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CHILD WELFARE

New Financing and Service Strategies Hold Promise, but Effects Unknown

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Child Welfare: New Financing and Service Strategies Hold Promise, but Effects Unknown

Madam Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the progress made by states and localities as they develop new financing, service-delivery, and accountability strategies for their child welfare programs. In the mid-1980s, child welfare agencies faced a poorly integrated patchwork of services for children and families accompanied by escalating costs. As we reported to this Subcommittee in October 1998, a number of states have incorporated or are considering incorporating some of the principles of managed care into their family preservation, foster care, and adoption programs.[1] Under a managed care approach, states and localities prospectively pay fixed, capitated amounts to providers to coordinate and meet all the service needs of referred children and families. The officials responsible for these new managed care initiatives saw this approach as a strategy both to improve the quality of care children and families in the child welfare system received and to control the rising costs of delivering services while holding all the partners in the system accountable.

Now that many of these initiatives have been in operation for 3 or more years, you asked us to report on their progress. As you requested, I will focus my remarks on (1) the financial and service-delivery changes states and localities have made in their managed care initiatives, (2) how they are measuring the initiatives' outcomes, and (3) what is known about the effect of these changes on children and families. My testimony is based on our past and ongoing work on 27 state and local initiatives that have been in operation since January 1998 or earlier.

In summary, states and localities that are implementing child welfare managed care initiatives are moving away from a traditional fee-for-service reimbursement approach to one that funds a single provider in advance under a capitated payment. This allows the single provider—now assuming greater responsibility for case planning and providing needed services—the flexibility to package and manage an array of child and family services. Under these new arrangements, states and localities are taking steps toward becoming more performance-based and results-oriented as they implement child welfare managed care initiatives. We found that the state and local agencies operating these initiatives are beginning to identify measures associated with five child and family outcome categories—child safety, a permanent home for the child, child and family well-being, the stability of out-of-home placements, and clients'

[1] *Child Welfare: Early Experiences Implementing a Managed Care Approach* (GAO/HEHS-99-8, Oct. 21, 1998).

satisfaction with the services they received. In addition, these agencies are using such strategies as setting performance standards and incorporating financial incentives in contracts with service providers to hold them accountable for their performance and ensure that desired results are achieved. However, we found that many of the state and local agencies operating these initiatives do not have appropriate data systems in place to store, analyze, and retrieve information on client outcomes. Most state and local officials we talked with who were responsible for the initiatives are encouraged by the changes occurring in child and family outcomes. While controlling costs was seen as a potential benefit of managed care, an equally if not more important goal was improved services for children and families. In fact, in some cases, overall spending has increased. Whether any outcome changes associated with these initiatives can be attributed to the new strategies is still largely unknown because they have not been rigorously evaluated. Planned evaluations under the federal waiver demonstration program will—in the future—yield additional information about the effectiveness of child welfare managed care arrangements.

Background

The Administration for Children and Families within the Department of Health and Human Services (HHS) administers the federal child welfare programs. Federal involvement includes monitoring states' compliance with federal statutes and regulations, providing technical assistance to states, and supporting research and evaluation efforts. In 1994, the Congress gave HHS the authority to establish up to 10 child welfare demonstrations that waive certain restrictions in title IV-E—the federal foster care program—and allow broader use of federal foster care funds. The Adoption and Safe Families Act of 1997 (P.L. 105-89) expanded HHS' authority to approve up to 10 states' waiver demonstrations in each of the 5 fiscal years 1998 through 2002. The purpose for granting waivers is to test a variety of innovations, including but not limited to managed care. Of the 21 states that have federally approved waivers, 12 states have waivers to test managed care or capitated payment systems.[2]

In our 1998 report, we concluded that initiatives in which principles of managed care were being implemented were still in the early stages of program development and, as a result, were largely untested. We found that, for these initiatives to mature and meet officials' program expectations, state and local agencies needed to resolve three important issues. The first was to address cash flow problems in a new environment

[2]None of the 27 initiatives included in this study were implemented with a title IV-E waiver.

of funding services prospectively under a capitated payment system while seeking reimbursement for the federal share of costs only after services are delivered. In addition, state and local agencies stood a better chance of reducing or eliminating the service access problems often associated with different eligibility requirements in categorical funding streams if there was funding flexibility. The second issue facing state and local agencies was to continue to improve their capacity to collect, analyze, and report client and service data. Such data are paramount for state and local agencies to set reasonable and appropriate payment rates and performance standards, make additional programmatic changes or give service providers feedback, and improve policies and procedures for serving children and families. The third issue requiring resolution was that state and local agencies needed to continue to develop and refine strategies to hold both themselves and their private partners accountable for achieving desired outcomes. Moreover, these agencies needed to develop the capacity to continuously measure and report their progress toward meeting performance goals. Outcome measurement and performance management were new areas of focus for the child welfare system.

States and Localities Implement New Financing and Service-Delivery Strategies

During the mid- to late-1990s, in an effort to reduce inefficiencies and improve the quality of care, states and localities began to implement new financing and service-delivery arrangements into their child welfare systems. By 1999, according to the Child Welfare League of America, 29 states had one or more initiatives to change management, financing, or service-delivery practices by adopting some principles of managed care.[3] Managed care arrangements in child welfare have two primary elements. The first is a financing system whereby the state or locality makes prospective, fixed or capitated payments to one or more service providers rather than traditional fee-for-service reimbursement payments. The second element is that, under this new payment method, a single entity is responsible for ensuring that children and families receive appropriate and quality services.

