evaluation capabilities. Part VI outlines the final steps in the planning process — completing a planning report and proposing both short-term improvements and long range innovations.

In this rapidly changing environment, it will be virtually impossible to accomplish a full, in-depth study of all the areas outlined in this guide. One might, more realistically, use the guide as a handbook of managed care issues to keep in mind and “keep an eye on” as one moves among the various changing elements of human service management.

PART I **VIEWING MANAGED CARE FROM A CFSS PERSPECTIVE**

The first step in evaluating the applicability of managed care practices to the child and family service system (CFSS) is to review the intended purpose of fundamental elements of managed care practices. As incorporated into managed health care, these practices are intended to produce positive health outcomes by applying a broad range of innovative mechanisms to organize service delivery, coordinate care, control utilization, and make effective use of resources.

The problems they are intended to correct might be summarized as:

- Fragmented service delivery and lack of orderly service planning for patients.
- Unacceptably high costs for health care services, insurance coverage, and residual health care expenses, and lack of incentives for either consumers or providers to control costs since most expenses are paid by a "third party" (e.g., an insurer, the government).
- Lack of direct accountability among those who finance, provide, and use health care services, which has contributed to an excessively expensive, fragmented, and cumbersome health care system.

GOALS AND MECHANISMS OF MANAGED CARE

Looking at the health care system's application of managed care principles is an important step in evaluating the potential use of these practices in the CFSS. Below are some of the goals and service-improvement mechanisms introduced under managed health care to correct or prevent perceived problems. The CFSS might then consider how applicable these mechanisms would be in achieving CFSS improvement goals. To help CFSS officials think through these issues, some similarities and differences between the health care system and the CFSS are reviewed and some questions CFSS officials will want to raise are posed at the end of this part of the guide.

GOAL: COORDINATE SERVICES

MECHANISM: CARE/CASE MANAGEMENT

Designating doctors or trained clinicians as "case/care managers" to develop, organize, coordinate, procure, and monitor the execution of service plans for patients facilitates service access and coordination. Case managers can be employees of a managed care organization or independent practitioners, as in primary care case management (PCCM) programs. In PCCM programs, a health care provider, often the primary care physician, is held responsible for approving and monitoring the provision of all services covered by a health plan to the patient and family. The provider acts as the insurer's gatekeeper for patient access to health care services. Primary care case managers are usually paid a fee and do not assume financial risk for the provision of health services.

MECHANISM: SERVICE NETWORKS

By incorporating a broad range of general and specialty services within a **single provider network** or organization, it is possible to **simplify access to a continuum of services** and assure **coordination of care**. The breadth of the network depends on how managed care is structured. Some services or service populations can be separated out and contracted to a separate provider organization or organizations or excluded altogether from the existing arrangement (“**carve out**”). (The reverse situation is sometimes referred to as a “**carve in**.”) Arrangements can be made for services from an **exclusive provider** or from a **small number of select providers**. Payment can be fee for services, case rated, capitated, or any combination of payment arrangements. (See p. 5 for a discussion of payment mechanisms.)

GOAL: CONTROL COSTS

MECHANISM: BENEFIT REDUCTION

Cost is lowered by **reducing the types and range of covered services**, by setting **limits on duration of treatment**, by setting **spending caps on services**, or by delineating more **restrictive access requirements** in benefit plans.

MECHANISM: UTILIZATION MANAGEMENT

Requiring **pre-authorization** for payment prior to admission to inpatient facilities, emergency rooms, or before other high-cost or high-risk service or treatment is provided discourages and thus reduces unnecessary procedures or inappropriate service use. Clinicians and facilities must meet accepted practices to receive payment authorization.

Applying **computer-assisted “intelligence systems” (treatment profiles)** to monitor diagnosis, using **standardized treatment protocols (also known as practice guidelines)**, and monitoring performance against **expected outcomes** improve consistency in treatment and make costs more predictable.

Concurrent review and approval of the appropriateness and necessity of care as a condition of payment authorization reduce excessively prolonged treatment or unnecessarily expensive treatment levels.

Retrospective review assures that diagnosis, treatment, and outcomes meet acceptable criteria. Profiles of providers can be analyzed to identify providers that routinely order high-cost treatment so that referrals can be directed to the most cost-effective providers. Corrective action can be taken when a pattern of ineffective or inefficient treatment is observed.

MECHANISM: NEGOTIATED DISCOUNTS

Negotiating **reduced charges, discounts, and bulk purchasing rates** with doctors, clinicians, and facilities brings down the price paid for services. Providers accept reduced fees in exchange for increased referrals (or to avert the prospect of reduced referrals) and agree to participate in utilization review and quality assurance programs. Reimbursements to providers are further constrained by requiring careful adherence to strict billing, access, and administrative and required clinical procedures and documentation as **conditions of payment**.

MECHANISM: LIMIT PROVIDER PAYMENTS

Payment levels are based on pre-established **discounted agreements** or on **area-adjusted patterns of treatment charges**. Fee schedules can include separate agreed rates for each sub-element of service or a single rate for all elements of a service encounter.

MECHANISM: ADOPT PAYMENT MECHANISM THAT SHIFTS RISK

Under the “**fee-for-service**” payment mechanism which formerly dominated the health care system, insurers carried the full risk burden for **charges billed retroactively for services already delivered**. Under managed health care, the insurer transfers some or all of the risk to providers via **service agreements and contracts** which define eligible services, level and method of payments. Shifting risk to providers can encourage more aggressive cost management. Risk-based agreements usually specify how costs or savings above predicted level will be allocated between provider and insurer. There are numerous versions of such payment systems, including:

- **Partial risk** — Provider covers all costs up to a defined limit beyond which the insurer pays additional monies to cover costs for unusually catastrophic cases. Certain high cost or highly variable services might be excluded from provider’s obligation. Savings are retained by provider.
- **Shared risk and benefit** — Both insurer and provider participate in the risk by each paying some predetermined portion of unexpectedly high costs and by each receiving some predetermined portion of savings achieved by efficiency improvement and/or reduced demand or utilization.
- **Full risk** — Provider accepts responsibility for all services needed by authorized recipients, paying whatever costs are incurred and retaining whatever savings are accrued through operational efficiencies or restrained demand.

Risk-shifting payment methods generally involve bundled rates. Payment is made on a fixed fee basis. Costs are aggregated for a related set of services and a single averaged rate is paid. These payment mechanisms limit the variability or “spread” of charges for a given service. Providers have an incentive to control expenses to avoid losses. Providers face a risk that the needs of certain patients may incur unexpectedly high costs.

- **Per diem rate** — Payment of a specified amount for all services delivered to a client within a single 24-hour period. As an example, this payment is frequently used for inpatient psychiatric services. Payment assumes that charges for most or all services are included in the rate. Providers are at risk if the types of patients served require higher than expected service levels, but they are not at risk for services of longer duration. Providers have an incentive to reduce inefficiencies or eliminate unnecessary services to keep costs down. They may also endeavor to turn away patients whose service requirements will be unusually costly, or they may have an incentive to retain patients longer whose treatment costs are lower.
- **Case rates** — A fixed fee is to cover all expected costs incurred for a specified patient per treatment episode. The provider is at risk if the service levels of patients, duration, and costs of service exceed projections. In addition to the efficiency incentives engendered by per diem rates, case rates give providers incentive to reduce the duration of treatment and avoid serving patients whose treatment will be lengthy. Some case rates may be established on an annualized

basis, allowing considerable flexibility to the provider but also placing the provider at risk if the service levels of the patient are higher than projected.

- **“Global case rate”** — Payment is based on an expected cost basis adjusted for severity, geographic area, and other factors.
- **Diagnostic Related Group Value (DRG)** — Certain standardized procedures are paid based on preestablished rates calculated from aggregated data on charges for a procedure or group of patients (with necessary adjustments for severity and regional variances).
- **Capitation payments** — A single previously-negotiated monthly or periodic payment is made for all members of a pool of potential service users. Payment is made whether or not the client uses any services. Payment is intended to offset the expense of all services delivered to the enrollees, as defined by a specified benefit (or service) package. Providers are at risk to respond to whatever level of service demanded by enrollees if the demand falls within contractual terms. Establishment of capitation rates presumes existence of valid data regarding patterns of actual past use to project expectable future enrollment and demand patterns.

Within a capitated system, it is possible to “sub-capitate” to providers who accept prepaid payment levels for a pool of beneficiaries being served within their practice. They assume a share of the risk for maintaining service levels within an expected range and can benefit from savings when service levels are below anticipated volumes.

GOAL: ASSURE QUALITY CARE

MECHANISM: PROVIDER PERFORMANCE MONITORING

Credentialing of providers and use of **performance rating systems** assure selection of and reliance on competent providers.

Requiring internal **quality assurance** assures screening of treatment against accepted treatment standards and correction of deficient practices.

Encouraging use of **continuous quality improvement/management** techniques facilitates system-wide identification and remediation of flawed or inefficient treatment systems and methodologies.

MECHANISM: OUTCOME MONITORING

Collection, aggregation, and analysis of massive amounts of **performance data** enable system-wide learning and improvement.

Use of **performance outcome ratings** allows patients to be directed to the most effective providers. Poor performers can be dropped from the network or trained to produce better results.

Customer satisfaction surveys provide valuable feedback to quality assurance activities. Their use assures maintenance of positive patient/provider/insurer relations and continuation of support for the chosen insurance and provider system.

MECHANISM: TECHNOLOGY IMPROVEMENT RESEARCH

Collection, aggregation, dissemination and testing of new and improved treatment models facilitate **performance monitoring**, enable identification of **best practices** and adoption of accepted **treatment protocols**.

Process and procedure studies identify emergent and ongoing effective and efficient techniques and technologies.

MECHANISM: SYSTEM PROFILING

Development of **common terminology** for various diagnoses and treatment protocols and use of **standard billing practices** enable generation of data on patterns of demand, costs of service, and volumes of procedures delivered. These, in turn, enable creation of fairly **reliable profiles of expected service demand** for various demographic groups and geographic areas and **projection of health cost profiles**. Such data is essential to projecting demand and estimating cost.

GOAL: DEVELOP INNOVATIVE MANAGEMENT AND SERVICE DELIVERY SYSTEMS

Managed care organizations (MCOs) are entities that use some or many of the managed care mechanisms described above. The term MCO is usually reserved to organizations which accept some level of responsibility and financial risk for delivery of comprehensive or specialized health care service to a beneficiary group. Many factors affect the structuring of managed health care organizations.

MCOs may or may not provide a risk-related insurance function. An MCO may be the insurer or provide services for an insurer. In most states, if an MCO is assuming financial risk for services to be provided, it must be licensed as an insurance company. States limit risk assumption by certain organizations (e.g., public hospitals might be constrained against ownership participation as a health maintenance organization). Some states limit the legal arrangements that can be made with physicians, thus affecting how an MCO can organize to deliver patient care services.

Services may be delivered directly by the MCO or through contracts or joint ventures with service providers. An MCO may provide a full array of services or it may contract out some or all services. Specialty MCOs take on full risk for administration and delivery of services within a specialty area, such as behavioral health care.

There are many types of MCOs, some of which are described briefly below:

- A **Health Maintenance Organization (HMO)** incorporates financial risk, administrative functions, and treatment responsibility within a single organization. The **staff-model HMO** employs physicians and other staff as salaried personnel usually operating within specialized treatment facilities. A **group-model HMO** relies on **affiliated physician and professional groups** to serve their members under contractual agreements. In an **open panel system**, any number of physicians or other providers can agree to serve HMO members under a payment agreement with the HMO. In a **closed panel system**, the HMO determines the numbers and types of providers it needs and limits access to members to those identified participants.

- **An Independent Practice Affiliation (IPA)** enables providers to retain their own practices and treat patients whose care is paid for by various payers. Providers within an IPA can contract with an HMO to provide patient care to their members. This model gives wider choice of providers to beneficiaries but lacks some of the efficiency and potential cost-savings of a staff- or group-model HMO. Under this system, physicians and other providers can directly control their scale of operation and maintain some control on patient volume.
- **A Preferred Provider Organization (PPO)** is a network of preselected physicians, professionals and other service providers who contract to provide services on a reimbursable (usually discounted) fee-for-service basis and agree to adhere to various types of utilization control and quality monitoring. Beneficiaries usually exercise their own choice in selecting a provider within the approved listing. They may choose to seek care out-of-network but usually incur some additional costs to offset the expected higher charges for service.
- **An Exclusive Provider Organization (EPO)** contracts with an insurer or other MCO to serve as the only provider of a type or set of services under prior agreement regarding payment, levels of service, access, review and monitoring, etc.

In addition to MCOs, an increasingly wide variety of arrangements have been developed to provide specialized management services to health care providers and insurers. They may also form alliances or joint ventures with other provider and management groups to provide full-service MCO capability. These include:

- **Management Services Organization (MSO)** — Physicians and service providers form or contract for management services to control costs by consolidating administrative costs and operations. MSOs serve as purchasing alliances and perform other functions such as scheduling, billing and collection, facility management, staffing and often represent provider interests in contract negotiations.
- **Administrative Services Organization (ASO)** — Health plan administrative functions for insurers, including self-insured employers, are performed through arrangements with ASOs. Services may include enrollment, eligibility determination, provider identification and credentialing, utilization control, performance monitoring, data analysis, claims, payment, and adjudication. They may also advise on benefit design and make arrangements for access to health care services through MCOs. Alliances between providers and ASOs to form full-service MCOs are increasingly common.

POTENTIAL USES FOR MANAGED CARE PRACTICES IN CHILD AND FAMILY SERVICES

There are numerous long-recognized areas for improvement in the CFSS where managed care practices might prove applicable.

- Improving service coordination by more effective use of case/care management practices and increasing use of coordinated service networks.
- Controlling costs by using concurrent review of ongoing cases, developing and applying service profiles and service protocols, and negotiating reduced rates and requiring risk-sharing with service providers.

- Improving the quality of services through more extensive adoption of quality improvement practices and use of performance data and outcome monitoring.
- Introducing innovative management and service delivery practices, which could enable new service practices and more efficient operational management.

Managed care principles and practices could encourage or facilitate the CFSS in:

- De-categorizing funding to enable payment for a wider range of needed services to a wider range of providers for services to children and families.
- Assisting providers to work together to simplify the coordination of service provision across organizational or operational boundaries.
- Breaking down administrative and procedural boundaries to enable a smoother flow of resources to children and families and to simplify the work of staff trying to serve them.
- Improving the professional competence of staff, including case workers, clinicians, and managers.
- Enhancing the satisfaction of those whose chosen work is to assist vulnerable children and families in the community through working in more productive and effective organizations.
- Reducing or increasing, as appropriate, the number of persons involved in providing or assuring access to compassionate care and support.
- Improving methods of monitoring to assure that the child and family conditions are improving, that providers are meeting expected standards of service, that the community's expectations are being met, and that resources are being used appropriately.
- Improving reporting methods so that the quality and usability of the information increase.
- Improving the effectiveness of monitoring methods while maintaining costs for monitoring at appropriate levels.
- Enabling the design of and payment for new types of services not presently available.

