

Child Welfare, Medicaid, and Managed Care: Lessons Learned in Iowa

January 2001

Report for:

Center for Health Care Strategies, Inc.
353 Nassau Street
Princeton, NJ 08540

By:

Charles Bruner, Ph. D.
Child and Family Policy Center
218 – 6th Avenue, Suite 1021
Des Moines, IA 50309

Preface

This paper describes Iowa's experiences in using Medicaid, as well as Title IV-E, funding for child welfare services and Iowa's efforts to construct a more flexible and integrated system while using these two federal funding streams. Iowa's approach ultimately involved efforts to incorporate Medicaid-funded child welfare services within a Medicaid 1915(b) waiver that is publicly managed.

While many of the experiences may be unique to Iowa, the paper also raises issues of applicability to other states using Medicaid as a funding source for child welfare and raises questions regarding possible new federal approaches that would enable states to develop more effective child welfare systems without sacrificing federal financing.

This paper was made possible by a grant from the Center for Health Care Strategies and additional support from the Annie E. Casey Foundation. Victor Elias and Monica Cameron provided assistance in doing valuable background research on Medicaid financing of child welfare services in other states. Victor Elias and Karon Perlowski provided additional assistance in reviewing and discussing all aspects of the paper. Deanna Brickles constructed Table One from published data from the Urban Institute and unpublished data made available by Robert Geen. Mary Nelson, Ed Schor, and Karl Valentine reviewed and provided valuable comments on earlier drafts of the paper. Kamela Allen and Karen Brodsky provided overall editorial guidance from the Center for Health Care Strategies, as well as directing the author to important information sources and contacts.

The author also drew upon his own unique experiences as a Co-Chair of the Treatment Component of Child Welfare Services Work Group in writing this report, for which leaders of the General Assembly are to be thanked. While written from a third-person perspective, my position enabled me to have a true insider perspective on the "devil in the detail" related to these complex issues. Hopefully, this detail and the insight it brought me will be helpful to others in identifying strategies to better use Medicaid and Title IV-E funding to create more comprehensive, integrated, individually-tailored, and results-accountability child welfare systems that keep children safe, achieve permanency, insure well-being, and address rehabilitative and habilitative needs.

Child Welfare, Medicaid, and Managed Care: Lessons Learned in Iowa

Charles Bruner, Child and Family Policy Center, December 9, 2000 DRAFT

Introduction

Medicaid can serve as a significant source of funding for state child welfare service systems. Under a traditional fee-for-service system, Medicaid also can bring certain constraints that make the use of Medicaid-funded services for child welfare clients problematic. The flexibility in service provision offered under managed care offers a potential solution to these problems.

In 1993, Iowa received Medicaid Plan amendment approval to bill for most child welfare services as rehabilitative services under the early periodic, screening, diagnosis and treatment (EPSDT) component of Medicaid. While bringing in substantial additional federal funding, the conversion also brought several unanticipated consequences. Specifically, it shifted some of Iowa's focus of service provision from a family to a child focus and from a psychosocial to a medical-behavioral treatment approach – shifts that did not necessarily provide the most effective, or cost-effective, treatment.

Since 1997, the state of Iowa has pursued a managed care (1915b) waiver for these services in order to provide greater flexibility in the provision of Medicaid-funded rehabilitative services to the child welfare and juvenile justice population. The state has sought to develop this publicly managed care waiver with the state child welfare system acting as the managed care entity, rather than contracting with an outside entity to authorize and manage services. In essence, the state agrees to assume financial risk under a capitated payment structure. Federal Medicaid managed care waivers were not structured with public systems as risk-bearing managed care entity in mind, however. Although they do not preclude public managed care waivers, they do not anticipate some of the special features that exist in such public management, especially as it relates to the child welfare population (e.g. the child welfare system assumes financial risk, guarantees fiscal solvency, and serves as the authorizing agent).

This paper describes Iowa's efforts to incorporate child welfare services within a Medicaid 1915(b) waiver that is publicly managed. While not yet actualized, the experience has raised a number of issues that merit broader attention. This paper first describes the child welfare system and its use of Medicaid financing, generally. The paper then details the complicated history of Iowa's efforts to incorporate managed care tools within that child welfare system through new Medicaid financing arrangements and, ultimately, a 1915(b) waiver. This history is necessary to draw the concluding observations and lessons

learned from Iowa's experience that may be relevant to other public system efforts both to use Medicaid as a funding source for child welfare services and to incorporate managed care tools into the child welfare system.