Capitated Payments Provide Flexibility

Some states and localities are developing new payment systems in which there are incentives to both seek the most appropriate placement for children and have the flexibility to provide the most appropriate array of

[3]Charlotte McCullough and Barbara Schmitt, *Managed Care and Privatization Child Welfare Tracking Project, 1998 State and County Survey Results* (Washington, D.C.: Child Welfare League of America, 1999).

services. In their managed care initiatives, states and localities—often for the first time—are making prospective, capitated payments to providers to serve a defined group of children and families. A capitated payment is a fixed fee that a provider receives either for each eligible client—that is, a single rate for each referred child or family—or for members of a pool of potential service users—such as a single rate to serve all eligible children and families in one county. The service provider must then manage clients' care within the fixed fee. This approach is a departure from the traditional fee-for-service system states and localities have used to pay service providers. Under a fee-for-service arrangement, providers are reimbursed for the number and types of services delivered. Such a payment approach offers few incentives for service providers to control costs by considering the most suitable arrays of services for children and families or more quickly returning children to their biological parent or seeking other permanent placements such as adoption.

To further increase service flexibility, some states and localities are funding capitated payment arrangements by pooling individual state funding streams that support different services that children and families in the child welfare system need. Because of restrictions on eligibility and prohibitions on certain uses of funds, public and private child welfare caseworkers often encounter problems accessing needed services for clients. By pooling or blending funds from various sources, these states and localities seek to reduce service access problems sometimes associated with categorical programs and increase flexibility in the use of funds. In Colorado, for example, the state blended funds from several child welfare and child care budget line items and allocated a fixed level of funding—equivalent to a block grant—to its counties. Block-granting state dollars in this way loosened the restrictions on the use of these typically categorical funds and increased counties' flexibility. Boulder County further pooled its child welfare block grant with funding from the mental health agency and youth corrections agency to finance its Integrated Managed Partnership for Adolescent Community Treatment (IMPACT) initiative, serving adolescents at imminent risk of placement in group or residential care.

Service-Delivery Changes Are Designed to Improve Access to Care

States and localities are trying to improve access to services for children and families by charging a single entity with the responsibility of identifying and providing all appropriate services. This approach is designed to reduce the need for families to navigate—often with little or no assistance—a maze of community services, as well as increase the likelihood that the service needs of children and families match the services they receive. In most of the 27 initiatives we studied, states and

localities have contracted with experienced private nonprofit, community-based providers—many of whom have a long history of providing child welfare services for states and localities. These services often included temporary housing for foster children, mental health services, services to improve parenting skills, and some case management services such as developing treatment plans. As the managed care entity operating under a capitated payment, these providers take lead responsibility for coordinating specified child welfare services for a defined population of children and families. As the single point of entry to the service system, the managed care entity usually must provide, create, or purchase a wide range of services to meet the needs of children and families. If not providing services itself, this primary contractor may develop and subcontract with a network of service providers to make available all the services referred clients need.

States and localities have also shifted more case management responsibilities—much of which public agency workers had performed—to private contractors as part of their new role as care coordinators. In an effort to better match services with client needs, the primary contractor in many of the 27 initiatives included in our study uses a team approach to managing its caseload of children and families. This approach is designed to avoid the duplication, time delays, and fragmentation that often result under traditional case management, when different service systems and the many providers involved in a child's care are not part of the treatment planning and decision-making process. In some initiatives, the treatment team consists of those individuals who are regularly in direct contact with the child, including the case manager, therapist, parents or guardians, school officials, and other service providers. In other initiatives, case management teams include representatives from multiple agencies, such as child welfare, mental health, and juvenile justice agencies.

In most of the 27 initiatives, states and localities have contracted both the management and the coordination of care for children who have been or are at risk of being abused and neglected. However, not all aspects of the child welfare system have been contracted to private entities. States and localities have retained certain functions that officials believe are critical to meeting their legal responsibility for the safety and well-being of children in the child welfare system. In every initiative, the state or locality continues to conduct all child protection functions related to investigating reports of child maltreatment and recommending to the courts whether a child needs to enter the child welfare system for protective or any other services. A child enters the managed care system on the basis of a referral from the state or locality to the managed care entity. In some initiatives, the state or locality also maintains its presence by retaining the authority

to approve contractors' decisions related to reducing a child's level of care, such as moving a child from residential care to family foster care.

States and Localities Are Taking Steps Toward a More Performance-Based and Results-Oriented Approach

For child welfare managed care initiatives to effectively monitor the progress of children and families and hold service providers accountable, states and localities recognize that data on services and outcomes are needed. We found that states and localities are taking steps toward establishing a more performance-based and results-oriented system. Experts have identified critical steps to developing such a system, including identifying the outcomes to be achieved and their measures, establishing accountability for performance and results, and developing a data system to manage information on outcomes.[4] We found that states and localities are identifying child and family outcome measures in the areas of child safety, a permanent home for the child, child and family well-being, the stability of out-of-home placements, and clients' satisfaction with the services that they received. Many agencies operating these initiatives are holding managed care contractors accountable for desired results by using outcome measures to establish performance standards and link performance to financial incentives. However, not all of the initiatives have the most appropriate data systems in place to enable state and local agencies to develop outcome measures and monitor and assess whether desired results are being achieved.