The challenge CFSS administrators and providers face is to examine the similarities and differences between the health care sector and CFSS and assess how applicable key managed care practices are to CFSS. For example:

- Opportunities for reconfiguring services to **reduce unnecessary expenditures** could be similar between health care and other elements of human services. Savings resulting from reduced use of in-hospital services in health care might be compared to potential savings in CFSS from reduced use of residential treatment centers for vulnerable children and youth. Realizing these potential savings can serve as a strong incentive for service system reform.
- **Improved documentation and analysis of trend data, and measurement of performance and outcomes** are essential, not only for health care management, but also for the broad range of human services. They facilitate monitoring how the system is currently performing and predict future patterns of risk and expected demand. CFSS administrators will be challenged to determine how readily these practices can be adapted in their system, given the current state of management information systems, existing data, and performance standards.

- **Risk management** challenges in CFSS may be different from those in health care. Projecting and controlling demand, use, and cost in health care are extremely complex because of wide variation among users. Factors such as causes and extent of illness or disability; cost, complexity, and duration of treatment; and level of expected recovery affect risk for providers and payers. Analyzing and projecting variations among CFSS clients may not present as great a challenge, but will remain significant in system planning, especially in preparation for any transfer of service and/or financial responsibility.
- **Transferring risk** as a mechanism to control unnecessary health care spending is another factor to compare against CFSS goals and responsibilities. In the health care system, managed care is attempting to correct for fundamental disincentives to restrain use or cost, both by the consumer and by the provider. But in CFSS, many clients have limited interest in receiving services; certain providers are unable to meet existing demand for their services and thus have limited incentive to “over serve.” However, many CFSS providers exhibit behaviors similar to health care providers in attempting to provide more expensive services than are deemed necessary. Another difference between the CFSS and the health care system is that courts are more likely to order that CFSS clients be provided particular services, thus requiring providers to incur costs beyond their control. Mechanisms to take into account a high level of court mandates are essential to adapting managed care risk shifting practices to CFSS.

There are also key areas of service system performance where the CFSS may be ahead of health care managed care. For example, consumers have strong advocacy voices in certain areas of CFSS such as service planning. Such consumer opportunities are receiving increasing emphasis in health care managed care. In other areas such as “consumer choice,” important health care system principles are offering new challenges to CFSS. How could CFSS benefit from introducing “consumer choice?” If CFSS clients were allowed to choose their own provider, what effects would that have on clients and providers? On what basis would clients make such a choice?

In studying managed care operations in the health care sector, CFSS planners and administrators might ask themselves continually:

- “How is this practice applicable to improving services and reducing unnecessary costs in the CFSS?”
- “Knowing that this is a highly valued practice in managed health care, what equivalent methods are currently available in the CFSS that could achieve similar goals?”
- Alternatively, “Why aren’t similar technologies generally practiced in the CFSS? What would it take to develop and implement them in the CFSS? Is there a good reason why these practices haven’t been adopted in the past? Are those factors still valid or do changed circumstances require a reevaluation?”
- “Is it possible that the use of this practice might potentially have adverse affects on the CFSS? If so, what action could and should be taken to correct this?”
- “Noticing that innovations have produced improvements in health care management, which similar innovations are evident but not widely known in CFSS? What would it take to disseminate these more widely or to adapt them for more wide acceptance?”

It is evident from the foregoing that selecting among managed care practices that have evolved in the health care field and adapting them to future demands of the CFSS offers exciting challenges and opportunities for CFSS administrators, providers and advocates.

CFSS PARTICIPATION IN MANAGED HEALTH CARE INITIATIVES

At the present time, many states and communities are involved in introducing more effective management methods into the care of persons receiving health and human services. Case management and other forms of service coordination or service integration are becoming common practices. Full- and partial-risk contracts have been awarded to MCOs to provide health care to Medicaid recipients. In other areas, specialty services such as mental health care are being provided and funded under capitated or rate-based agreements. These new contractual arrangements are significantly affecting the services available to vulnerable children and families.

Past human service funding policies deliberately focused on the Medicaid program as the primary funding source for health and related support services to vulnerable populations. Rather than perpetuate a growing number of separate health-related programs, legislative and administrative policies during the 1970s and 1980s focused on Medicaid as the primary funding and oversight mechanism for these programs. Health-related social support and service coordination functions were increasingly funded through expansions of Medicaid authority. For example, the CFSS has built up effective networks of health-related services through school clinics and family health centers. The CFSS has also used Medicaid to encourage programs with unique cultural competence. Thus, the CFSS has a vital interest in decisions affecting the organization, delivery, and administration of Medicaid managed care initiatives. CFSS administrators and advisors should have a strong presence in planning, implementing and monitoring these initiatives. Feedback from CFSS providers and stakeholders on how these initiatives are affecting services to CFSS populations should receive serious consideration.

If a Medicaid managed care contract has not yet been announced, CFSS officials should request training to enable them to provide informed input into contract planning and to participate in the implementation and monitoring process. In order to assure their inclusion in managed Medicaid provider networks, CFSS administrators might advocate that Medicaid contracts:

- Require that MCOs under contract with the state include CFSS traditional “safety net” providers in their provider networks, that training on contracting be provided to safety net providers, and that these providers be offered opportunities to enter into future provider contracts;
- Evaluate MCOs on their level of success at incorporating innovative or previously effective CFSS-related health providers into their system;
- Include provisions to monitor the reasonableness of MCO rate setting to assure viability of providers who traditionally serve higher-need populations; and
- Require that MCOs solicit CFSS consumers, community advocates, and safety net service providers in their satisfaction reporting process and evaluate the results as a MCO performance rating element.

State Medicaid managed care initiatives offer CFSS administrators an opportunity to observe first-hand the actual operations of managed care services and administrative systems. Collaboration with governmental managers of Medicaid managed care initiatives can contribute to ongoing efforts to improve all human services within the state. CFSS agencies should invite suggestions on how innovations in managed health care could be applied to the CFSS. State CFSS officials and data and finance officers might participate with Medicaid officials in a mutual learning context to track

implementation of managed care in the health care sector and explore its applicability to other service systems.

Early participation in managed care initiatives and a thoughtful consideration of its applicability to the CFSS are key in assessing appropriate adaptation of these methods for serving vulnerable families and children.

PART II

ESTABLISH A MANAGED CARE PLANNING PROCESS

In order to assure adequate consideration of the needs of vulnerable children and families in publicly-assisted programs and services during this period of major change, CFSS administrators are challenged to establish an ongoing reform planning process to conduct a systematic review of the CFSS in light of new managed care practices. This review may suggest short and long range strategies for adapting managed care practices and related innovations to CFSS.

The focus of public leadership in many areas of human services is shifting from providing and administering services to defining needs, setting and monitoring adherence to standards, and managing resources that enable the provision of human services. These changes are manifest in federal and state health and welfare reform initiatives and legislative changes that may radically alter governmental CFSS functions. Administrative changes such as governmental managed care reforms are also affecting CFSS functions. As administrators of state and local Medicaid managed care initiatives gain prominence in shaping statewide health policy and practice, their influence inevitably extends to other human service domains. CFSS administrators must be deliberate in deciding in what direction to take the CFSS.

TASK 1. DECIDE LOCUS OF POLICY AND ADMINISTRATIVE AUTHORITY

A system-wide review of the CFSS requires designation of an agency or agencies to coordinate the process. If the CFSS is already incorporated within an integrated human service agency, leadership of the process may be readily determined. However, it is possible that even within such an agency, control of planning may be split between fiscal policy makers and specialists with direct service or population focus. Optimally, such a planning process would operate within a clearly defined policy authority in order to facilitate its effectiveness. Issues to be addressed include:

- Where will planning and policy authority be vested?
- Where will responsibility be vested for implementing the planning process?
- What agencies will be required to provide support to the process?
- Who will direct that this support be provided?
- Which staff members will be directed to participate in this process?
- What resources will be required?
- Where will resources for the planning process come from?

Since there are so many governmental agencies responsible for or affecting the lives of vulnerable children and families, it is essential that these agencies collaborate on CFSS planning initiatives. Establishing collaborative exchange among staff with various levels of managed care expertise will assure a more realistic appraisal of the implications of managed care technologies for CFSS. Teaming CFSS administrators with staff involved in managed care initiatives could enable rapid transfer of technology to CFSS while assuring that CFSS staff have a valid role in shaping managed care policies that affect vulnerable children and families.

Staff involved in this process need to have a viable structure for sharing information, resolving differences and working out solutions to organizational boundary disputes. A “council” of senior officials might be established to direct, review, and approve the activities of one or more working group(s). Consideration should be given to intra-departmental and inter-department participation and to inclusion of officials from other government entities. Issues to be addressed include:

- Who are the key decision-makers? Who will convene them, and how?
- How will the numerous organizational, policy, and cross-cutting operational issues be addressed and resolved?
- What forums exist for collaboration on conducting the plan, sharing information, analyzing opportunities, coordinating input and resolving operational questions?

TASK 2: CONDUCT CFSS MANAGED CARE IMPROVEMENT PLANNING PROCESS

Optimally, the agency or agencies that take responsibility for an effective CFSS managed care planning process will establish an orderly process for conducting a comprehensive system-wide review of the CFSS to determine its current and future capabilities in light of managed care practices. The agency/agencies responsible for the planning process will set a timeframe for completing the study, assign responsibilities, and assure prompt resolution of policy issues. The lead agency will keep various interests involved and informed and will encourage as wide a participation in the process as is feasible.

As detailed in the next sections of this guide, this review will:

- Secure input from key interests (“stakeholders”);
- Analyze current CFSS performance, including provider capabilities, system funding, management information systems, staff capabilities, and performance evaluation capabilities;
- Analyze roles and expectations of public agencies; and
- Develop proposals for short-term and long-range improvement goals.

Each stage of the planning process will generate a report summarizing the findings of that aspect of the process. These reports will culminate in a final blueprint for recommended CFSS reform. For a suggested template for this final CFSS planning report, see Appendix B.

PART III

ASSURE PUBLIC INPUT TO THE PLANNING PROCESS

Effecting a successful change in the operations of any public system demands that persons with a “stake” or interest in these activities — “stakeholders” — have an opportunity to share their valuable knowledge and perspectives on potential reform endeavors. A thorough discussion of change options provides an excellent forum for learning and facilitates a gradual or even rapid movement in new directions. Stakeholders are also more likely to support changes which they have helped to shape. Activities to obtain stakeholder input into the planning process should seek to generate answers to the following questions:

- What are the various voices saying about human welfare?
- What do people consider primary responsibilities in maintaining the public trust of caring for vulnerable children and families?
- What are religious, cultural, and ethnic groups; professional associations; the business sector; families; parents; communities; and others saying about their expectations of the CFSS?
- What do taxpayers expect of the CFSS and what are they willing to pay?
- What are people not daring to say about the CFSS but expecting that it is recognized anyhow?
- What are people presuming or assuming are inherent values to be protected, even if these perspectives are not expressly articulated?
- What can government continue to do for vulnerable children and families? What can't it do any more? What should it do? What should it quit promising to do? What should it quit trying to do?
- What must government do, despite the unwillingness of some interests to agree?

Officials responsible for a comprehensive CFSS managed care planning process have an important role in facilitating a stakeholder dialogue.

TASK 1. IDENTIFY STAKEHOLDERS

Developing a comprehensive articulation of community values requires the input of all types of people including those who have tried innovations and failed, those who embrace change, those who refuse to accept change, and those who are mediators and stabilizers. It must include the perspective of those whose voices speak of ideas that are unconventional, discontented, and contrary — not merely the ones that sound agreeable and comfortable.

Statewide and community-level perspectives are essential in the development of an improved CFSS. An effective dialogue provides a two-way flow of information between statewide and community groups. Also, input should be an ongoing process, not a once-only at-the-beginning endeavor. Expectations and conditions change rapidly and stakeholders have their finger on the pulse of changing conditions. Their continuing input is invaluable and absolutely essential. When seeking input from various CFSS stakeholders, there must be realistic assessment of who has time to work on this. Who can wrestle with disparate ideas and suggest new integration? Who can research? Who will write reports and summaries? Who has time to meet and will keep these

commitments? Who will provide prompt and incisive review and comment? Who has the energy and the passion?

Assign Responsibility

- Who is responsible for assembling a list of stakeholders to invite to participate?
- Who will verify completeness?
- Who will manage and coordinate the process and keep it on track?

Review Past Stakeholder Activity

- What efforts have been made to conduct public education and information sessions to enable informed public input on managed care changes?
- How has their input been solicited in the past?
- Have hearings been scheduled previously?
- What results have been obtained?
- What effort has been made to synthesize the results of these sessions and secure feedback from participants as to whether the synthesis adequately captures the nature of the deliberations?

Select Participants

- Who has an interest, claim or “stake” in the reshaping of the service system?
- Who are likely to be affected by changes in operational and funding policies of the CFSS now or in the future?
- Are stakeholders knowledgeable about forces outside the service system that are pressuring for change or likely to effect changes within the CFSS?
- Have they indicated interest in managed care reforms?
- What will it take to increase their understanding of managed care?
- What do they know already that would benefit the public agencies or benefit other related interest groups?

Sample list of potential stakeholders:

Adoption agencies	Foster parents
Business leaders	Heads of human service agencies
Child and family advocates	Health care system administrator(s) (public/private)
Child welfare representatives	Juvenile justice representatives
City council members	Lawyers
Community organizers	Mental health representatives (public/private)
Courts	Other service providers
Cultural groups	Parent groups
Economists	Pediatricians/other health professionals
Educational representatives	Philanthropies
Ethnic group representatives	

Residential treatment center providers
State finance officers
State legislators
Teachers

Vulnerable families
Welfare agency representatives
Etc., etc., etc.

It is important that stakeholder discussions include participation by administrators of public agencies who are clearly knowledgeable about the CFSS in federal, state, and county/city government. They know legislative and general legal requirements, administrative practices, policy enactments, and fiscal expectations. These participants should be considered respected voices in the process of discussing stakeholder concerns. These public officials can provide informative input to discussions. They can identify and champion innovative ideas that emerge from stakeholder discussions. They might also use the occasion to sample informal feedback from stakeholders on potential new CFSS management ideas being considered within the government.

TASK 2. DEVELOP BACKGROUND MATERIALS TO INFORM THE PUBLIC

The purpose of securing input from CFSS stakeholders is to develop a broad-based consensus on future values and goals for a reformed system. While the focus of these discussions is on managed care and its potential impact on CFSS, stakeholders may want to consider more fundamental changes. What information will people need to help them understand the context for change? Are they aware of key conditions precipitating the pressure to rethink the existing system? What else will participants need to make effective contributions?