Child Welfare, Medicaid, and Managed Care – A Brief History and Context

State child welfare systems serve children who have been abused or neglected or determined to be children in need of assistance (CINAs).¹ Responsibilities include providing children with a safe home, when their own family cannot provide that safety. Responsibilities also include treatment services to address the child's physical and psychological well being. These treatment services include counseling and other supports to families and children when the child remains in the home and services provided to children in placement settings, both in family foster care and group foster care (residential treatment) arrangements. While states vary widely in their definitions of child abuse and neglect and the services they provide to children and families within the child welfare system, all states provide some array of treatment services directed to the behavioral/psychological needs of the child. Historically, most of these child welfare services have been provided by human service agencies that are social service and not medical providers.

Federal funding support under Titles IV-B and IV-E of the Social Security Act. Financing of the child welfare system has come from a mixture of state (and in many states, county²) dollars and federal funds specifically targeted to serve children and families in the child welfare system – most notably Titles IV-B and IV-E of the federal Social Security Act.

Both Title IV-B and Title IV-E were designed to serve children and families in the child welfare system in addition to adoption subsidy payments for eligible children. Title IV-B is a formula grant that provides states with a specific amount of funding for services that largely are provided to children and families who do not require placement. Title IV-E provides federal funds to match state expenditures on maintenance and administrative costs (including case management) to serve children who have been placed outside the home or

¹ States have an investigative process to confirm or “found” allegations of child abuse or neglect. This does not necessarily lead to the provision of services, however. Services can be provided voluntarily, without a court hearing, or after a court determination that the child is “a child in need of assistance” and requires help.

² The responsibilities for administering the child welfare system vary across states. Some states are largely state-administered, and some states are largely county-administered. Meanwhile, Medicaid is administered at the state level. Iowa is a state-administered child welfare system. For states with county-administered systems, some of the issues that Iowa faced – particularly around separation of authority – would be moot, as the state would, in essence, contract with the county system as the managed care entity. Most of the other issues raised in this paper apply equally to both state and county administered systems.

would have been placed outside the home without additional support.³ Title IV-E covers children whose families meet the eligibility definitions for the Aid to Families with Dependent Children (AFDC) program as the AFDC program existed within a state on June 16, 1996, pursuant to Public Law 105-33. Maintenance costs relate to the costs of maintaining the child in an out-of-home setting, which include room and board and supervision costs but do not include treatment services. Maintenance costs also include adoption subsidy payments for eligible children. Administrative costs relate to the costs of managing and administering the system, including case management activity on behalf of open protective, foster care, and adoption cases and other children found to be at risk of foster care absent the provision of preventive services. The rationale for tying funding to AFDC eligibility is that the federal government has assumed a responsibility for participating in the maintenance costs of “dependent” children, which may be in their own home (under AFDC) or in an alternative setting (foster care – family or group).

The federal government has established three specific goals for child welfare – safety, permanence, and well being. Safety means freedom from abuse and neglect. Permanence means a stable home environment, either in the parents’ home or through adoption or, in some instances, long-term foster care or independent living. Well-being, the third element, is the least defined of the three but includes physical and emotional health, and education.⁴ The physical and emotional health goals also are goals for another federal program serving children, the Medicaid program.

Medicaid as an additional funding source. Some children, who come to the attention of the child welfare system, even when they are determined to be CINAs, do not require treatment services. Most of these are infants who have been abandoned or cannot be returned home.⁵

³ A DAB decision on a Missouri claim found in favor of the state allowing Title IV-E claiming for administrative activity on behalf of children at risk of placement absent the provision of preventive services. Subsequently, many states have sought to broaden their use of Title IV-E to include more activities that relate to children who have not been placed.

⁴ The Safe Families and Adoption Act of 1997 required states to report to the Administration for Children and Families on outcomes in the child welfare system. The Administration has defined the specific outcomes as: reduce recurrence of child abuse and/or neglect; reduce the incidence of child abuse and/or neglect in foster care; increase permanency for children in foster care; reduce time in foster care to reunification without increasing re-entry; reduce time in foster care to adoption; increase placement stability; and reduce placements of young children in group homes or institutions. The first report was released in August, 2000. U.S. Department of Health and Human Services. *Child Welfare Outcomes: 1998: Annual Report*. Administration for Children and Families, Administration on Children, Youth, and Families, and Children’s Bureau: Washington, D.C., 2000.