Agencies Are Beginning to Identify Various Child and Family Outcome Measures

State and local agencies responsible for the managed care initiatives have identified a variety of child and family outcomes to monitor—and the associated measures for those outcomes—that traditionally reflect the child welfare system's priorities. These outcomes include measures of child safety, permanency, and well-being—that is, children remain safe from harm, achieve a permanent home in which to grow up, and are physically and emotionally healthy. Other types of outcomes for which measures have also been identified include the stability of out-of-home placements—sometimes measured by the number of times children are moved from one foster care placement to another—and client satisfaction—sometimes defined as the extent to which children or families express positive or negative feelings about the services provided by public or private agency workers. Most agencies have established a

[4]National Partnership for Reinventing Government, *Balancing Measures: Best Practices in Performance Management* (Aug. 1999); Casey Outcomes and Decision-Making Project, *Assessing Outcomes in Child Welfare Services: Principles, Concepts, and a Framework of Core Outcome Indicators* (Englewood, Colo.: 1998).

range of measures that cover some, if not all, of the five outcome categories. (Examples of the child welfare outcome measures for each of the five outcome categories are illustrated in table 1.) This strategy enables a dual focus of ensuring desired results are achieved—such as finding children a permanent home in a timely manner—and unintended results are not overlooked—such as children needing to reenter care because they were inappropriately discharged. Under a permanency outcome for its foster care initiative, for example, Kansas seeks to reunite children with their families in a timely manner and measures the percentage of children who return home within 6 months. To ensure that contractors responsible for managing the initiative provide quality services and do not return children to an unsafe home, the state also—under a safety and a permanency outcome—measures the recurrence of abuse and reentry into foster care within 12 months of reunification.

Table 1: Examples of Child and Family Outcome Measures

Category	Outcome	Measure
Safety	Children are safe from maltreatment	Confirmed reports of abuse and neglect in the general population
		Recurrence of abuse or neglect while children are receiving in-home services
		Reports of abuse or neglect while the children are in out-of-home care
		Recurrence of physical abuse, sexual abuse, or neglect after children have left care
Permanency	Children are placed in a permanent home in a timely manner	Children who are returned to their parents or relatives within a specified time
		Finalized adoptions
		Children who achieve permanency within a specified time
		Average length of stay in out-of-home care
		Children who are maintained in their home and do not enter out-of-home care
	Children maintain the permanent placement	Children who reenter care within a specified time
Well-being	Children function adequately in their families and communities	Children's emotional and behavior crises that result in hospital use or police calls
		Children's behaviors related to sexual misconduct, running away, and suicide
		Children's scores on standardized tests of childhood functioning
		Children's movement to less restrictive placement settings

Category	Outcome	Measure
		Youths discharged from care who have completed high school, have obtained a general equivalency diploma, or are participating in an educational or job training program
	Families function adequately in their communities	Families' adaptation to caregiving
Stability	Children experience a minimum number of placements	Number of placements while in out-of-home care
	Children maintain contact with their family and community	Children placed with at least one sibling
		Children placed within their home or contiguous county
		Children placed out-of-state
Satisfaction	Clients are satisfied with services	Youths who reported satisfaction with services, as measured by the Client Satisfaction Survey
		Children who reported satisfaction with their foster care placement, based on an exit interview
		Families who reported that the initiative provided them a valuable service

Source: GAO analysis of interview data.

We also found that states and localities are measuring different outcomes, depending on the population served by the initiative and the states' or localities' goals. For example, El Paso County's initiative in Colorado encompasses all children and services in the county's child welfare system; as a result, the county established a broad safety outcome and is measuring child abuse and neglect rates among the general population. In contrast, Massachusetts targets older children in residential care for its Commonworks initiative in which the lead contractors only serve children, while the state serves the family and decides when a child can return home. Instead of monitoring the recurrence of maltreatment, the state measures outcomes related to children's movement to less restrictive settings and reentry into residential care. One of Illinois' goals for its performance contracting initiative is to find foster children a permanent home in a timely manner while minimizing multiple out-of-home placements. To monitor progress toward this goal, the state established several outcome measures, including average length of stay and the number of placements in different foster homes while children are in out-of-home care.

Agencies Are Attempting to Hold Service Providers Accountable

States and localities responsible for these child welfare initiatives are using their outcome measures to establish performance standards for both public and private service providers. By doing so, they are trying to hold all the parties in the initiative accountable for results. States and localities have established performance standards for 11 of the 27 initiatives we reviewed. Most performance standards are expressed as a specified level of outcome to be attained. For its Multi-Agency Team for Children (MATCH) initiative for seriously emotionally disturbed children, for example, Georgia has included standards that 40 percent of the children will improve their functioning and be discharged to a less restrictive placement setting, and that a 20-percent decrease will occur in the frequency with which children harm others.

As states and localities gain more experience with managed care, officials expect to adjust existing standards or introduce new ones. For example, in Kansas' foster care initiative, state officials realized that their first-year performance expectations for the lead contractors were in all likelihood unrealistic because the standards were not based on past program performance. As a result, Kansas officials expected to and did adjust performance standards annually as more current information was collected. In contrast, Massachusetts took a more incremental approach for its Commonworks initiative. The state did not introduce performance standards in the lead agencies' contracts until the third year of operation, after sufficient information had been collected to establish a baseline from which to set standards.