Stakeholders can make more appropriate recommendations if they have information on the problems and challenges facing the CFSS in a changing financial and operational environment. Stakeholders should have information on:

- How the CFSS is currently structured,
- How managed care initiatives may affect the CFSS,
- What new managed care mechanisms might be introduced to the CFSS and what that might mean to CFSS clients and services, and
- Relevant evaluation data from managed care initiatives.

“White papers” might be developed summarizing forces potentially affecting the future status of the CFSS. Background bibliographies would also be useful. This information might be researched and reported by graduate students, professional groups, specially assigned staff members, or consultants. This information would be useful as briefing information for study groups, hearings, and forums. Copies could be circulated requesting public comment regarding the expected impact on human services for children and families.

Assign Responsibility

- Who will develop a statement of explanation, white papers, and supporting materials?
- Who will review and approve such materials?
- How will they be disseminated? By whom? When?

TASK 3: GATHER INPUT FROM STAKEHOLDERS

It is important that participants be provided a clear statement of expectations of participants in the planning process and some information on governmental activities exploring managed care innovations for the CFSS. The challenge for all participants is to help assess the CFSS' current performance, reconceptualize current practices, and introduce suggestions for innovation in light of current and future expectations and possibilities about managed care and other human service management and funding innovations. Organizers must select feasible and efficient methods and gather input from stakeholders. Task forces, focus groups, public forums, surveys, use of experts, and collection of existing reports are some of the processes that enable public input. Some issues to be considered for each method are listed below.

Task Forces

- What responsibilities and tasks could be assigned to the group? Who will define them?
- Who will lead? Who will participate? Who selects? How are they contacted?
- Will the group need information, education, or training? How, when, and by whom will this be provided?
- How will their work be accomplished (individuals, teams, whole group)?
- Where will the group meet? Who will schedule meetings?
- Will there be costs? Who will pay?
- Who will determine deadlines?
- To whom will their results be reported? In what form?

Focus Groups, Public Hearings and Forums

- Who will organize? Who will convene?
- Who will participate? How will meetings be structured?
- Do participants have adequate information and understanding to make beneficial contributions?
- Will information, education, or training be part of the process?
- Is there time to conduct them? Is there funding to pay for them?
- Where will they be held to assure broad-based and geographically diverse input?
- How will results be reported, summarized and validated? Who receives feedback?
- Whose perspective has been left out? How can this be corrected?
- How will differences be resolved?

Surveys

- What survey instruments already exist? What survey results already exist? How current are they?
- Who will design any new surveys? Who will validate their content?
- Are there any authorizations needed to conduct a survey?
- Who can conduct the study?
- Will there be a time delay or necessary clearances to enable them to act?
- How will a valid sampling be secured?
- What will it cost? Who will pay? How long will it take?

Experts, Key Informants, and Specialty Consultants (Interviews, Reports, etc.)

- Who has unique expert knowledge to be sought out?
- How and when will it be secured? By whom?
- Should paid consultants be used? Who will pay? Who defines and monitors performance?
- How will consultant contributions be incorporated into the whole perspective?

Collection and Analysis of Reports, Speeches, etc.

- What other information is readily available?
- Who will read it and incorporate its perspective into the total input gathering effort?

TASK 4. PREPARE REPORT OF "FINDINGS"

The planning group should collect and summarize the stated expectations of various stakeholders and integrate these perspectives into the overall planning process. The key question to be answered is: What does all this add up to in suggesting the future direction for the CFSS? What would be the presumed or expected role for various businesses, organizations and the government in assuring a healthy, stable, effective family environment for children?

Assign Responsibility

- Who will integrate the "findings" from the various sources and prepare a written statement articulating the consensual values and expectations?
- How will these be verified?
- Who will "accept" these results?
- How will they be used?
- Will they be considered and adopted? By whom?

Report Requirements:

- States clearly and succinctly the values and goals commonly agreed to by the various sources of input;
- Explains alternate objectives that were not pursued and justifies why they were rejected;
- Identifies the “higher good” values that have been applied when necessary to mediate differences in expectations (e.g., citizens’ preference for lower taxes versus expectation of government to provide adequate support for children and families);
- Provides resolution to issues where stakeholders don’t agree;
- Identifies alternative suggestions not previously considered;
- Identifies additions as insertions, distinguished from the prior deliberations;
- Proposes an “action agenda” that adheres in good faith to community perspectives while upholding governmental responsibilities; and
- Adapts objectives to new reality until there is a reasonable fit of objectives balancing against the various interests.

TASK 5. MAINTAIN ONGOING STAKEHOLDER FEEDBACK ON CFSS REFORMS

It is important that governmental CFSS improvement planners maintain an ongoing dialogue with the various “voices” or stakeholders committed to the betterment of the CFSS. Stakeholder representatives should continue to be engaged in the system reform process and insure that fundamental values are protected.

To assure continuity of this public feedback process, states might mandate that counties and cities form collaborative boards of consumers (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). Such boards could be convened periodically to guide the development and monitor the responsiveness of the local CFSS performance.

In order that maximum benefit be achieved from this public input, a broad range of public officials whose actions affect the CFSS should participate in this feedback process. These officials might be required to review their current and future system reform plans relative to the values and expectations developed and monitored in this process.

PART IV

EVALUATE CURRENT SYSTEM PERFORMANCE

A major step in determining whether managed care practices are transferable to the CFSS is to conduct a realistic appraisal of the existing CFSS at all levels — governmental and nongovernmental — to determine its compatibility with managed care practices. Numerous “readiness” inventories exist for conducting such analyses for health care organizations. Many of these are quite comprehensive. But some focus on identifying a desired “end state” of capability, while providing only limited guidance on how to achieve that capability or explanation of why it is needed. Because these inventories focus primarily on health service delivery organizations, most of them will require significant adaptation to make them useable for other types of human service organizations. Nonetheless, they could serve as a guide to the expectations of managed care service environments.

Invariably, the planning process will require a strategy for gathering information about the existing CFSS system and its operation. The planning group will have to decide what can be reasonably achieved within available resources and time constraints. At the “simplest” level, staff might summarize existing data on the current system from past studies and reports augmented by reports from “key experts” within the group and a limited number of outside experts. Internal staff could be surveyed, asking them to provide available documentation to substantiate their assertions. Any existing strategic plans should be reviewed. Staff with grant or contract management responsibilities may be knowledgeable about provider performance. In turn, providers might be asked to complete “readiness” strength/weakness inventories. Management information system (MIS) staff should be surveyed to provide whatever data exists to fill in use and cost profiles.

Part IV lays out a more comprehensive road map. It is unrealistic to expect that an all-encompassing review of the system will be conducted before any action is taken towards adopting managed care practices. The following sections suggest areas for consideration and information that would be helpful for leaders to know in order to understand how the CFSS is or is not positioned to adapt to changes in its market.

Completion and circulation of a written report summarizing what has been discovered about the CFSS and factors influencing its future will build momentum for system-wide change. The report should take realistic cognizance of political, legislative, and administrative trends at all levels of government. It should reflect information gathered about trends affecting the CFSS, stakeholder perspectives, and the evaluation of system capabilities. It should conclude with a statement of proposed goals and timetables. Optimally, a draft report should be circulated for comment from key stakeholders prior to finalization and acceptance by the appropriate authorities.

ANALYZE THE CFSS

If one is going to improve a system, one must be reasonably familiar with the structure and capabilities of the current system. It is essential to know “who” is being served, “what” service is being delivered, and “how well” the system is currently functioning. Stakeholders will provide an important perspective on what the CFSS should be doing, how its performance should be measured, and what various interests think should be done better. These views should be considered when evaluating the system.

TASK 1: DETERMINE KEY COMPONENTS OF THE CURRENT SYSTEM

Service Providers and Service Coordination

- Who are the major providers?
- Do any of these serve formally or informally as “leaders” of the system?
- Which other providers are essential components of the system?
- Which components of the system are publicly operated? Private? How are various components of the service system connected together?
- What kinds of working relationships exist? Are there historic alliances or animosities?
- How interconnected are funding and referral arrangements?
- What is the nature of agreements or financial connections between and among public and private providers/organizations and for-profit and non-profit providers/organizations in the system?
- Are there special interest groups or formal affiliations among elements of the service system?
- Does the political clout of certain provider groups mandate a key role for them?
- Are there any potential anti-trust issues that require consideration? Are there any other legal or political factors that support the existing system or influence the options that are feasible for system change?

Services Provided

- What types of services comprise the CFSS?
- How are they structured?
- How are they labeled? Are these labels consistently used?
- How are they counted?
- Are any services being inaccurately counted for lack of a definition or category that more accurately captures that form and cost or because reimbursement structures favor particular designations?
- Are some services being used because money is available to pay for them while other, preferable services are being bypassed because payment is not readily available or they are otherwise not accessible?

Persons Served

- Who is being served?
- How many are they?
- Who is being served but shouldn't be? Why?
- How many are not being served but should be? Why? Where are they? Are they being served elsewhere?

- What is the potential level of under- or over-service?
- Is there a commonly accepted instrument for assessing vulnerability and service need?

System Entry

Information on how children and families enter the system is important in determining the amount of control that can be exercised over demand and how any future managed care arrangements must be configured. Do they enter:

- Through investigation of an allegation of abuse, neglect or dependency?
- Through commission of a crime by a juvenile and referral to Juvenile Court?
- Through referral of a child or adolescent for mental health services paid with public monies?
- Through referral by special education?
- Through other means?

Planning and Monitoring Services

- How are needs assessed and services planned?
- Is there some instrument commonly accepted for developing a “special care” or “needs” plan?
- What methods for accountability are most widely used?
- How effective are they?
- How is “progress” defined, measured, reported, and monitored?

TASK 2. ASSESS THE CURRENT CAPABILITIES OF CFSS PROVIDERS

CFSS leaders and service providers should examine the structural changes in the provider system in the health care industry under managed care and project potential impacts of such changes to CFSS providers. The direction seems to be towards provision of services and administrative functions through larger, more complex organizations and networks of organizations. It has been suggested that human service organizations smaller than \$20 million in annual revenues cannot survive in the future human service delivery market. This may be true when one considers the sophistication that will be required in MIS capabilities, detailed reporting requirements and radical shifts in demand and service patterns under increasingly tight financial arrangements. Realistic scrutiny of the service system will likely identify some providers or service elements that cannot continue to operate in a more intense, competitive, and stringently operated service environment.

In order to plan for innovation and reform in the CFSS, planners should evaluate honestly the current capabilities, strengths, and weaknesses of CFSS providers. Such an evaluation is essential in determining where change is needed and whether managed care or other human service management technologies offer opportunities to facilitate this improvement. Because the provider system is such a crucial element of the CFSS, later sections of this guide also contain suggestions relevant to evaluating the provider system.

The following is a sample of issues that an assessment of providers should address.

Overall Organizational and Operational Capabilities

- How big are these organizations?
- How “mature” are they in their development and operation?
- Are facilities accredited? Licensed?
- What service elements are provided within each organization?
- Do they have areas of specialty (e.g., serving particular ethnicities)?
- What is their annual revenue? Expenditures? Funding sources?
- Who owns them?
- What else do they do? For whom?
- Are they responsive to changing expectations for their organization?
- What capacity do they have to expand, contract, restructure?
- Are there union agreements that affect their structure and operation?
- Can staffing levels be adjusted for fluctuations in service demand or intensity?
- How effective are these organizations in working with the community?
- How effective have they been in coordinating with other service providers? With public agencies?
- What results have they achieved?

Legal and Contractual Capabilities

- Do providers have the contractual sophistication and legal and accounting capability or access to advice to assist them in responding to contractual-based funding mechanisms?
- Do they possess negotiating expertise and effective negotiating power?
- Do they know what performance documentation will be necessary to satisfy contractual agreements?
- Do they understand the liability and risk implications of performance contracts?

Administrative and Financial Management Capabilities (Also, see pp. 27-42)

- Are administrators and board members knowledgeable about managed care practices and capable of adapting to more stringent operating demands?
- Have managed care implications been considered in their long range plans?
- Do they have adequate capability to project costs with minimal “cushion” and to adjust operational projections based on changing use or financing patterns?
- Are current revenues adequate for operational needs?
- Are financial systems adequate?

- Can providers manage multiple funding streams?
- Do providers have reserves to cover costs of system change, assume risk, and expand or revise services?
- Are communication capabilities adequate to provide “quick response” to information and access requests in order to meet stringent performance requirements?
- Is there capability to write proposals or service plans to participate in new service networks?
- Are management information systems adequate?
- Can data be transmitted and received electronically?
- Are client and service tracking data capabilities adequate?
- Is there adequate administrative staff to handle major paperwork and documentation increases involving credentialing of staff in provider networks, contract preparation and review and management, complex reporting and monitoring documentation, and diverse billing requirements?
- Are clinician and other personnel files complete for purposes of preparing applications to be credentialed in several provider systems?

Clinical/Social Services

- Are services designed to enable prompt and humane access for clients?
- Are services designed and managed considering efficient and cost-effective methods?
- Are clinicians and other staff knowledgeable about intensive therapies and social interventions?
- Are staff “outcome” oriented?
- Are staff able to devise new service delivery methods in response to potential MCO requirements?
- Do they currently use clinical/service protocols, practice guidelines, or other methods for standardizing basic service practices?
- Do they have the capability to develop and document new protocols?
- How do they handle any document exceptions to the protocol and monitor these exceptions?
- Can services be readily reconfigured to reduce or increase intensity of service as a client requires less or more support?

Client Responsiveness and Appeals Procedures

- Do providers have an appeals system that can respond to client complaints or questions?
- Are they prepared to appeal service denials of an MCO on behalf of a client?
- How would they address conflicts between contractor limitations on service access and utilization versus client needs or expectations?

- Do providers have an ethics committee or process in place to deal with ethical issues, such as those that might arise from conflicting expectations about service “necessity” and “appropriateness?”
- Are client confidentiality protections adequate and updated to accommodate new technology requirements?

Cultural Competency

- Are providers presently able to respond to the needs of children and families with sensitivity to their unique cultural backgrounds?
- Are services and programs and related materials provided and communicated in a form and manner that is understandable by persons from different linguistic, cultural, or social groups?
- Are staff available or readily accessible with proficiency in languages with which clients are most comfortable?
- If language-proficient staff are “borrowed” from other providers or organizations, is their expected workload or availability reasonable?
- Where might shortages of culturally competent staff appear if organizations were structured with more rigid boundaries (e.g., became “competitors” within different service networks)?