⁵ These infants may not have clear signs of needs for rehabilitative services. Increasingly, however, child mental health advocates are encouraging infant screening and early intervention for high risk children and families, believing that there often is substantial need for rehabilitative or restorative services even for very young children who do not manifest symptoms capable of clean diagnosis.

Most children served by the child welfare system, however, have treatment, as well as supervision and maintenance, needs. The abuse or neglect they have experienced has caused some psychological or physiological damage. In-home services provided to children and their families within the child welfare system can include both individual and family counseling, including work with parents to create a safe and nurturing home environment. Services provided to children while in placement can include both individual and group counseling, skill building, and therapy.

Historically, except when these services have been provided by the medical community (by psychiatrists through office visits or within acute inpatient psychiatric hospitals), Medicaid has not participated in paying for these treatment services. Social service providers – those who provide the vast majority of all services to children in the child welfare system, including in-home services, supervising foster parents in the care and treatment of children placed in family foster care, and providing group home residential care – were not considered as medical providers and their services were not billed to Medicaid.

In the 1980s and 1990s, however, many states have pursued Medicaid funding for some child welfare treatment services. They generally did so either under the rehabilitative treatment provision within EPSDT or through targeted case management. Under EPSDT, a child is determined by a licensed practitioner of the healing arts to have a rehabilitative treatment need.⁶ Parenting education is not generally a Medicaid service. These services must be child-focussed and rehabilitative, but can include family counseling and parenting health guidance directed at enabling the parent to support the child's rehabilitative treatment goals. Under Medicaid supported targeted case management, care coordination services are provided to insure the child's medical, behavioral, educational, and social service needs are addressed.⁷

⁶ 42CFR 440.130(3) defines rehabilitative services as “except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. Under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provision of the Medicaid program, a Medicaid-eligible service determined to be medically necessary for a child must be provided by the state irrespective of the state's Medicaid plan. In essence, this provision allows Medicaid services to be provided for children that a state does not have to provide for adults. Further, states generally are able to limit the set of children who receive these services to those children in the custody of the state or children for whom the state has assumed responsibility through its child welfare or juvenile justice services program, thereby enabling the state to control service utilization. The most common service adopted under EPSDT has been the rehabilitative service option, a set of services that could be provided in the clinic, school, home, or community and could be authorized by a licensed practitioner of the healing arts, which for child welfare usually was a licensed clinical social worker. In Iowa, the definition of “rehabilitative treatment need” was treatment for a “function that was lost or never gained as a result of abuse,” which establishes the boundary between “rehabilitation” (a covered service under Medicaid) and “habilitation” (a non-covered service under Medicaid).

⁷ Targeted case management is the only Medicaid service that can be limited to a particular group or geographic area without requesting waiver status. States have been successful in

As with Title IV-E, the federal government provides matching federal funds to the state for Medicaid services. Recent federal and state expansions of Medicaid eligibility criteria for children have made substantially more children eligible for Medicaid than are eligible for Title IV-E. While 50-70% of children in the child welfare system who remain in their own homes are likely to be Title IV-E eligible, 70-90% are likely to be eligible for Medicaid. For Title IV-E to participate in paying for services, however, the state must have specific documentation (in case plan or court order) that, if not for the service, the child would be placed into foster care, while for Medicaid the determination is made on “medical necessity,” a potentially broader standard. For Title IV-E, this 50-70% eligibility figure remains the same for out-of-home placements, but increases to near universal eligibility (90-99%) for Medicaid. This higher Medicaid eligibility makes Medicaid a preferred funding source whenever it can be appropriately applied for children in foster care or other out-of-home settings.⁸

State experiences in securing IV-E and Medicaid funding as a funding source for child welfare. In the 1980s and 1990s, many states took steps to expand federal financial participation in their child welfare systems – either through Title IV-E or Medicaid or both. Under IV-E, these included efforts to expand the definition of coverage to include in-home supervision as well as out-of-home care (in addition to securing additional funding, this helped diminish Title IV-E’s funding bias in favor of out-of-home placement). Under Medicaid, states have identified the portion of out-of-home and in-home treatment services and claimed Medicaid reimbursement for these services. They also have converted child welfare and juvenile probation services to Medicaid supported targeted case management.

In April 1999, in an attempt to document these efforts, the Urban Institute’s Assessing the New Federalism project released an occasional paper based upon a state survey of federal financial participation in child welfare spending in effect in 1994.⁹ Table One provides a description of the relative share of child welfare spending within states that is financed through Title IV-E and through Medicaid, based upon this survey.¹⁰

limiting providers to public child welfare and juvenile probation service workers, making this an attractive option for funding child welfare and juvenile justice services.