Another strategy to hold managed care providers accountable for their performance and achieving desired results is to link financial rewards and penalties to outcomes. In some initiatives, the state or local agency offers bonuses as a financial incentive for the managed care entity to meet performance standards and penalties for poor performance. In the TrueCare partnership initiative in Hamilton County, Ohio, for example, the managed care contractor can earn bonuses when it meets individual performance indicators related to (1) child and family outcomes, such as ensuring children's safety and reducing the risk of harm, and (2) management services, including maintaining a competent provider network and maximizing revenues. Similarly, the contractor can incur financial penalties when it fails to meet the performance indicators. Massachusetts offers bonuses to the lead contractors for achieving interim or successful outcomes. In Massachusetts' Commonworks initiative, a lead contractor can earn bonuses at three different intervals—when a child transitions to a less costly level of care, when a child leaves placement, and when a child does not re-enter the lead contractor's care within 6 months of discharge. In addition, in the Massachusetts initiative as well as

others, poor performers risk not having their contracts renewed. However, even satisfactory performers may lose their contracts because of other factors. For Illinois' performance contracting initiative, foster care providers that met performance standards but were not the top performers lost their contracts when the successful outcome of a declining child welfare population resulted in a need for fewer providers.

Data Systems Are Needed to Manage Information on Outcomes

Data systems are the linchpin between a state or locality's efforts to identify and measure outcomes and fully implement a performance-based, results-oriented system. As states and localities move from a process-monitoring environment to a performance-based approach, information on client and service outcomes is needed to develop outcome measures and to monitor and assess whether desired results are being achieved. Nearly all the state and local officials we contacted reported that developing data systems to implement, manage, and monitor their initiatives continues to be a challenge.

Although agencies are taking steps to identify and measure outcomes, many have done so without appropriate information systems in place. In many instances, private service providers and states and localities are working with multiple, incompatible, or manual systems. While these systems may yield information on child and family outcomes, they are inefficient. For example, the lead contractor for the managed care initiative in Sarasota County, Florida, uses three separate, unintegrated data systems to track client and service data, and must enter duplicate information into each system and physically locate the three computer terminals side-by-side to ensure consistent data. For some initiatives in other states, agency staff manually collected outcome data because information systems had yet to be developed.

In several locations, data systems were developed specifically for the child welfare managed care initiative. In both Massachusetts' Commonworks and the Hamilton County, Ohio, TrueCare Partnership initiatives, the state or local agency required one of its managed care contractors to develop a data system specifically for the managed care initiative at the same time that new financial and service-delivery arrangements were implemented. These systems were not integrated with the state or local agencies' child welfare information systems at the time of our study, but may be in the future.

States and localities have not used federally supported statewide data systems to implement, monitor, or manage their child welfare managed care initiatives.[5] Among the 12 initiatives we contacted about this issue, none of the state or local agencies are using their state's Statewide Automated Child Welfare Information Systems (SACWIS) to manage information on their initiatives' clients, services, or outcomes. Whether the state's SACWIS was operational or still under development, officials for some initiatives told us they hoped to either link their initiatives' data system to SACWIS or incorporate SACWIS into their initiative in the future.

Effectiveness of Managed Care Initiatives Is Largely Unknown

Most of the states and localities involved in the 27 initiatives are encouraged by the results of the new financial and service-delivery changes. In particular, available data show that some of the ongoing managed care initiatives are associated with improved child and family outcomes in one or more areas of child safety, permanency, and well-being. In some initiatives, children are spending less time away from their biological parent or another permanent family than was the case before. While controlling costs was seen as a potential benefit of managed care, an equally if not more important goal was improved services for children and families. In fact, in some cases, overall spending has increased. Although reported results generally appear positive, few rigorous evaluations have been completed to determine whether the managed care arrangements are more effective or efficient than traditional financial and service-delivery methods. Future, planned evaluations under the federal title IV-E waiver demonstration program are expected to yield additional information about the effectiveness of child welfare managed care arrangements.

Officials Report Improved Child and Family Outcomes

For at least half of the managed care initiatives we reviewed, state and local child welfare officials said that they believed the initiatives resulted in children spending less time in out-of-home care and away from their biological or other permanent family, improvements in children's well-being, and less maltreatment recurring. For most of the 27 initiatives, available data reflected results encompassing outcome measures in three

[5]The Congress had authorized enhanced funding to states under the Omnibus Budget Reconciliation Act of 1993 for the development and implementation of Statewide Automated Child Welfare Information Systems (SACWIS) amid concerns about the lack of information on children in the child welfare system and their families. As of May 2000, HHS reported that 27 states' systems were fully or partially operational—including some of the states with ongoing child welfare managed care initiatives; the remaining 23 states were not yet operational, and 1 state had elected not to pursue a statewide SACWIS.

areas—permanency, child well-being, and child safety. About half the initiatives resulted in improvements in the number or percentage of children for whom a permanent home was found and, in some instances, they did so more quickly. In Florida, for example, the state reported that adolescents spent 66 percent less time in out-of-home care in District 4's managed care initiative when compared with another location where children were served by the traditional state service system. A third of the initiatives reported that children and families improved their well-being in such areas as their involvement in the community, the family's relationships with one another, parenting skills, and children's school performance. For example, Tompkins County in New York reported in 1997 that its youth advocate program resulted in all families improving parenting skills, all the youths improving their ability to control violent and impulsive behaviors, and 55 percent of the youths improving their school performance. Lastly, Colorado reported in 1999 a decrease in the incidence of abuse and neglect ranging from 18 to 23 percent compared with the previous year in the four counties with ongoing initiatives. (See appendix for a summary of the reported outcomes for the 27 initiatives.)