TASK 3. PREPARE CURRENT CFSS STATUS REPORT

Based on the information gathered in Tasks 1 and 2, CFSS managed care planners should summarize how they adjudge the current structure and capabilities of the system in light of the managed care-oriented future. The report may differentiate among regions or localities that are more or less ready for or in need of managed care innovations. This summary of the CFSS’ current status will serve as a departure point to ensure that any contemplated managed care innovations are factual based and respond to the strengths and weaknesses of the existing system.

ANALYZE SYSTEM FUNDING

In a managed care-influenced practice and resource environment, motivations and economics of the CFSS will be dramatically and irrevocably altered. It is imperative that system planners consider the current state of funding and mechanisms for disbursing money and other resources throughout the CFSS. At the governmental level, it is important to recognize the dramatic impacts that result from altering various aspects of traditional financial practices. At the provider operations level, administrators must consider how radical changes in financing mechanisms could affect their entire organization, both its service culture and its financial stability.

It is important to know how closely current revenues match realistic demands. What is “hidden?” What is considered “excessive?” What is “inadequate?” What is “nonexistent?” Public officials, including legislators, should be cautious in building false expectations about cost-efficiencies and major savings, especially in a system that has, traditionally, been inadequately funded with extensive mingling of public, private, and donated resources.

Inadequate and unreliable data about the functioning of the existing CFSS, as well as major variations in levels of control of access to and use of data, present major problems in deriving the true cost of services. These limitations would, in turn, present major barriers to the CFSS' adopting risk-based per capita funding as a financing method. Assuming risk requires some degree of control; but, the CFSS has limited control over its domain. These factors suggest that it might be difficult to negotiate and adhere to CFSS contractual agreements based on specified payments, client selection, and services criteria.

Control of service decisions by the courts is one of many areas where the CFSS may be responsible for services but have only limited control on the overall service plan. Judges may have the primary voice in deciding on service plans for children. Yet, court backlogs could delay custody determination, leaving case workers and existing providers with untenable options under some contractual service systems.

Screening and investigations have a major impact on the size of caseloads and the numbers of persons served in the system. Under contractual performance requirements typical of most managed care systems, stringent criteria are applied in selecting cases. Prior variations in application of access criteria could distort expected service demands.

TASK 1. EVALUATE EXISTING GOVERNMENTAL FINANCING AND FINANCIAL ADMINISTRATION TO ACHIEVE CFSS GOALS

Planners should consider the relation between existing financing mechanisms and stated public CFSS goals. What is the public demanding? What reforms do legislators want? What reforms do administrators desire? Current operations should be reviewed with an eye towards these potential "futures."

Public Funding Assumptions

- Will financial mechanisms be expected to save money?
- Are they expected to reduce existing spending levels or curtail growth in expenditures?
- Are they expected to serve more people and/or provide more services without increased funding?

Revenues

- What funds are available now?
- What is the source of these revenues?
- Is the current system adequately funded? Overfunded? Underfunded?
- What short-falls (or excesses) currently exist and what changes are needed?
- What levels and sources of funds can realistically be expected in the future? Are they likely to be stable?
- What are the projections about potential levels of federal, state, and local public funding?
- What trends are likely in private funding and related resources for the CFSS?

- How much money is actually being spent on CFSS services?
- How much control does the CFSS have over these allocations?
- How much is built into legislative or budgetary and regulatory requirements?
- What would happen if these requirements were changed? For example, if changes enabled freeing the funds to be used for purposes other than for CFSS clients, what would be the impact on CFSS services?
- What would happen if CFSS funds were “decategorized” — ending constraints on groups and services for which funds can be used?
- What does CFSS gain/lose?
- What other changes are happening now or in the future which will affect CFSS funding?
- Is money available for start-up investment capital? From general tax revenue? Where else?
- Is funding available for ongoing operations of new, innovative services?
- Will unspent monies be retained within the CFSS or revert to the state’s general fund?

Cost Information

The actual costs of CFSS services are generally underreported because significant levels of “invisible funds” currently supplement the public funding of the CFSS. These resources include donations, volunteer services, and contributions of staff or providers who work or provide services beyond their stated or reasonably expectable capacity. It can be anticipated that adherence to explicit standards typical of managed care contractual agreements will inevitably cause “contributed” capacity to disappear. A more competitive and cost-conscious environment will make it more difficult for people or organizations to “give generously” of their time and energies because they themselves will be under increased resource and demand pressures. Some suggest that 20 to 50 percent of donated and contributed funds used by non-profit organizations would “dry up” if non-profit and for-profit organizations compete in the same marketplace. Others assume that most of this funding would continue to flow to non-profit providers, even if they are performing services to for-profit networks. Calculation of “real costs” is essential in predicting future resource requirements, especially in a contractual environment where contractors could be at-risk for these costs.

- What do the currently available services actually cost?
- How accurate are current cost projections?
- What resource allocations are currently not accounted for?
- Where are hidden funding and resources coming from? Can they be sustained?
- What would it cost to replace donated or other funding if it were to decrease?
- What changes in service costs can be anticipated in the future?
- Is it possible to track actual or estimated costs for single cases across all service elements?
- Can costs be projected within similar groups of clients requiring different levels of service intensity?

- Is it possible to calculate the amount of free or contributed services also being allocated to each client?

Financial Decision Authority

It is important that financial decisions be tempered by a humane understanding of the people whose lives are affected by fiscal policies and administrative practices. Financial management staff can benefit from informed advice from service and program staff.

- How is the financial system structured?
- Who controls financial decisions at various levels in the system?
- Do program and service staff have input into fiscal decisions?
- How is accountability and control over funds maintained?
- How much do these financial managers understand about the services they are purchasing?
- What is their level of knowledge about managed care practices as it affects financial transactions?
- How do they monitor the quantity of services procured?
- What interaction do they have with staff involved in determining access, utilization control, and other factors affecting resource allocation?

Procurement Practices

A main question to be answered is whether existing role relationships, operational practices and administrative capabilities are adequate to support major changes in financing procedures within the CFSS. Governmental administrators should:

- Review grant and other resource distribution procedures to identify inefficiencies and opportunities for innovation.
- Review procurement and contracting procedures for compatibility with service and resource management practices under managed care.
- Assure that contract management staff develops expertise on managed care technologies affecting financing and service procurements.
- Determine whether contract management and program staff have capability to jointly prepare written specifications for service procurement.
- Determine whether state or local governmental agencies can participate in new service acquisition agreements offered by federal, other state, or local governmental entities.
- Determine whether governmental agencies interested in such procurement opportunities have authority to enter into risk-based contracts or other forms of financial and service acquisition agreements (e.g., some county-owned hospitals or mental health centers do not have legal authority to enter into HMO-type risk contracts).

TASK 2. EVALUATE FINANCIAL MANAGEMENT CAPABILITIES OF CFSS PROVIDERS

As part of the overall evaluation of provider capabilities in a managed care environment, it is important to look at the financial management resources to assure that providers with essential service capabilities can cope with new or changed funding mechanisms. Similarly, it is important to ascertain what new provider arrangements might emerge as a result of managed care initiatives in the CFSS.

- Do the providers have the capability to convert from existing funding mechanisms to newer managed care-type approaches, such as contracting to provide services on a “bundled-rate” basis, incorporating all costs into a single charge?
- Are they in a sufficiently strong financial position to assume risk?
- Do they have accurate knowledge of actual operating costs and the ability to control costs? For example, can they flex staffing and operating capacity in response to fluctuating demand in order to stay solvent?
- Do public or private provider agencies have administrative and financial capabilities to collect funds from contractual operations?
- Would funds under capitation or other fixed rate agreements enable maintenance of uncompensated services provided on a community-wide basis?
- If not, how would these services be maintained?
- What would be the implications if they were discontinued?

TASK 3. EVALUATE APPLICABILITY OF MANAGED CARE FINANCING MECHANISMS TO CFSS GOALS

Existing CFSS funding mechanisms have some shortcomings compared to those being adopted in the health care system. Grants, procurement of treatment/service “slots,” or payment on a fee-for-service basis offer limited incentives for providers to develop more innovative services, to restrain costs, or respond to changing demand in a timely manner. Ability to exercise prompt quality control overfunded organizations can be difficult under these arrangements.

Under a more flexible managed care-oriented system there is a broader range of funding options for securing services for clients. However, these systems are initially quite complex to design and negotiate and they ultimately move governmental authorities to a more arms-length relationship with providers than is currently the case in the CFSS.

In conducting a managed care review, CFSS administrators must determine whether the CFSS could benefit from shifting risk outside governmental responsibility. In a grant-funded system, demand can vary considerably, but service capacity is fairly inelastic. The state assumes all risk for solving the problem of shortage of funding or inadequacy of services. There is little motivation to save money or introduce efficiencies except to relieve the pressure of waiting lists or client and citizen complaints.

Under a “full risk” capitation contract, the state and an MCO could agree on a certain number of persons for whom a specified range of services would be provided for a fixed payment. The state

assumes no risk if demand exceeds funding, nor does it benefit from any savings from under use or improved efficiency.

The state could assume partial risk by establishing contractual terms with an MCO whereby the state covers costs above a certain ceiling, possibly participating in some level of shared risk at levels up to that ceiling; similarly, profits or savings would be shared at varying levels between state and provider.

The questions for CFSS administrators continue to be:

- How could some combination of new and/or revised financing methods improve access and operating efficiency of the CFSS?
- What will be the dominant forms of support for providers in order to assure availability of needed services in the future?
- How will service contracts or performance agreements fit into the evolving CFSS?
- Would it be appropriate to transfer full service and administrative responsibility for a designated CFSS client group or for CFSS services in a geographic area to a provider under a contract?

ANALYZE MANAGEMENT INFORMATION SYSTEM (MIS) CAPABILITIES

Managed care relies heavily on increasingly sophisticated data systems. Thus, current and future capabilities of the CFSS' MIS and the competence of its staff are critical to the success of managed care practices in the CFSS. Inadequate technical capacity, inadequate funding for MIS improvement, and/or resistance by staff can pose insurmountable barriers to CFSS reform.

Sophisticated technology now exists that can enable increasing precision in monitoring the "vital signs" of the performance of human service systems. MIS staff should be encouraged to demonstrate creative skills at translating existing data intended for specialized purposes such as financial management into useable forms for operational and service management purposes. They should be challenged to help interpret data produced by their operations in collaboration with program and financial administrators to make valid projections of future scenarios.

It is important that data system planning include consideration of appropriate direct and indirect controls over system design by government agencies. What should be contracted out and what should be retained as in-house capability? Certainly at a minimum public administrators require ability to plan and monitor system standards and to establish and maintain software and data capabilities essential to administration of public resources and to maintain a responsible standard of publicly-sustained information access. In evaluating MIS capabilities, planners should apply similar questions at both the macro (governmental) and micro (provider/service system) levels.

Planning and monitoring performance of a more precise, cost/demand/use-driven, contract-based managed care environment demands data systems capable of:

- Collecting and analyzing common data across the CFSS-provider system.
- Monitoring costs and service utilization and accurately projecting future resource commitments.

- Tracking clients and services.
- Monitoring performance against expected outcomes.
- Providing real-time reports of operations.
- Performing administrative functions.

TASK 1. EVALUATE GOVERNMENTAL AND PROVIDER CAPABILITY OF MIS PERSONNEL AND TECHNOLOGIES

Governmental MIS staff are challenged to perform a realistic assessment of their own capabilities. At the same time, MIS staff need either to directly evaluate MIS capability of providers or to assist providers conducting a self-assessment, to develop a consolidated assessment of system-wide MIS capability. Such information is essential for determining what resources will be required to upgrade the MIS capabilities of providers in a more intensive information-oriented environment.

In planning for system-wide upgrading, MIS staff should consider whether individual providers or provider systems can best determine their own needs or whether they could benefit from governmental review and evaluation of a number of potential data systems. Rather than require a redundant process for numerous small agencies to evaluate, procure, and install new data systems which may not be compatible with future system requirements, it should be possible to identify and evaluate existing software and suggest those that meet reasonably compatible reporting requirements. It may be possible for state and local government MIS experts to provide consultation to private agencies on software and hardware requirements in the process of evaluating system capabilities.

System-wide Structure

- Who is responsible for MIS planning? MIS operations?
- How is the MIS system currently organized?
- What are the existing hardware and software capabilities?
- What information on the CFSS is currently being gathered?
- Who is responsible for data gathering and analysis functions (e.g., individual tracking, producing and aggregating information, handling financial claims, producing useful information for budgeting, producing evaluation data)?
- Can current MIS staff manage an increasingly complex systems?
- Who are the current users and how are they using the data? Users might include:
 - Academics
 - Administrators
 - Advocates
 - Clients and families
 - Clinicians
 - Courts
 - Elected officials
 - Financial analysts
 - Planners
 - Service providers
- Are they satisfied with MIS performance?
- What changes do they, or potential users, want and need?

- What MIS improvements are currently planned? At what cost?
- What long range improvements are needed? At what cost?
- What is the existing or proposed timetable for improvements?

System-wide Capabilities

It is generally recognized that MIS capability for the CFSS is woefully inadequate. Whether or not managed care practices are formally adopted, the CFSS data systems must be upgraded to reach acceptable standards for MIS performance which is essential to sustain responsible business management. Without these improvements, CFSS officials cannot adequately plan and maintain control over service system performance.

- What actual and potential capability does the public MIS system have to analyze, interpret, and monitor performance of the past, current, and future CFSS service system (e.g., costs, utilization, budget, effectiveness)?
- Do existing data systems have a way of tracking or reporting the services delivered by a specific provider? Is there a “unique identifier” for each provider? Individuals? Provider organizations?
- Can the performance of an individual service provider be tracked? Within organizations/facilities? Alone?
- Do providers have adequate capabilities for transferring data via computerized data bases, electronic data exchange?
- Are data systems compatible between and among governmental and service system entities?
- Are data elements compatible across reporting entities?
- Do the system and staff have capability to do “system modeling” for projecting, analyzing, and monitoring performance against various scenarios?

MIS Staff

Successful MIS updating can be enhanced by collaboration between system planners and users, including administrative, operations (i.e., fiscal, contracting) and programmatic (i.e., services) staff.

- What knowledge does MIS staff have of CFSS operations and changing management practices?
- How do MIS staff balance challenges of “system integrity” with support for program goals?
- How does the MIS balance emphasis on “financial data management” with support for “administration” and “service operations management?”
- How effective are MIS staff at collaborating with staff responsible for new program start-up or system change and reform?
- Do staff have the capability to design and supervise vendor contracts to purchase all or part of the information needs of the system?
- What would it take to bring the staff up to adequate skill levels and operational capability?

- Who could be trained to become more productive or innovative in MIS design and operation?