State and local agencies used their outcome measures to track their initiatives' progress in several ways. For some initiatives, outcomes were reported as change that occurred during the initiative. The Colorado example on the reduced incidence of abuse and neglect used the previous year as a comparison. For other initiatives, agencies reported outcomes without any indication of change—sometimes because comparisons had not been made. Initiatives that targeted the hard to serve and most costly children—those in need of placement in residential treatment centers—were considered to have had a positive outcome when children successfully transitioned to less restrictive, less costly placement settings. For Georgia's MATCH initiative, for example, officials reported that 41 percent of the program participants improved functioning and were discharged from a more restrictive residential setting to a less restrictive placement, such as a group home, treatment foster home, or their own home.

While the potential to control costs attracted state and local child welfare agencies to managed care, their primary objective was not necessarily to reduce spending. Instead, some officials expressed a desire to reduce certain types of costs—such as the living expenses for out-of-home placements—or to use existing funds more efficiently and reinvest any savings into services. For some initiatives, officials reported that overall spending has actually increased as a result of additional administrative costs associated with private entities assuming responsibility for managing clients' care and the state or locality overseeing contracts. For example,

Massachusetts reported that its Commonworks initiative is costing more, overall, despite realizing savings in some specific areas. Out-of-home placement costs averaged 3 percent less than the lead contractors' capitated payment rate. Although spending for in-home or aftercare services increased 80 percent as more children moved from residential treatment to less restrictive settings, the net effect was a cost reduction in spending for out-of-home and in-home services combined. Both the state and its lead contractors have reinvested the service-cost savings into program development. However, the state has incurred additional costs for an administrative services organization (ASO) to provide management services, lead contractors to manage their respective service-provider networks, and the state's oversight and management of the ASO and six lead contracts.

Lack of Rigorous Evaluation Leaves Initiatives' Effects Unknown

Although state and local child welfare agencies are tracking progress on most initiatives' identified outcomes—some by independent researchers—and reporting positive results, more rigorous studies are needed to determine whether the results can be attributed to the initiatives' new service-delivery and financial strategies. To date, few rigorous evaluations of the 27 initiatives we studied have occurred. Two evaluations, both completed in 1999, respectively included three local initiatives in Florida and a county initiative in California, and they attempted to compare program outcomes with a comparison group of children who were not participating in the initiative. However, both studies had serious design and data comparability problems and were inconclusive in their findings. A Colorado evaluation, which includes four of the county initiatives in our study, has established comparison groups for evaluation purposes. However, the study is ongoing and results have not been released.

While the 27 initiatives included in our study have had limited evaluation, planned evaluations under the federal title IV-E waiver demonstration program will yield additional information about the effectiveness of child welfare managed care arrangements. By law, states receiving this waiver must have an independent evaluation of the initiative that, at a minimum, compares and assesses child and family outcomes, methods of service delivery, and fiscal consequences. According to HHS officials, evaluations for the 12 waiver states that are testing managed care principles for child welfare services should be completed within the next 5 years. To date, one ongoing evaluation—of Ohio's demonstration of child welfare managed care in several counties—has compiled baseline information on child and family outcomes. Evaluation results are not yet available from any of the waiver states.

Madam Chairman, this concludes my prepared statement. I will be happy to respond to any questions that you or other Members of the Subcommittee may have.

GAO Contact And Acknowledgments

For further contacts regarding this testimony, please call Cynthia M. Fagnoni at (202) 512-7215. Individuals making key contributions to this testimony included David D. Bellis, Karen E. Lyons, Ann T. Walker, and Rodina S. Tungol.

Child Welfare Managed Care Initiatives' Outcomes to Date

Table 3 includes the 27 managed care initiatives about which we collected information regarding documented child and family outcomes, as of April 2000. In particular, we list quantitative results in the outcome areas of child safety, permanent homes, child and family well-being, out-of-home placement stability, and clients' satisfaction with the services that they received. Preinitiative baseline data were generally not available. We indicate changes and describe cost savings where data were available. In some cases, results were not reported for individual initiatives but were aggregated across multiple initiatives in a single state. Unless otherwise noted, the combined outcomes are shown for (1) the three district initiatives in Florida and (2) Champaign and Madison Counties in Ohio.

Table 3: Child and Family Outcomes for 27 Ongoing Child Welfare Managed Care Initiatives, as of April 2000

Location and project name	Managed care model[a] and project description	Child and family outcomes
State-level initiatives		
Georgia	Public model	Fiscal year 1998-99 results
Multi-Agency Team for Children (MATCH)	Statewide residential treatment services for severely emotionally disturbed children	Children's behavior improved—incidents of negative behavior, such as aggression, self abuse, and property damage, decreased 21 percent between the 6-month and 12-month evaluations for children admitted during 1998, and decreased 35 percent between the 6-month and discharge evaluations for children discharged during 1998 41 percent of the children were either discharged from the project or stepped down to a less restrictive setting during 1999 66 percent of the children who were discharged from the project were still in a less restrictive setting 6 months after discharge during 1999 42 percent of the children who had progressed to a less restrictive setting were still in a less restrictive setting 6 months after their transfer in 1999 All children were placed within the state during 1999
Illinois	Public model	1998-99 results
Performance Contracting	Relative and traditional foster care statewide	Permanency rate in 1999 increased 149 percent over the previous year in Cook County's Home of Relative Foster Care program Number of 1999 adoptions increased 70 percent over 1998 and 228 percent over 1997 3,660 children achieved permanency through subsidized guardianship between 1997 and 1999 Number of reunited families increased 12 percent between 1997 and

Location and project name	Managed care model[a] and project description	Child and family outcomes
		1999 Movement of children to more restrictive placement settings fell by more than half statewide
Indiana The Dawn Project	Managed care organization model Wraparound services for seriously emotionally disturbed children, aged 5 to 17, who have been impaired for more than 6 months and involved with multiple service systems in Marion County	Outcomes were not provided
Kansas Foster Care Privatization	Lead agency model Statewide foster care services to children in state custody	Year 3 evaluation results, Jan.–Sept. 1999 99 percent of the children did not experience abuse or neglect while in out-of-home placement (consistent with years 1 and 2) 97 percent of the children did not experience abuse or neglect within 12 months of reuniting with their families (same as year 2) 27 percent of the children placed in out-of-home care were returned to their families within 6 months (consistent with year 2; decrease of 49 percent from year 1) 41 percent of the children placed in out-of-home care were returned to their families or achieved other permanency within 12 months (increase of 24 percent from year 2) 74 percent of the children who returned to their families did not reenter out-of-home care within 12 months of returning home (increase of 9 percent from year 2) 81 percent of youths, who were aged 16 and over and released from the state's custody, had completed high school, obtained a general equivalency diploma, or were participating in an educational or job training program (increase of 8 percent from year 2 and 53 percent from year 1) 99 percent of the children experienced no more than three placement moves while in out-of-home care (consistent with years 1 and 2) 71 percent of all children were placed with at least one sibling (decrease of 9 percent from year 2; consistent with year 1) 78 percent of the children were placed within their regional boundaries (consistent with year 2; decrease of 9 percent from year 1)

Location and project name	Managed care model[a] and project description	Child and family outcomes
		47 percent of the adults and 70 percent of the youths (aged 14 and over) reported satisfaction with services (decrease of 6 percent for the adults and consistent for the youth from year 2)
Massachusetts	Administrative services organization with lead agency model	Administrative services organization report, 1999
Commonworks	Statewide foster care for adolescents needing group care or residential treatment	More children moved from residential treatment to less restrictive settings—the use of group homes, specialized foster care, and independent living increased 73 percent from July 1997 to June 1999 Children's placement in less restrictive settings was supported by increased provision of aftercare services—expenditures for aftercare services increased 80 percent, and the monthly average number of clients receiving aftercare services increased 51 percent over 1998 Recidivism rate of 6 percent for youths who had a planned discharge, such as return to home; 17 percent for all youths discharged, including unplanned discharges such as running away from foster care placement (Jan. 1997-Sept. 1998) Savings achieved for out-of-home and aftercare services in 1999 (excludes administrative costs associated with the administrative service organization, lead contractors' management of provider networks, and state oversight)—lead contractors' monthly client placement costs averaged 3 percent less than the capitated case rate
Michigan	Lead agency model	Descriptive evaluation results, 1998
Interagency Family Preservation Initiative (MIFPI)	Wraparound services for seriously emotionally disturbed children involved with multiple service systems at selected sites	Child abuse and neglect rate of 9 percent during families' involvement in MIFPI (compared with the rate for all children in the state of 8.4 per 1,000 in 1996) Child abuse and neglect rate of 2 percent after families' involvement in MIFPI Out-of-home placement rate decreased 38 percent during involvement with MIFPI for children who were in a placement setting at the time they entered the project; decrease of 39 percent for children who were not in a placement setting at the time they entered the project Children and families improved, on average, on all scales of well-being and functioning, such as family and peer relationships, community involvement, behavior, school experiences, and family's adaptation to caregiving, with the greatest improvement in lowering detentions and increasing the family's adaptation to caregiving 94 percent of the parents involved in MIFPI reported satisfaction with the services they received
Tennessee	Public model	Annual report, July 1998-June 1999
Continuum of Care Contracts	Statewide foster care for older children with moderate to severe emotional and behavioral problems	59 percent of the children discharged were discharged to their own family, an adoptive family, or a less restrictive setting

Location and project name	Managed care model[a] and project description	Child and family outcomes
Wisconsin Safety Services Program	Lead agency model Family preservation services for noncourt families in Milwaukee County	Outcomes were not provided
Local-level initiatives		
Alameda County, Calif. Project Destiny	Lead agency model Foster care for seriously emotionally disturbed children in residential treatment in the county	Evaluation results, 1999 Project children were at least as safe as children in the comparison group on risk indexes such as alcohol and drug use, abuse against other children, medical emergencies, and running away 75 percent of the project children were residing in a less restrictive setting; 25 percent of the children could not be maintained in less restrictive settings (comparison data were not available) No significant difference in improvement in children's mental health between the project and comparison groups Academic performance of project children was comparable to the comparison group on three measures—school attendance, conduct reports, and academic improvement; however, project children's academic performance relative to grade level declined significantly over time while the comparison group improved on this measure Reduced levels of placement were not stable for a majority of the project children—60 percent of the children experienced two to eight additional changes in placement (comparison data were not available) Project very nearly reached its goal of revenue neutrality by the end of the second year; between 1997 and 1999, the project realized a net gain of 2 percent of its capitated rate
Boulder County, Colo. Integrated Managed Partnership for Adolescent Community Treatment (IMPACT)	Public model Foster care for adolescents needing group care or residential treatment in the county	State managed care report, 1999 Confirmed reports of abuse and neglect decreased 23 percent over 1998 baseline Finalized adoptions increased 13 percent over 1998 baseline Savings were reinvested in child welfare services—the county realized a savings of less than 1 percent of its capped allocation from the state in 1998; the dollar amount of savings increased 128 percent in 1999
El Paso County, Colo. Child Placement Agency Pilot	Administrative services organization with lead agency model Foster care for children placed by Child Placement Agencies in the county	State managed care report, 1999 Confirmed reports of abuse and neglect decreased 19 percent over 1998 baseline Finalized adoptions increased 84 percent over 1998 baseline Savings were reinvested in child welfare services—the county realized $1.3 million in savings in 1999