TASK 2. PREPARE MIS STATUS REPORT AND IMPROVEMENT PROPOSALS

Governmental CFSS administrators, in collaboration with MIS staff and experts from the provider sector, should consolidate available knowledge about the state of MIS capability in the CFSS and make recommendations for improvement both at the public and provider levels. Plans should be realistic in terms of scope and cost. They should review the current system's capabilities, outline what information would be needed by managed care, and provide options for meeting those needs. Cost and likely CFSS reform implementation timetables are important considerations in efforts to make more significant changes in the MIS. It is also important to assure that any recommendations regarding CFSS managed care data requirements are compatible with standards already beginning to consolidate within the managed health care area.

MIS Improvement Planning

It is critical that planners realistically assess the time and level of effort necessary to make substantial changes in MIS capabilities at system and operational levels. Hasty planning, design, and implementation can result in incomplete or wasteful decisions, necessitating delays and redesign. It is important that MIS initiatives be introduced ahead of major managed care initiatives.

- What organizational and/or operational changes would be needed to establish adequate MIS capability?
- What authorities would be needed to effect major MIS improvements?
- What financial resources would be needed to build an adequate MIS?
- What monies are available now?
- What action must be taken to secure adequate funding?
- How long would it take to implement an improved MIS system?

ANALYZE STAFF CAPABILITIES

Introduction of managed care practices to the CFSS can have major implications for CFSS personnel. Throughout the process of conducting a planning review, consideration should be given to the staffing implications of potential changes. In the long run, adopting managed care practices in the CFSS is likely to result in a new mix of job responsibilities. In some cases, direct service providers may be expected to provide services to more people, potentially with less money and fewer staff than had been true in the past. Other organizations and providers may find themselves challenged by increasing funding, staffing, and service demands. Organizational structures will be changed. Ownership and control of elements of the CFSS are likely to change dramatically as providers and governmental administrators reconfigure the CFSS for the future.

Managed care technologies focus on providing high quality services using resources more effectively and efficiently. They rely on streamlining and systematizing operations to yield more predictable results. There is a strong emphasis on continually improving methods so "the system" is learning from its successes and correcting mistakes to reduce risk and variability. Initially CFSS personnel may find the language and practices of managed care disconcerting, fearing they will

contribute to “dehumanizing” the CFSS. Staff who pride themselves on their unique “expert knowledge” may be reluctant to adopt standardized methods for conducting and reporting the results of their work. They may be uncomfortable about sharing certain aspects of their knowledge and skill base with others lest it jeopardize their long-term employment prospects.

New service delivery, financing, and management technologies may require a different skill mix of staff. Managed care practices emphasize efficient and effective service methodologies and maximum efficiency in staffing and other resources. Any excess in staff resources is reduced or eliminated. Roles and functions are redesigned to assign duties to staff with skills appropriate to that function. In some cases this may mean use of employees with lower skill levels than currently used. Efficiency in use of staff can result in merging of redundant positions and functions, elimination of some functions, and introduction of more efficient methods of accomplishing assigned duties. Organizations with union agreements may have special challenges in making necessary changes in their staffing structures. All of these changes will impact directly on the staff. Reform planners need to consider the impacts at every step in the change process.

TASK 1. ASSESS THE KNOWLEDGE BASE, ABILITY, AND CAPACITY OF GOVERNMENTAL STAFF TO ADMINISTER CFSS FUNCTIONS IN A MANAGED CARE ENVIRONMENT

As managed care practices stimulate consolidation of human service systems, control will pass to ever-larger and more sophisticated and technically advanced management organizations. Leaders of these organizations will have access to highly sophisticated management technologies, financial structuring capabilities and advanced legal counsel. Governmental officials will be challenged to meet this sophistication with sufficiently clear and precise expectations. They must be conversant with contractual terms and terminology and skilled at contract negotiation in order to be “smart purchasers” of human services. Staff must also have time to do the work of design and implementation. Without some slack in staff capacity, it will be difficult to make staff available to plan and implement original or innovative programs. A hard look at staff requirements and capabilities must ask:

- What type and level of staffing will be required for government administration and monitoring?
- Do staff understand the legal, fiscal, and operational changes that managed care practices will require of their organization?
- Do they have necessary financial, service, and administrative and legal sophistication to implement a managed care-oriented CFSS system?

If introduction of managed care practices in CFSS stimulates new service configurations, state and local governments must have adequate capacity to accredit, license, and monitor new programs and services. Knowledgeable staff will be needed to:

- Develop and authenticate criteria,
- Train and supervise reviewers,
- Set up monitoring mechanisms, and
- Manage administrative details.

One approach to implementing managed care is to increase the functions that are contracted out. If increased privatization of CFSS appears likely, officials should consider opportunities for protecting employees against unnecessary hardship. They might look at such options as:

- Mandated or first-opportunity employment of displaced employees by private vendors,
- Reassignment,
- Retraining,
- Attrition, and
- Benefit protection (e.g., pension portability)

Alternatively, CFSS officials might elect to adopt incorporation of managed care technologies into their government-operated system. This too would require substantial changes for government staff. Cost allocation practices and referral and utilization procedures would require rethinking and redefining. Moving from a care-providing or grant-making orientation to “you’re now a cost/expense-center” orientation would require important rethinking of roles and functions. Government program staff would become less advocacy-oriented and more cost/performance oriented.

- Are credentialing procedures adequate to substantiate responsible screening of contract staff?
- Are reporting systems and methods adequate to substantiate responsible monitoring of contract staff performance?
- Is there adequate potential within existing staffing to accommodate changes in operational emphasis?
- If the CFSS undergoes major shifts in control and service delivery, what actions should human resource administrators take to plan for these changes?
- How should employee considerations be incorporated into proposals to change service and financing mechanisms?
- What agreements and commitments do employers have with current employees regarding job stability?
- What impact could changes have on employee union agreements?
- How might the existence of union agreements influence system reform options?
- How might union leaders help facilitate reform efforts?

TASK 2. ENCOURAGE CFSS PROVIDERS TO REVIEW STAFFING IN LIGHT OF MANAGED CARE PRACTICES

Whether or not the state or local governments make any “formal” changes to the CFSS in response to managed care influences, these reforms in the health care sector are having profound influence on the delivery of all human services. Similar to challenges that will face governmental administrators, personnel managers of provider organizations must evaluate existing staffing and plan staffing patterns and practices that can accommodate new service and management practices.

The “services on demand” or “as needed” nature of many managed care practices will necessitate more stringent control of staffing allocations and tight restraint on administrative staff overhead expenses. Providers will not be able to afford to maintain full staffing levels when operating at low capacity. Yet they will need to staff up quickly when demand necessitates. This may require increased reliance on part-time and contractor staff. Providers may need to restructure jobs, organizational units, operations, and functions as a result.

- How will present personnel adjust to an on-demand employment market?
- What protections of employee benefits and retirement systems must be considered if employment patterns are changed?
- Recognizing that some positions are likely to be eliminated and other positions restructured, how will employee rights be protected in a downsizing or “resizing” of the organization?

It will be important to help staff adjust to the greater precision in planning for client care, documenting services and client progress towards achieving stated outcome expectations, and responding in a timely manner to managed care reporting requirements. Government administrators might develop or identify a self-assessment instrument that could be used by provider organizations to review the current and future staffing requirements and identify changes that may be necessitated in a managed care environment. They should be encouraged to provide a copy of this report (which may need to be kept confidential by use of some type of identifier) to the planning group. Alternatively, a sampling of provider agencies might be made by the planning committee. Key experts could be used to make their best estimate of the implications. A primary value of this process would be to encourage providers to think now about the impacts of managed care innovations on their personnel.

TASK 3. PREPARE REPORT ON MANAGED CARE STAFFING IMPLICATIONS FOR THE CFSS

CFSS managed care planners should summarize, to the best of their ability, the findings regarding staffing implications of managed care improvements. This report should be incorporated into an overall system assessment and plan for future improvements to the system. Some of the elements to be included in this report might be:

- What will the future service delivery system require in governmental and provider staff skill mix?
- What will the optimal administrative skill mix be?
- What will be the new balance between staffing with direct care responsibility and those with performance audit responsibilities?
- How might direct service staff respond to a shift in duties towards audit and performance functions?
- How and by whom should positions be redesigned?
- What models exist for key positions characteristic of managed care service environments?
- What new training or retraining will be needed?
- How will training be provided and financed?

- How and by whom will training and education be accomplished?
- Do governmental staff have the capability to help train existing providers in managed care performance skills?

Managed care innovations offer a major challenge to everyone employed in the CFSS. Staff must be informed about managed care practices and be encouraged to actively consider how they can fit into this new service environment. Providers have the option of taking the initiative to introduce changes appropriate to their own organization or be challenged to change in order to remain an active participant in a managed care CFSS environment in the future. Successful adjustment to these changes can best be accomplished within an environment of open communication where leaders and employees are partners in the process.

ANALYZE PERFORMANCE EVALUATION CAPABILITIES

In introducing performance-based managed care agreements into the health care system, health administrators could count on the existence of reasonable consistency in performance among professionals who have met common licensing and credentialing requirements. They have been able to rely on fairly common definitions of services, generally accepted patterns of practice, some commonality of expected outcomes and measures of effectiveness, and common billing practices. Admittedly, there is a broad range in these "commonalties," but they have met at least minimal requirements in the early stages of managed care operations.

There is less commonality in other areas of the CFSS in terms of stated standards or practice definitions. For example, the skill levels, workloads, and turnover rates among child welfare staff is highly variable. Case worker judgment has produced divergent results in the CFSS because a broad range of competencies have been acceptable for persons in similar roles. Yet case worker discretion has been a primary factor in managing service planning in child welfare. In such a practice environment, professionally developed protocols and assessment instruments have not received ready acceptance.

In many cases, service plans in the CFSS have been influenced by factors other than service requirements including:

- Size of worker caseload,
- Complexity of the intervention provided,
- Court system influences,
- Cooperation of client/family,
- Level of service demand, and
- Availability of appropriate placements.

In a managed care environment, especially where contractual obligations are involved, there is less tolerance for variance. Greater standardization of performance is desired, where people in relatively similar circumstances can expect to be served in a relatively similar fashion.

As government increasingly contracts with for-profit organizations, the ability to specify expected results becomes essential. For-profit organizations cannot be expected to exceed the literal

specifications of a contract. And non-profits will no longer be able to remain financially viable if they deliver services that exceed their resources. Vague, nonspecific expectations of providers will give way to a more businesslike environment, where the questions will be:

- What service was expected and required of the provider?
- What service did the provider agree to perform?
- How did both parties agree to measure performance of the required service? (“How will you know they did what they said they’d do?”)

Managed care practices emphasize the importance of linking assessed problems with interventions and measuring the level of success in producing positive outcomes for the person being served. Practice protocols measure length, type, and intensity of intervention. They can also identify essential conditions, circumstances, analyses, interventions and outcomes indicative of effective client intervention. Benchmarks suggest the need to change or terminate services and call attention to unexplainable lack of progress.

It is important to distinguish between measurement of “system performance” versus individual performance. Patterns of service access and macro factors about utilization trends and service coordination may be important measures of the overall system performance. Client satisfaction data may or may not give meaningful indication of performance. Data at the individual provider level is important in evaluating the effectiveness of that provider. Analysis of aggregated data on provider service patterns and variances may give useful information about the overall performance of the system. Yet reliance on data on short-term performance of expected tasks may not provide meaningful information by which to measure long-term outcomes.

As changes are made in the CFSS, performance measurement capabilities should be built into new treatment modalities and service models. These performance measurements should reflect changing expectations and definitions of positive outcome and should be adapted to shifts in service control, financing, and risk management.

TASK 1. ASSESS CURRENT CAPABILITIES FOR MEASURING PERFORMANCE WITHIN THE CFSS

Administrators throughout the CFSS must determine what capability currently exists for measuring performance and outcomes in CFSS service planning and delivery and what is needed in terms of:

- Common standards and service definitions,
- Capability to link assessments, diagnoses, interventions and outcomes,
- Ability to convert “anecdotal” case information into measurable elements,
- Reliability of outcome indicators or measures, and
- Ability to analyze existing data to assess utilization patterns.

For example, are there currently reliable protocols that could assist in standardizing:

- Risk assessments for in-home versus out-of-home placements,
- Family assessments which identify family level of need,
- Level of care assessments,
- Service placement levels, and/or
- Measures of expected outcome or progress?

If the CFSS is to systematize practices to achieve more consistency in outcomes, administrators must identify acceptable service protocols, guidelines, and measurements that adequately assess and document performance. Protocols and guidelines should include those indicators over which the system has reasonable control. They should measure the impact of interventions directed by the CFSS itself, not those resulting from actions of related systems. Such protocols might include:

- Standardized assessment,
- Standardized decision-making process,
- Flexible range of interventions,
- Standardized set of conditions under which intervention is offered,
- Defined and measurable expected outcomes, and/or
- Predetermined time frames for achieving outcomes.

In assessing current capabilities for performance evaluation, state and local CFSS administrators should determine what they already know about the long-term outcomes for children who have received various interventions from the CFSS. MIS staff might help to review existing databases and assess how they could be mined to produce useable information on CFSS use, outcomes, and best practices. They might also collaborate with philanthropic groups, universities, and various professional and special interest groups to collect and analyze existing studies of CFSS interventions and outcomes to develop a catalog of protocols known to be effective.

Providers should be queried to determine what performance monitoring systems they are already using.

- Do providers have quality monitoring systems in place?
- Are there standards or benchmarks for acceptable or exceptional performance?
- Can they fully document outcomes?
- Can they participate in reporting systems for outcomes analysis?
- Do they have a system in place for ongoing review of the services and processes, with a method for correction of problems?
- Will they require additional money to improve documentation?
- What incentives are in place to motivate desired outcomes?

Staff might devise a questionnaire or self-assessment tool to be used by providers. Planners should review this information to determine what commonality exists among providers and what gaps exist.

It might also be desirable to establish a forum for sharing innovative service and measurement models. This forum could identify sources of technical knowledge that could be transferred to the public authorities and potentially to non-profit providers and service sponsors. Many for-profit organizations are developing these capabilities, but their instruments and methods should be reviewed to identify elements that are uniquely specialized to the interests and needs of these organizations.

TASK 2. SUMMARIZE CURRENT STATUS AND IDENTIFY IMPROVEMENTS NEEDED IN PERFORMANCE MONITORING

Based on the information gathered through various methods such as those sketched above, CFSS administrators should identify current capabilities and limitations in methods of tracking clients and documenting and evaluating performance of administrative and clinical practices. Special attention should be paid to collecting performance information on the entire CFSS. Problem areas should be identified and suggestions made for how these could be corrected, including estimates of costs and time required to develop improvements. This information should be incorporated into the overall system improvement strategy, identifying immediate and long-term changes that should be made.