Location and project name	Managed care model[a] and project description	Child and family outcomes
Jefferson County, Colo. Child Welfare Pilot	Public model All child welfare services in the county	State managed care report, 1999 Confirmed reports of abuse and neglect decreased 18 percent over 1998 baseline Finalized adoptions decreased 23 percent and family reunification increased 21 percent over 1998 baseline Savings were reinvested in child welfare services—the county accrued no savings in 1998 and $175,000 in 1999
Mesa County, Colo. Child Welfare Pilot	Public model All child welfare services in the county	State managed care report, 1999 Confirmed reports of abuse and neglect decreased 20 percent over 1998 baseline Finalized adoptions increased 118 percent over 1998 baseline Savings were placed in a reserve account in 1998 and reinvested in child welfare services in 1999—the dollar amount of savings to the county increased 50 percent between 1998 and 1999
District 4, Fla. Privatization Pilot	Administrative services organization with lead agency model Foster care and independent living services for adolescents in the district	Outcome evaluation report covering all Florida initiatives, 1998-99 Placement rate was 69 percent more than the comparison site (specific to District 4) Length of stay was 66 percent less than the comparison site (specific to District 4) 73 percent of the families served in Districts 4, 8, and 13 combined were satisfied with the care they received (similar to comparison sites)
District 8, Fla. Sarasota County Privatization Pilot	Lead agency model All children needing protective services, foster care, and adoption services in Sarasota and Manatee Counties	Outcome evaluation report covering all Florida initiatives, 1998-99 86 percent of the cases in Districts 8 and 13 combined were closed in 1997-98 without reported recurrence of abuse or neglect within 1 year of case closure (similar to statewide rate) Placement rate in Districts 8 and 13 combined was 29 percent less than the comparison sites Cases were closed at a faster rate than the public agency had before the initiative (specific to District 8) Average length of stay in Districts 8 and 13 combined was 111 days (similar to comparison sites) 20 percent of the children in Districts 8 and 13 combined were placed with a parent, guardian, or relative within 15 months of the date of removal from their home (43 percent less than the comparison sites) 40 percent or more of the children legally available for adoption were adopted (specific to District 8)

Location and project name	Managed care model[a] and project description	Child and family outcomes
		77 percent of the children in Districts 8 and 13 combined were still in foster care 15 months after removal from their home (51 percent more than the comparison sites) 73 percent of the families served in Districts 4, 8, and 13 combined were satisfied with the care they received (similar to comparison sites) Average case cost in 1997-98 was about 10 percent less than what the public agency spent before the initiative (specific to District 8)
District 13, Fla. Bridges Program	Lead agency model Children needing foster care and adoption services in Lake and Sumter Counties	Outcome evaluation report covering all Florida initiatives, 1998-99 86 percent of the cases in Districts 8 and 13 combined were closed in 1997-98 without reported recurrence of abuse or neglect within 1 year of case closure (similar to the statewide rate) Placement rate in Districts 8 and 13 combined was 29 percent less than the comparison sites Average length of stay in Districts 8 and 13 combined was 111 days (similar to comparison sites) 20 percent of the children in Districts 8 and 13 combined were placed with a parent, guardian, or relative within 15 months of the date of removal from their homes (43 percent less than the comparison site) 77 percent of the children in Districts 8 and 13 combined were still in foster care 15 months after removal from their home (51 percent more than the comparison sites) 73 percent of the families served in Districts 4, 8, and 13 combined were satisfied with the care they received (similar to comparison sites)
Albany County, N.Y. Preventive Services	Public model Children needing preventive services in the county	Outcomes were not available
Broome County, N.Y. Child Welfare Care Management	Lead agency model Children needing family preservation, foster care, and independent living services at one site	Outcomes were not available. The pilot project has been discontinued because of problems with implementing new financial and service-delivery arrangements in accordance with federal and state regulations.
Oneida County, N.Y. Kids Oneida	Lead agency model Wraparound services for seriously emotionally disturbed children in the county in or at risk of out-of-home placement	Outcomes were not available
Onondaga County, N.Y.	Public model	Outcome data, 1994-98

Location and project name	Managed care model[a] and project description	Child and family outcomes
Family Support Center Program	Children needing emergency foster care services in the county	Foster care days were reduced—children admitted and discharged from the program avoided staying in foster care 246,834 days since 1994 Children were discharged from foster care more quickly—76 percent of the children were discharged from foster care; half the children who were placed in foster care since 1994 were discharged in 79 days (decrease of 77 percent from 1992, 78 percent from 1991, and 75 percent from 1990) 56 percent of the children who were discharged returned to their parents and 33 percent were released to relatives Children had early contact with their families, where appropriate—70 percent of the children visited with a family member within 72 hours of placement and 41 percent visited within 24 hours 88 percent of the children with siblings were initially placed with their siblings 20 percent of the children discharged from foster care were readmitted (14 percent less than the overall county rate) Educational continuity was maintained—all school-aged children attended their home schools
Tompkins County, N.Y. Youth Advocate Program	Lead agency Wraparound services for youth in residential or institutional placements in the county	Program review, 1997 86 percent of the youths were free of legal involvement, such as arrests All families improved their functioning, such as parenting skills All youths improved their ability to control violent and impulsive behaviors both inside and outside the home Little effect in reducing youths' involvement with drugs and alcohol—17 percent of the youths improved on this measure School performance varied among participants but improved for 55 percent of the youths 60 percent of the youths had successful reports from their employers 88 percent of the youths improved in their community involvement
Champaign County, Ohio Human Services/Adriel School	Public model Foster care for children needing out-of-home placement with a nonrelative in the county	Outcomes report covering Champaign and Madison Counties, 1999 All children discharged from managed care in Champaign and Madison Counties were discharged to a less restrictive setting In 1999, 63 percent of the children who were placed through managed care did not reenter a managed care placement within 12 months

Location and project name	Managed care model[a] and project description	Child and family outcomes
Crawford County, Ohio Out-of-County Placement	Lead agency model Foster care for children placed outside the county in therapeutic family foster home, group care, or residential treatment	Outcomes were not available
Hamilton County, Ohio TrueCare Partnership	Managed care organization model Foster care and independent living services for children in outpatient mental health and therapeutic placements.	Managed care entity report, 1998 62 percent of the children who had been in a more restrictive setting—such as residential treatment, group home, treatment foster care, or day treatment—were able to remain in a stable, less restrictive setting after 6 months
Madison County, Ohio Adriel Out-of-Home Care Placements	Lead agency model Foster care for children in the county needing nonrelative, out-of-home placement	Outcomes report covering Champaign and Madison Counties, 1999 All children discharged from managed care in Champaign and Madison Counties were discharged to a less restrictive setting In 1999, 63 percent of the children who were placed through managed care did not reenter a managed care placement within 12 months
Dodge County, Wis.[b] Family Partnership Initiative	Lead agency model Wraparound services for adolescents in child care institutions or juvenile corrections in 10 counties	Outcome report, Aug. 1997-Aug. 1999 Status offenders—youths with delinquent behaviors such as disorderly conduct, fighting, truancy, possession of marijuana, and curfew violation—had fewer contacts with the courts after participating in the initiative: 70 percent of the youths had no contact, 25 percent had one to five contacts, and 5 percent had six or more contacts compared with before the initiative, when 42 percent had no contact, 44 percent had one to five contacts, and 14 percent had six or more contacts Criminal offenders—those youths with delinquent behaviors such as theft, criminal damage to property, burglary, bomb threat, battery, sexual assault, receiving stolen property, possession of a firearm, and auto theft—similarly had fewer contacts with the courts: 75 percent had no contact and 25 percent had up to five contacts compared with before the initiative, when 72 percent had no contact, 43 percent had up to five contacts, and 15 percent had six or more contacts Truancy rate improved from 25 percent before the initiative to 15 percent after the initiative
Milwaukee County, Wis. Wraparound Milwaukee	Public model Wraparound services for children in the county in or at risk of residential treatment	Quality assurance/improvement and utilization review report, second quarter of 1999 Youths spent less time in residential care during their first year in the program—the percentage of days youths were in residential care decreased 29 percent Youths spent more time with their parent—the percentage of days youths were with their biological parent increased 32 percent

Location and project name	Managed care model[a] and project description	Child and family outcomes
		Children experienced an overall improvement of 21 percent on measures of behavioral change—such as symptoms of depression, anxiety, withdrawal, social problems, delinquency, and aggressive behavior—at 12 months after entry into the program Children experienced an overall improvement of 34 percent on scales of child-adolescent functioning, such as their ability to function adequately at home, in the community, and at school; their behavior toward others; emotional problems; self-harmful behavior; and substance abuse, at 12 months after entry into the program Average monthly cost of providing services decreased 8 percent between the first and second quarters of 1999

[a]Organizational arrangements among public and private entities generally fell into one of the following managed care models: (1) public model, which maintains the traditional management and service-delivery structure while the public agency incorporates managed care elements into its own practices and existing contracts with service providers; (2) lead agency model, where the public agency contracts with a private entity that is responsible for coordinating and providing all necessary services—either directly itself or by subcontracting with a network of service providers—for a defined population of children and families; (3) administrative services organization model, where the public agency contracts with a private organization for administrative services only, and direct services are structured as in the lead agency or public models; and (4) managed care organization (MCO) model, where the public agency contracts with a private organization as in the lead agency model, but the MCO arranges for the delivery of all necessary services by subcontracting with other service providers and does not itself provide direct services.

[b]Ten-county initiative includes Columbia, Dodge, Green Lake, Jefferson, Manitowoc, Ozaukee, Sauk, Sheboygan, Washington, and Winnebago Counties.

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