PART V ***ANALYZE ROLES OF PUBLIC AGENCIES***

A comprehensive CFSS managed care review invariably calls into question the future roles and relationships among governmental authorities and private sector organizations which fund and/or administer various aspects of CFSS. On the positive side, under a managed-care oriented system, boundaries between public and private child and family services would be blurred, enabling a more seamless and potentially more efficient service system. Pooling funding (through grants, contracts, etc.) within larger administrative entities might encourage consolidation of services and streamlining of management practices. Within governmental organizations, special population-focused programs might be merged to allow more flexible use of funding and program resources at the service-delivery level.

Adopting various managed care practices could enable public administrators to exert reasonable control over service outcomes while allowing flexibility to providers. For example, requiring ongoing "concurrent review" of care for CFSS clients assures appropriate levels of service and protects against unnecessary or inappropriate services. Requiring that providers adopt "standards of practice" encourages greater consistency among service providers and enables monitoring of service for unusual patterns of care. Requiring outcome monitoring and ongoing quality assurance and quality improvement programs focuses attention on overall performance within and among providers. In turn, data from these monitoring procedures facilitates documentation of overall performance of CFSS.

But caution must be exercised lest the public commitment to protect its most vulnerable people be lost in the drive to achieve economic efficiency. Administrators must assess whether managed care technologies and practices appropriate to the private sector adequately adhere to public values in supporting vulnerable children and families. And, if public functions are transferred to the private sector, government must retain sufficient internal capacity to control policy and monitor performance within the private sector in order to assure that public health, security, and safety requirements for vulnerable people and their communities are maintained. Furthermore, the balance of administrative authority and responsibility between state and local governments must be reexamined. Realistic assessment of the capabilities at the various governmental levels is essential to plan the transfer of functions among federal and state and local levels. Dialogue among local and state governmental representatives is necessary to explore future options for changes on a statewide basis and to decide at what level of government various CFSS leadership and support functions should reside.

Public administrators need to continually analyze how managed care and related trends would affect future CFSS practices:

- What changes will be needed in the organization of public agencies and their program and funding authorities in order to enable CFSS managed care reform?
- What state and federal agencies and programs are essential to CFSS in the future?
- Which CFSS functions must remain government administered, and which could or should be transferred to the private sector? What capabilities are needed in the private sector to absorb responsibilities formerly administered by the public sector?

- How will the government remain in control of CFSS functions that are transferred? What new capabilities will be needed in the public sector to oversee performance of public functions by the private sector?

In sum, the public sector must examine what its role will be. If responsibilities are to be transferred to the private sector — or even to other levels of government — care must be taken so that the public trust in serving vulnerable populations is safeguarded. To preserve its heart, the public sector must uphold certain objectives by retaining core functions that cannot be delegated. Exactly what these objectives should be will depend in part on what are still considered to be public responsibilities in light of changing expectations for government. But despite the limits that some stakeholders would place on government, there are functions that the government must continue to perform. The remainder of Part V lists the core functions for which the public sector will be held accountable and the strategies that could be pursued in a managed care environment to assure that these functions are discharged.

- **Assure maintenance and promotion of the safety and health of children, families, and communities.**

Conduct needs assessments. Government must collaborate with the private sector to enable determination of projected CFSS demand, service capacity requirements, and reasonable cost expectations. Successful application of managed care practices will require realistic projection of under- and over-service, as well as accurate counting of applicable resources and identification of underfunding.

Define the target CFSS client population for whom service delivery and costs must be considered. Government retains responsibility for determining who are considered vulnerable children and families for whom special care is needed.

Define the base level of required service, mandating “socially necessary” services for CFSS clients. Public officials must be clear on what minimum services and expected outcomes are presumed to be available and achievable for the CFSS in a managed care environment. They must be able to specify what services are fundamental to client health, security, safety and stability in terms that can be used as legally enforceable specifications for “socially necessary” services under managed care contractual terms. Government may need to specify “minimum benefit” terms or “basic coverage” for the CFSS.

Promote public education and early intervention. Functions that require extended periods before results are evident will require ongoing governmental leadership and the development of incentives that foster such activities.

- **Assure achievement of positive life outcomes for vulnerable children and families by facilitating prompt access to a “safety net” of community-based, integrated systems of care.**

Structure the CFSS system. Government has a key role in determining service system network requirements and relative roles of government and the private sector; determining whether functions will be contracted out to the private sector and what level of competition will be involved; determining selection of providers, criteria for performance, payment levels; and supporting system innovation.

Create partnerships with other service systems and promote coordination. Government officials will continue to have an important role in helping different human service sectors to collaborate in meeting the needs of CFSS clients. They will have new challenges enabling private and public, non-profit and for-profit providers, management organizations, and interest groups to work together on behalf of vulnerable clients, under more tightly controlled economic agreements.

Encourage development of credibility with courts. Government officials will need to help facilitate improved relationships between providers and courts recognizing that providers working under contracts will have binding legal and financial obligations in domains dominated by court decision-making.

Protect traditional safety net capacity. Providers who have traditionally served uninsured or non-paying clients may need special consideration in shifts to managed care in the CFSS. Strategies to protect safety net providers include limiting contractors to local non-profits, mandating or providing incentives to include these providers in service networks, requiring referrals to traditional safety net agencies, and helping safety net providers adapt to a managed care environment.

Address the needs of special populations by assuring that services reflect reasonable accommodation to individual preferences, and are culturally and linguistically accessible. Service contracts can mandate adherence to cultural and linguistic competency standards; require practice protocols that consider impact of culture, language, race, and ethnicity; encourage contractors to collaborate with community-based organizations involved with special populations; mandate contractor sensitivity training; and require outcomes for special populations comparable to general populations.

Conduct outreach to vulnerable populations. If the CFSS shifts more towards a contract-based managed care provider system, providers may have limited interest or capability to reach out to vulnerable populations. Government officials will be increasingly responsible for assuring that vulnerable populations are identified and connected with appropriate service providers.

Make placement decisions. While protecting vulnerable children and family members, the public sector must also uphold the value of family preservation while guarding against excessive intrusion into the family. Public officials must assure collaboration with courts in custody and incarceration decisions.

- **Assure adherence to democratic principles by preserving rights, protecting citizen privacy and involving or assuring involvement of clients and advocates in planning and policy development.**

Preserve rights. Government must promote basic constitutional rights and equal protection under federal, state, or local statutes.

Protect privacy. Government must set, monitor and enforce standards and arbitrate problems associated with maintenance of privacy of personal information regarding CFSS clients while enabling transfer of relevant information among courts, providers and provider systems. Written releases should be required. The use of non-identifiable data and continued refinement of computer data security systems are essential.

Mandate communication with clients and install effective mechanisms to assure client participation and protection. All interests and “stakeholders” should be considered in decisions to adopt managed care and other service innovations. Principles of client-centered service should underlie policy and operational decisions. Managed care CFSS providers can be required to establish advisory committees, hold public hearings, disseminate information and otherwise enable public participation in managed care development and implementation. Providers should demonstrate responsiveness to client satisfaction information. Client protection and grievance systems should be operated by both providers and government.

- **Assure responsible use of public resources by establishing and monitoring adherence to service and financial standards.**

Establish effective mechanisms for monitoring, regulating, licensing, certifying, standard setting, and sanctioning CFSS providers. CFSS officials must assure consistent implementation of service outcome and system performance measures at all levels, and assure the use of these measures for provider profiling, system cost-effectiveness monitoring, and continuous quality improvement.

Develop regulations. Government must monitor adequacy of provider credentialing and private industry-sponsored quality improvement procedures. Government must have adequate capacity to set standards, license and/or certify providers, establish consumer rights, protection and grievance procedures, and otherwise regulate the system.

Set minimum qualifications. Public officials must assure that providers and managed care organizations meet minimum qualifications, licensing or credentialing as appropriate. Competency measures for various types and levels of sophistication among providers must be assured. Providers must have proven financial and operational capability.

Finance the system. The government is responsible for making sure that resources are collected and disseminated to capitalize, operate, maintain and improve humane services and supports for vulnerable children and families. Government should assure that services procured are cost-efficient and cost-effective. It must guard against inappropriate cost-shifting between the private and public sectors and among public sectors.

Reexamine procurement operations. Slow, cumbersome and inflexible government procurement procedures must be revised to enable more effective purchasing of human services. Staff managing procurements need collaborative support from persons with program and service knowledge.

Set adequate rates. The more explicit nature of managed care-oriented services will challenge public officials to develop realistic cost projections for the CFSS, taking into consideration funds and other resources from the voluntary sector that have traditionally subsidized the CFSS, but may no longer be available.

Award appropriate length contracts. Long-term risk-based contracts may be required in order to accommodate longer cycles in patterns of demand and service use and to encourage prevention and early intervention initiatives. Public procurement procedures may need to be changed to support these contracting requirements.

Maintain adequate risk sharing. Risk transfer practices applicable to child and adult health services may not be applicable to other children and family services. Careful use of stop-loss protections, profit/savings sharing, and risk-pooling will be essential to protect against under-service of CFSS clients.

Delineate reasonable limits on profits and overhead and address issues of risk and profitability in service contracts, so as to use savings for public purposes. Government has an essential role in maximizing public resources, insuring that services procured are cost-efficient and cost-effective. It should encourage savings through management efficiency and clinically appropriate utilization management and require that reasonable levels of savings are reinvested in essential service system infrastructure and new services. Government should endeavor to control inappropriate cost- and care-shifting among private and public sectors. Policies enabling retention and reinvestment of savings of public funds within the CFSS must be explored. Limits on profits and distributions to private investors may be necessary to prevent under-service or cost-shifting.

Use incentives to promote public goals. Contracts and other agreements between governments and the private sector affecting the CFSS might reward improved access, outreach, service coordination, high consumer and service network member satisfaction, prevention and early intervention initiatives, and positive outcomes. Penalties should be specified for failure to meet stated goals or for failure to adhere to acceptable CFSS levels of practice.

Define outcomes and require that providers and provider systems conduct ongoing performance evaluations and establish quality improvement systems. Public officials must establish criteria for effectiveness and monitor outcomes. In addition to positive client outcomes, performance goals should include: prompt and humane service access including culturally diverse and geographically isolated populations, preserving continuity of care, cost-effectiveness, consumer satisfaction, public education, and prevention and early intervention. Contractors must establish acceptable evaluation systems and report results for government oversight. Adequate governmental enforcement criteria, procedures and capabilities are essential.

- **Advance knowledge and assure currency of public policy, legislation, and regulation through research, data acquisition and analysis, and dissemination of information.**

Mandate reporting of data: Contractors and providers should be mandated to provide data sufficient to monitor performance, enable policy decisions, and facilitate ongoing research.

Collect, manage, and analyze financial, administrative, clinical, and epidemiological data for the purpose of making policy decisions. Government must retain capacity to collect and serve as the central repository of publicly-accessible information that is key to planning and measurement of health and security status of the population, as well as for tracking costs and use of public resources.

Institute information systems improvements. Governmental data capability is essential. Similarly, advanced data capability at provider system and service provider operational levels are critically important. Public leadership and financial support to enable information system improvement may be required.

Create and disseminate knowledge. Government must mandate and facilitate continued research and development of new methodologies and facilitate the exchange of knowledge within and among the private sector and public agencies.

Oversee development and implementation of practice protocols. CFSS managed care initiatives will require improved information on links among symptoms, diagnoses, interventions, and outcomes. Government will have an important role in helping develop and assure dissemination of nonproprietary protocols.

Facilitate collaboration between public and academic institutions and professional associations. Government must continue to engage academic institutions in the collaborative development of new methodologies and technologies in human service management. Such knowledge will assure future-oriented policy and management practices and it will assure that students and upcoming professionals have realistic understanding of changing trends in human services.

PART VI ***COMPLETE PLAN AND PROPOSE*** ***MANAGED CARE INNOVATIONS***

TASK 1. COMPLETE THE PLANNING REPORT

The CFSS managed care planning team must decide whether the strengths and weaknesses, operational realities, and public expectations are such that introduction of some or all of the managed care technologies would create an improvement in the overall effectiveness and efficiency of the child welfare system. It is further challenged to determine which changes will yield the best results, and in what sequence changes should be introduced. Additionally, they must determine what reasonable and feasible resource allocations would be necessary.

The sequence of issues outlined in this guide might serve as a framework for the planning report. (See Appendix B for a suggested template of a planning report.) The report should summarize:

- Stated values and assumptions as offered by stakeholders through a public input process (see Part III);
- Findings from the various aspects of the system-wide review (see Part IV), looking at overall provider capabilities, funding and financial management, MIS requirements, staffing, and performance monitoring capabilities; and
- Current and future governmental roles in the CFSS (see Part V).

In each of these aspects, the key questions should be whether and how managed care practices could improve current operations and, if so, which ones might be preferable. Pros and cons of key choices should be provided and alternative strategies that were not proposed should be explained briefly. The planning report should conclude with a proposal and rationale for short-term and long-range system improvements and how they will be monitored. Legal authorities should be taken into consideration and any changes in legislative or administrative authorities necessary for the proposed system changes should be identified.

TASK 2. PROPOSE SHORT-TERM IMPROVEMENTS

Short-range improvements can, most likely, be implemented with little formal action. For example, existing Medicaid managed care initiatives can be reviewed to consider how they might be adapted to enhance achievement of CFSS goals. And many managed care practices can be introduced within existing administrative authorities.

Based on stated CFSS improvement goals, planners might identify managed care technologies that hold greatest promise for improving CFSS while demanding the least resources. There are a number of practices in managed health care that could be adapted to the CFSS to reduce costs, control utilization, improve service delivery, and assure effective measurement of quality and outcomes.

Developing and testing service protocols, practice guidelines, and continuing care review guidelines uniquely tailored to CFSS responsibilities could have immediate impacts on system

effectiveness. Reexamining service plans to identify “*best practices*” in terms of outcome relative to cost could effect improved services and eliminate or reduce use of less reliable services. Computer-assisted data systems could be continually updated to develop more reliable means of tracking and analyzing assessment, service, and outcome profiles, which might lead to better service planning.

Financial efficiencies might be introduced by reexamining current service patterns. For example, if out-of-area placements are consuming valuable service funds, planners might, in the short-term, institute *restrictions on use* of such placements. Local area providers might be encouraged to absorb youth currently in out-of-state placements into their service population by *expanding or restructuring their services*. *Rate adjustments* might be introduced to encourage providers to set up new services. Different types of *payment mechanisms* might be used to help the system move away from current practices which are regarded as too restrictive.

Planners might consider whether there are other opportunities for *public and private collaboration* for CFSS improvement. Could MCOs assist public agencies with the *transfer of technologies*? What help could public agencies provide to private and non-profit agencies to *reconfigure their administration* and services to be more cost effective?

If it is likely that CFSS administrative functions will shift to an MCO-managed system, government administrators might consider what help small providers will need to successfully maintain presence in the system. Governmental CFSS administrators might *assist small providers to learn* new management and administrative practices to prepare for successful participation in newly formed provider networks. Alternatively, administrators might *assist providers to form* their own networks and ASOs.

Again, the strategy is to identify techniques and practices in managed care that could be adapted and adopted within the CFSS. Many small improvements can add up to major system changes without embracing the potentially radical changes currently happening in managed health care.

TASK 3. PROPOSE LONG-RANGE INNOVATIONS

Once states and local governments are clear on their goals for the CFSS, they can more readily determine what managed care practices or new methodologies to adopt. One likely scenario is that certain authorities will be shifted from states or counties or cities. Alternatively, these functions could be transferred to the private sector or to some combination of public and private partnerships. Such radical shifts are more likely if the planning process has confirmed that there is a reasonably adequate capability within the governmental and private systems to accommodate such changes.

In the long run, it is likely that a significant restructuring of the CFSS will be called for. The devolution of responsibilities from federal to state to local governments is a trend that must be reckoned with. More importantly, the emphasis on public/private partnerships and privatization of governmental functions suggest that CFSS planners consider mechanisms for transferring more of their functions to the private sector. In proposing long-term innovations, CFSS planners must address the following issues:

- Scope and control of the innovation,
- Population definition,

- Services to be included,
- Determinants of and methods to control risk,
- Alternative contractors,
- Competitive provisions,
- Selection of service providers,
- Methods for monitoring and evaluating performance,
- Client protection and satisfaction,
- Timetable for implementation, and
- Potential sources of failure.

Scope and Control

Managed care offers major potential for assisting states and communities to realign responsibility for providing and paying for CFSS services among the different levels of government and with the private sector.

- Should system-wide managed care initiatives be implemented as a pilot? As a series of comparable demonstrations? In a specific geographic area? Statewide?
- Is one area of the state more ready than another? On what basis is that judgment made?
- What would it take to prepare other areas?
- How will other areas be phased into the process?
- Are certain program initiatives appropriate for initial incorporation into the innovations?
- Are certain programs appropriate for replication through demonstration model funds?
- What services for CFSS populations would be involved? Health? Mental health? Foster care? Special education? Juvenile justice?
- Would CFSS services be provided more effectively within a single integrated system — including health, mental health, public assistance, child welfare, special education, and juvenile justice — or would maintenance of separate administrative and/or service entities assure better care for clients?
- Could some services be provided more appropriately and effectively in a separate, specialized service system (“carve out”)? Which one(s)?
- How would carve-out services be coordinated with other services?
- Is it better to remain centralized or decentralized?
- Who would control the system: The state? County? City?
- How much community control would be appropriate? Desirable?
- What are community capabilities for CFSS control?
- How much control should be given to the private sector? Non-profit? For-profit?
- Where would administrative responsibility be vested? At the state level? County? City?

- Could states and counties collaborate on fulfilling administrative responsibilities?
- Could nongovernmental organizations take over key administrative functions? Which ones?
- If funding is disbursed on a contract basis, could a city or county serve as an Administrative Services Organization (ASO)? As an MCO?

In order to answer these questions, the state should know the level of administrative capacity, system flexibility and diversity, community acceptability, political support, knowledge of new technologies, and capability to monitor and respond to performance feedback.

Population Definition

The nature and size of a population — as well as its service needs and historical utilization of services — must be estimated as accurately as possible so that the potential size and cost of the proposed effort can be projected. This type of information can be used to determine which groups to include or exclude in a particular managed care 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. Enrollment processes can also be tailored to address characteristics and issues related to distinct populations.

- Who will be served in the revised system?
- How will they be “enrolled” or designated for participation?
- How many clients and what types of clients are likely to be involved?
- Should the service system reconfiguration address the needs of all at-risk families and children or only sub-groups of the at-risk group, such as those who have the most (least) pressing needs? What is the basis for that judgment?
- Will the entire eligible CFSS population be incorporated into the reform initiative at the beginning?
- Will only part of the population be covered and others phased in later?
- How would other populations be incorporated?
- Are some sub-groups to be handled “outside” the reform system?
- At what stage of implementation might additional persons be included?
- Who is eligible and competent and appropriate to determine needs?
- How would clients become “eligible” for services?
- What is commonly accepted as indicating need for CFSS services? Child’s violent action? Abuse or neglect? Families experiencing high stress levels or those with inadequate coping skills? Illness or disability? Poor school performance? Child’s disruptive behavior? Child’s failure to achieve developmentally appropriate competencies? Court judgements?
- How are needs of the family accommodated in relation to individual family members?
- What constitutes a “family” for purposes of the CFSS managed care initiative?
- Will participation be “voluntary” or will all (or a subset of) CFSS clients be obligated to participate?

- Will procedures change for people already using CFSS services?

Services

Managed health care relies on a “benefit package” to help delimit service obligations of providers. CFSS relies on case worker expertise to assess the client’s situation and develop and execute a remediation plan that satisfies the public and community’s minimal requirements for humane and ethical treatment of its vulnerable children and families and for adequate protection from actions that might endanger the community. While managed health care uses the term “medical necessity” to define covered services, the relevant concept in the CFSS is “social necessity.” The primary concern in devising performance agreements and service contracts is to determine what will be the minimum and basic core of services and special add-on services around which the case worker or provider can design a service plan. CFSS managed care contracts will have to address the following questions:

- To what extent will the state define an acceptable program of services, versus allowing the program to be defined by MCOs and providers? For example, should the state specify whether transportation services must be included or should that be left to the MCO?
- 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?
- If there is more than one MCO, how will uniformity among MCOs be achieved to guarantee the comparability of services?
- Are there some aspects of services and some service providers that require special protections?
- To the extent that services will continue to be provided directly by the state, what role do the public agencies have in the overall managed care effort?
- Who pays for court-ordered services?
- What elements of the service system should be included (e.g., residential treatment services, assessment and disposition, investigation, school clinics, inpatient psychiatric care, and case/care management)?

Determinants of and Methods to Control Risk

There is a broad range of options for reallocating risk between government payers and public or private providers. At one end of the spectrum, requiring greater control of performance and negotiating discounted payment rates could produce improvements in effectiveness and reduce costs to the government with limited transfer of risk from government. At the other end of the spectrum, capitation arrangements would transfer the greatest risk to the provider, with the government-as-payer retaining the lowest risk. The provider incurs the highest likelihood of benefiting or losing from savings and losses. At the same time, the payer is protected from incurring some or all losses but has lowest likelihood of benefiting from savings.

In deciding if it will proceed with a contractual transfer of responsibility and risk to other sectors, governmental planners must consider a number of determinants of level of risk for themselves as payer versus contractual providers. Knowledge of these factors is essential in contract negotiation since they are fundamental elements in projecting contract rates and terms.

Client factors: Information regarding past patterns of use and anticipated future use by various groups is key to determining potential volumes and costs. Officials (and potential contractors) need to know:

- Characteristics of the participating group (i.e., what is their service-use profile), and
- Patterns of service use (i.e., how different groups use different services).

Service cost factors: Services with low fixed costs and flexible staffing can most readily adapt to changing demand volumes. Services with high indirect costs or with high fixed costs cannot easily adjust to reduced utilization. Different payment rates and payment methods must be chosen, especially for providers who are expected to deliver services which have low profit margins.

Plan factors: Benefit or service plans delimit the extent of expectations on the service contractor. In addition to stating what services they are generally required to deliver, it is important to state the minimum amount of services expected to be provided. Contractors could use discretion in how to achieve these minimums.

Risk pool: Numbers and types of persons in the participant group. The larger the pool of participants, the less likely there will be to have major variances among participants. Social support service funding has usually assumed more limited participation than is common in health care, where beneficiary pools can be quite large. Therefore, risk for variances are likely to be higher in many human services contracts.

Estimated risk: Government officials can use various combinations of actuarial analysis (retrospective analysis of past use) or prospective risk simulation (statistical modeling with different demand assumptions) to project an estimate of risk.

In order to control risk, a contract might contain terms that allow:

- Risk adjustment — Contract could authorize higher payments for high risk clients.
- Risk-limiting — A ceiling on losses for providers could be specified.
- Risk-sharing pools — Providers could be authorized to establish reserve funds to be drawn against in the event of service demands that exceed expectations.
- Re-insurance — Providers could secure insurance against catastrophic costs.
- Extended contract period — Multi-year contracts assure a long enough timespan to accommodate normal fluctuations in demand, thus evening out periods of high and low demand.
- Limits or expansion in covered population — Limiting the range of population to be served enables more rate stability. Expanding the population covered spreads out use patterns, thus reducing variances in costs that exceed projections.

Cost reduction: Providers must exercise close control on operations to stay within cost projections. Risk is reduced to the extent that providers can reduce costs by:

- Changing the pattern of use — Based on past use patterns, they could project savings resulting from introduction of more efficient methods of service.

- **Reducing the rate of use** — Providers could estimate cost-saving benefits of establishing prevention or early intervention procedures.
- **Reducing inappropriate use** — Incurring costs only for required services saves money for the provider.
- **Reducing the cost of a unit of care** — Increased staff productivity and decreased operational expenses produce lower cost per client, resulting in savings and potential profit for the provider.

All of the above factors must be taken into consideration both by the government procurement officials and by potential contractors. These factors must be built into contract specifications and rate negotiations, and they must be factored into various monitoring and evaluation strategies.

Shifting to risk-based contracting using typical managed care mechanisms will require states and local governments to be much more explicit about their service requirements. They must be clear on what they are purchasing, how much, what they need to know about potential contractors, how they will evaluate the contract proposals, and how they will monitor contractor performance. (See Appendix C for suggested elements of a capability statement and proposal to be required of prospective contractors.)

Alternative Contractors

CFSS administrators should consider realistically the strengths and weaknesses of various organizational options in determining future CFSS operational leadership. Numerous for-profit, non-profit, and joint venture options will present themselves. Each has potential strengths and weaknesses, some of which are listed below.

Private, for-profit MCOs: These organizations, most of which are health service-related in origin, have the advantage of being technologically advanced in managing complex systems. They are generally sufficiently capitalized to take risk in exchange for opportunity, and they are large enough to achieve economies of scale. However, these organizations may have little direct connection with the community where services are needed. Their background as predominantly health service providers may have afforded them little experience in working with the CFSS population at risk. Furthermore, service limitations and profit motives may not always be consistent with CFSS goals.

Private, non-profit human service networks: These groups are usually closely involved with the life of the community where services are needed. Their non-profit orientation means they are more likely to tolerate unprofitable clients or services since their mission is more clearly identified with the needs of the CFSS population. They know the population in need and the services that work for them. However, these organizations can have limited technological capabilities and administrative controls. They are sometimes inefficient and fragmented and lack the financial capitalization or administrative sophistication to manage a large service network.

Joint ventures (profit/non-profit, public/private, etc.): There is a wide range of opportunities for various types of organizations to work together to form and operate a service network. Optimally, such ventures involve the joining together of organizations to take advantage of their best assets. For example, the administrative aspects of the system might be managed by a for-profit MCO that specializes in administrative services. Services might be provided by a network of affiliated community providers. Both groups could join together to submit a contract

proposal with the MCO providing organization and oversight, and funding passing through to a service provider network. Such arrangements enable involved parties to retain their autonomy while working closely to achieve a goal. Agreements can be formulated with minimal financial entanglement or legal requirements, thus enabling rapid response to contract opportunities. Alternatively, agreements can entail equity-sharing provisions, essentially merging the two organizations. Joint venture agreements would spell out how the involved entities will share responsibility for such activities as network development, contracting, financial risks, marketing, provider relations, service delivery, utilization management, quality assurance, and credentialing.

Competitive Provisions

Government officials may want to utilize competitive forces to achieve some of the aims of their CFSS reform. Competition is often introduced in the procurement process. It permits selection of only the most qualified contractor(s), potentially drives the price down, and creates incentives for contractors to provide efficient and effective services in order to continue being selected on subsequent re-bidding or renewal cycles. However, competitive procurement can result in disruption to the service system, forcing clients to change providers as contracts are awarded to different bidders over time. In order to avoid disruption, and because it is so difficult to assess beforehand an organization's ability to perform, officials have a tendency to continue contracting with the same vendors. Furthermore, unless government payers have set the price and force bidders to compete on the basis of quality alone, there is a danger that contractors will submit low bids that are not sufficient to support adequate service delivery. Officials can endeavor to assure a successful competitive contracting environment by:

- Assuring all potential bidders an opportunity to participate in design of the managed care initiative,
- Establishing a contract negotiations process that is not too formal or cumbersome,
- Providing enforceable inducements and penalties to encourage competition among contractors,
- Setting equitable rates and allow reasonably-sized market shares, and
- Maintaining adequate risk protection for contractors against unanticipated costs.

In establishing a competitive procurement process, CFSS officials would have to answer the following questions.

- How would potential bidders be identified and notified of announcements of service procurement or other service acquisition arrangements?
- On what basis would bidders be considered eligible?
- How would a bidding process be conducted?
- Who would manage the bidding and selection?
- Who would negotiate new service contracts?
- What staff would serve as expert consultants in the review and negotiation process?

Government could also infuse competition into the CFSS by contracting with more than one entity and letting them compete for the same pool of enrollees. This type of competition encourages both quality and efficiency, and affords the maximum amount of choice to clients. However, a major

drawback with establishing competition among contractors is that it can create incentives for them to vie for the least expensive clients and avoid serving the neediest, more expensive ones. This danger can be avoided by assigning clients to contractors instead of letting them choose, but this negates the advantage of this approach of affording clients more choice. Contracting with multiple contractors also decreases the size of the risk pool, making it more likely for any given contractor to face unexpectedly high costs. Questions to be considered by CFSS officials in making decisions regarding competition for enrollees include:

- Will clients be permitted to choose among contractors?
- If so, what information will be provided to help clients make their choices? How will the information be made culturally and linguistically appropriate?
- What measures will be taken to prevent marketing abuses? Establish marketing guidelines? Employ an independent broker or government staff to enroll clients? Use client advocates?
- If clients are not permitted to choose, or if clients do not exercise their right to choose, how will clients be assigned to contractors? Random? Geographically based? Preference given to pre-existing relationship with provider?
- Will clients be able to switch contractors? Will there be any limitations on the timing or frequency of such changes?
- Is there sufficient geographic concentration of the client population in all areas where reform is being initiated to support more than one contractor?
- What is the maximum number of contractors that will permit sufficient risk pools?
- What is the maximum number of contractors that will permit a sufficient concentration of resources such that each contractor will be able to offer the full spectrum of services?
- How will the CFSS assure that competition is actually be achieved and that contractors are not carving out their own niches in the market and effectively avoiding competition?
- What additional governmental administrative and monitoring resources will be needed to oversee multiple contractors?

Selection of Service Providers

CFSS officials may wish to be highly specific regarding who should be included in the provider network(s), or may allow many of the decisions regarding providers to be made at the contractor level. Some questions to consider are:

- How and by whom will services be provided? By: Any “willing provider?” Existing providers? Providers selected by a MCO? Based on special competency (e.g., “safety net” providers, special cultural competency, etc.)? Providers accredited/credentialed by professional organizations?
- Who sets minimum standards for qualifications of staff?
- What and who determines satisfaction of qualifications?
- Do procedures exist to grant exceptions to qualification requirements?
- Should all existing providers be given automatic or presumed status in the revised system?
- What assistance would existing provider organizations require to be fully effective participants?

- Should some providers participate despite lack of readiness?
- What assistance should be given them to alter operations to correspond to the changed system?
- Who will provide this assistance? Who will pay for it?
- What assistance could organizations with managed care experience give to less-ready colleagues?
- Has special attention been paid to unique organizations who provide a highly specialized service or to organizations whose services are especially suited to needs of cultural or ethnic groups?
- What support do they need and where will it come from? Who will pay for it?
- For how long should assistance be provided to organizations before they are presumed to be able to operate under the restructured system's culture?
- Will special rate protections be necessary in order to enable specialized, intensive, or extended services providers to participate in provider networks?
- Should this be included in contract terms?

Methods for Monitoring and Evaluating Performance

Regardless of how much responsibility the state cedes in the actual design and implementation of the CFSS, the state still has an obligation to assure access to the system, that services are of appropriate quality and culturally competent, and that the proper amount of service is provided. Staff must have demonstrated competence and adhere to acceptable performance standards. Levels of service must meet service criteria. These and many other factors must be considered in evaluating the performance of providers and in monitoring the service system overall.

Many different elements of the service system require monitoring. A sample of possible elements includes:

- Service populations. How many and who is being served?
- Utilization. How appropriate are services and use of resources, based on concurrent review and retrospective audits?
- Adherence to stated criteria for admissions, transfers and discharges or terminations. Is the "necessary" level of care being delivered? Are "enabling" services to facilitate access available? Is movement between different levels of care easy? Are "socially necessary" services provided?
- Outcome in relation to severity of need and services delivered. How is "outcome" evaluated as a measure of provider performance? How is "successful outcome" defined and measured?
- Process of service delivery. How long does it take to get to a service? How long does it take to get an appointment? How available are certain services and providers?
- Performance relative to cultural competence. Has knowledge about cultures of clients served been acquired? Have skills relative to cultural requirements been developed?
- Satisfaction surveys. Whose input should be sought among various stakeholders (e.g., clients, payers, providers, courts)?

- **Quality assurance and quality improvement systems. Are adequate methods employed? what problems have been identified? What improvements or changes have been made?**

In addition to deciding what must be monitored, CFSS officials must decide how monitoring will be accomplished.

- **Who is responsible for monitoring?**
- **If monitoring responsibility is spread across the CFSS, how will monitoring be coordinated?**
- **Is there sufficient government capacity to adequately monitor contractors and providers?**
- **What monitoring methods will be used? Periodic reports? Site visits?**
- **How, and how often, will contractors and/or providers be required to report?**
- **What format will be used?**
- **To whom will reports be submitted?**
- **By whom will they be analyzed?**
- **How is the CFSS agency prepared to deal with the fiscal, legal and political consequences of damaging suspended or failed operations?**
- **What criteria will be used to measure clinical/service performance? Administrative performance?**
- **How will adherence to government-imposed treatment and/or staffing standards be ascertained?**
- **How will the effectiveness and efficiency of the overall system, and providers within the system be measured?**
- **What factors will be considered in developing or adopting appropriate outcome measures?**
- **What validated measures exist?**
- **Are proposed performance or outcome criteria meaningful?**
- **What measures are currently in use? How effective are they?**
- **What new ones will be needed?**
- **How will standards be interpreted and success measured among different groups, geographic areas, ethnic populations?**
- **How will administrative performance be measured?**
- **What experts are available to assist in the adaptation or development of measures?**
- **What level of performance will be considered adequate during phase-in?**
- **At what point should full performance be required?**
- **If financial incentives or penalties are imposed on providers based on performance reports, what appeal mechanisms are in place in the event of ambiguous or negative results?**
- **What if there is disagreement on interpretation? Is there a dispute mediation process in place?**
- **If performance monitoring indicates a need for change or improvement, how will that be enacted? By whom? Under what authority? With what control or consequences?**

- At what level will major changes or suspension of the process be considered?

In addition to using performance reports to monitor CFSS reforms, officials should consider conducting a formal, system-wide evaluation. In structuring such an evaluation, officials will need to develop responses to the following questions.

- Who will design the system-level evaluation? “In-house” staff? “Outside” consultants?
- How would external evaluators be chosen: By competitive bid? As exclusive providers?
- Who should be involved in the evaluation design?
- What requirements have been imposed on contractors to supply data and otherwise cooperate with the evaluation?
- Will evaluation designers work directly with staff to assure that their evaluation design is consistent with program expectations?
- Have the interests of funding bodies been adequately considered?
- Will the data provide feedback on whether the system is working more effectively and efficiently than before the changes were made?
- Will evaluators communicate directly with providers to test the viability of their proposed evaluation mechanisms?
- Has the evaluation design been reviewed to address potential problem areas in advance of implementation?
- What relationship would system-wide evaluation have to ongoing performance monitoring?
- Are there mechanisms in place to collect data in support of these evaluation measures?
- Can data be collected quickly, easily?
- Can it be analyzed and interpreted easily? By whom?
- Will there be/has there been any testing of the model in advance?
- If the evaluation design is contracted out, what timeframes will be built into the contract?
- How do these timeframes coincide with the overall timetable for the entire system redesign process?
- What levels of action are planned in response to different evaluation results?

Client Protection and Satisfaction

Government must promote basic constitutional rights and equal protection under the law by refraining from violating rights or discriminating, and preventing any one in the CFSS to do so. In addition to protecting against illegal infringements, public officials are bound to protect the privacy of children and families. Lack of privacy can jeopardize personal, family, and job security. There are a variety of mechanisms to ensure that client protection principles are adhered to and that clients are satisfied with the CFSS reforms instituted.

- How will clients be involved in the planning and monitoring of the CFSS reform? How frequently will clients be able to provide feedback? What methods will be used to collect public feedback?

- Will consumer satisfaction be surveyed? Only by providers, or also by government or independent contractors?
- Will other forums for obtaining client feedback (e.g., public hearings, focus groups, regional workshops) be utilized?
- Will a contractor-operated grievance process be instituted? What evidence will be required to show that it is operational?
- Will a government-administered grievance process be instituted?
- How will clients be informed about the existence of the grievance processes? Will the information be jargon-free and linguistically appropriate?
- How will grievance processes be kept informal and flexible?
- What provisions are in place to ease the transition and to redress client complaints if there are implementation problems?
- Where can clients lodge emergency appeals for intervention?
- Will grievance procedure staff be trained to be aware of and responsive to language needs and cultural differences of the communities they serve?
- Will ombudsmen/advocates be available to guide clients through the grievance process?
- Will written releases signed by clients and families to authorize the sharing of sensitive information be required?
- How will security of information systems be established?
- How will staff be trained to follow all confidentiality procedures?

Timetable for Implementation

System change does not occur overnight. Failure to allow sufficient time to prepare for and implement a major reform to the CFSS could lead to turbulence in the provider community and hardship for clients. Contracts should anticipate a realistic implementation cycle during which the contractor gradually assumes responsibility for the service system. Adherence to the agreed-upon timetable should be monitored lest the implementation proceed too quickly or fall too far behind schedule, creating possibly damaging disruptions to services. Government officials should consider in advance how long they expect operations to be in place before the contractor should be expected to be in full compliance with contract requirements. Contract monitoring procedures should spell out these expectations.

An outline of an implementation timetable might look like the following:

- Phase I (months 1-9): — Program start-up. Contractor will structure and staff the operation, establish service networks and negotiate agreements with providers, train providers on managed care practices, establish intake and assessment procedures, establish quality assurance standards and protocols, etc. Payment will be on a cost reimbursement basis.
- Phase 2 (months 10-18) — Transition. Contractor will phase-in acceptance of new cases and all cases begun a specific number of months prior to the contract. Older cases or those nearing completion are not be transferred to contractor. Initial range of services and populations served may be limited. Payment rates reflect transition issues and do not transfer risk.

- **Phase 3 (months 19-30) — Implementation.** Contractor provides full range of services to full range of clients, but risk is still not shifted to contractor.
- **Phase 4 (months 31-42) — At Risk.** Contractor is held fully accountable for outcomes and phase-in of risk sharing provisions is completed.

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Anne B. Drissel has been involved in mental health policy, planning and administration for more than 20 years. As Administrator of the Pavilion Behavioral Health Center and Vice President of Northwest Texas Healthcare System, she created a carve-out managed behavioral healthcare system for a 40,000-person HMO and served as interim executive director of the Panhandle Provider Organization, a preferred provider organization. Ms. Drissel served as the Executive Director of the Arlington (Virginia) Community Services Board, the designated county mental health, mental retardation and addiction services authority. At the National Institute of Mental Health she coordinated development of the *National Plan for the Chronically Mentally Ill* and was one of the founders of the Community Support Program (CSP) and the Child and Adolescent Service System Program (CASSP). She was also federal programs advisor for the National Association of State Mental Health Program Directors. Ms. Drissel was appointed Executive Director of the Policy Resource Center in October 1996.

APPENDIX A

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APPENDIX B

SUGGESTED TEMPLATE FOR CFSS PLANNING REPORT

Trends

- Current and future trends in managed care.
- Pressures for change and future expectations.

Current CFSS Capabilities

- Description of state/region/locality.
- Current assessment of providers, funding, MIS, and government staff.
 - Strengths, and basis for this judgment,
 - Weaknesses, and basis for this judgment.

Governmental Roles

- Current and future responsibilities.

Recommended Areas for Improvement

- Reasons why change is necessary.
- Key areas identified for improvement and why selected.

Applicability of Managed Care Technologies

- How new technologies and methodologies can build on strengths and correct weaknesses of current CFSS.

Recommended New Managed Care Methodologies

- Basis for their selection and recommendation.
- Other options and methods considered but rejected and why.

Description of Modified CFSS

- Proposed new managed care-oriented CFSS and how it will work for:
 - Various client populations,
 - Providers,
 - Related public systems,
 - State and local government agencies,
 - Communities, and
 - Other.
- Impact of proposed changes on existing system.
- Transition plan.

Quality Assurance

- How system improvement outcomes will be monitored and evaluated.
- Evaluation of current quality assurance capabilities and recommended improvements.
- Plan to achieve adequate QA capabilities.

Recommended Changes in Funding Mechanisms

- Proposed method(s) for reallocation of risk.
- Proposed source(s) of funding for the system.
- Proposed methods of disbursing funds.
- Financial safeguards to assure fiscal responsibility and viability as the changes progress.
- Action plan to implement new financing mechanisms.

Proposed Changes to Management Information Systems

- Data capabilities needed to manage and monitor operation of new systems.
- Timeline and projected costs for implementation.
- Proposed implementation plan.

Methods for Monitoring and Reporting on Progress

- Protections and monitoring stages to prevent excessive or avoidable damage.
- Methods or basis for measuring system performance.
- Agency(ies) to participate in and direct the monitoring.
- Actions to be taken to correct or ameliorate problems.

Cooperating Agencies and Organizations

- Those which have agreed to cooperate in accomplishing these changes.

Key Officials

- Leadership to manage system changes.

Key Agencies

- Agency/Agencies to be responsible for administering, funding and evaluating.
- Changes in organizational structure and operational practices to support the reform effort.

Implementation Timetable

Background on How the Planning Process Was Accomplished

- People who have been involved.
- List of background papers and reports.

Person(s) to Contact for Further Information

APPENDIX C

SUGGESTED ELEMENTS OF A CONTRACTOR CAPABILITY STATEMENT AND CONTRACT PROPOSAL

History of Organization

Key Officers

Financial Viability

- Capitalization for start-up and ongoing cash-flow

Evidence of Liability Insurance

Serving Children and Families

- Philosophical approach (vision, mission, underlying values)
- Past experience and current capabilities in serving children and families

Administration and Organizational Structure

- Organizational structure
- Responsibilities of each administrative unit
- Capability for MIS, capital formation, financial operations
- Phase-in and implementation management

Establishing Managed Care Service Network

- Current network capabilities
- Plans to expand (establish) network
- How will network be developed? By whom?
- Projected status at start-up
- Recruitment methods
- Payment rates to providers
- Credentialing
- Provider standards
- Ability to meet cultural, racial, linguistic and special service needs of clients

Eligibility of Providers

- Procedures for selecting and credentialing network participants (e.g., must be Medicaid providers)
- Adequate provider-to-client ratios
- Service capacity
- Maintenance of provider standards
- Meeting cultural, racial, linguistic and service needs of client populations

Training and Support for Providers

Services to be Provided and How They Will be Organized

- Services to be provided
- Expected geographic coverage and locus of providers
- Provision for 24-hour intake, assessment, and service response

-
- How client services will be coordinated relative to intake, share eligibility information, share data
 - Accessible staffing
 - Physical location

How Coordination Will be Provided

- List agencies with which it proposes to coordinate and collaborate
- Issues about which it will coordinate and collaborate
- How coordination and collaboration will be accomplished
- Provide copies of coordination agreements and letters of support

Cost and Claims Reporting Capability

- Claims processing and MIS capability to support network provider claims, payments, and data reporting, including client eligibility, units of services provided, and costs of services
- Ability to make “shadow claims” reporting (equivalent to fee-for-service billing)
- Software compatibility with state fiscal agent’s requirements

Utilization Management

- Utilization goals
- Control of utilization patterns
- Development and use of clinical protocols

How Quality Assurance will be Established and Operated

- How any relevant federal requirements will be met
- How outcome will be measured
- How client satisfaction will be measured
- How provider satisfaction will be assessed
- Risk management procedures established
- Measures of ongoing quality

Response to Monitoring Requirements

- How monitoring findings will be addressed
- Corrective action undertaken in response to negative performance findings

Appeal and Grievance Procedures

- Handling of complaints
- Criteria to be used and methods to appeal denial, discontinuance, or reduction in service
- How disputes with clients will be addressed
- How disputes with providers will be addressed
- How disputes with government agency will be addressed

Proposed Rate Assumptions

- Proposed cost or payment rate and assumptions on which they are based
- Expected level of utilization/participation on which assumptions are based
- Proposed methods for handling benefits of cost savings (profits) or risk of cost overruns (losses)

Implementation Timetable