⁸ The nature of the service rather than the proportion of children found eligible is more likely to be the determining factor in selecting either Medicaid or Title IV-E reimbursements; but selection of the type of service to be offered also could be influenced by the availability of federal funding support.

⁹ This is the most recent year for which such data is available. Since that time, the use of Medicaid has increased substantially.

¹⁰ Geen, Rob, Shelley Waters Boots, and Karen C. Tumlin. *The Cost of Protecting Vulnerable Children: Understanding Federal, State, and Local Child Welfare Spending*. Assessing the New Federalism Program of the Urban Institute: Washington, D.C., 1999. The report did not break down state responses in the manner presented in this paper, instead lumping Title IV-B and IV-E together as traditional funding sources and Medicaid with a number of other funding sources as nontraditional funding sources. The Urban Institute provided additional information about each

As Table One shows there are huge variations across states in their use of these two matching federal funding sources. States vary in the percentage of their child welfare budgets financed by Title IV-E from under 4 % (Arizona and Wisconsin) to over 40 % (Michigan and New York). For Medicaid, eight states reported no Medicaid involvement, while four states received over 20 % of their child welfare funding from Medicaid (Rhode Island, South Carolina, Tennessee, and West Virginia). Overall, states' combined uses of Title IV-E and Medicaid federal funding sources ranged from 4% of total spending (Arizona and Wisconsin) to 57% of total spending (West Virginia). Conversely, states pay from 43% to 96% of the costs of their child welfare systems from state and county funding sources.

Clearly, states vary significantly in the degree to which they have pursued these two federal funding streams. Further, some have emphasized one federal funding stream over another. While technically distinct (IV-E covers maintenance, supervision, and administrative costs and Medicaid covers treatment and targeted case management services), in practice these can be subject to overlap. Title IV-E supervision and Medicaid supported targeted case management may be applied to the same activities.¹¹ Medicaid, like IV-E, can cover maintenance costs in one instance – the psychiatric hospital or residential treatment facility that meets the requirements of a psychiatric facility serving children under the age of twenty-one.¹² The more common overlap occurs within non-medical foster care institutions where the room and board function is supported by Title IV-E and the treatment function is supported by Medicaid. Overlap occurs in the area of supervision by workers, which can be called either part of room and board under IV-E or part of the treatment function under the Medicaid rehabilitative service option.

state's responses that enabled the construction of Table One. Correspondence from Rob Geen, Urban Institute, to Veronika Kot, Child and Family Policy Center, July 30, 1999.

¹¹ In this instance, the proportion of children eligible for one or the other program may determine which is in the state's best interest, although documentation requirements may differ. Medicaid targeted case management is a service, and thus must generate an individual billing ticket for each unit of service. Title IV-E is an administrative activity, where claiming is based on a time study and cost pool strategy, which generally is more compatible with the functioning of large public organizations, although states have designed Medicaid supported targeted case management so that it fits into state administrative structures without increased risk of audit disallowance's (memo from Carl Valentine to author, December 4, 2000).

¹² Several states have made use of this option to cover the full cost of treatment and room and board maintenance activities for at least some programs, including Iowa through its psychiatric medical institutions for children (PMIC) designation.

**Table One:
Federal Participation in Child Welfare Spending for State Fiscal Year 1996:
Table Based Upon Urban Institute Data Report***

State	# of Children	Total Child		% of Total		Total Medicaid or IV-E Spending
		Welfare Spending	Medicaid	IV-E	Medicaid or IV-E	
Alabama	1,233,000	\$ 89,912,351.00	12.4%	9.9%	22.3%	\$ 20,026,279.35
Alaska	221,000	\$ 50,275,042.00	0.0%	17.1%	17.1%	\$ 8,589,308.18
Arizona	1,348,000	\$ 142,318,711.00	0.3%	3.7%	4.0%	\$ 5,760,727.83
Arkansas	715,000	\$ 91,941,416.00	2.9%	29.7%	32.6%	\$ 29,944,439.28
California	9,611,000	\$ 1,895,032,292.00	1.2%	22.6%	23.8%	\$ 451,638,064.02
Colorado	1,081,000	\$ 191,305,156.00	7.8%	15.0%	22.8%	\$ 43,648,583.22
Connecticut	889,000	\$ 202,105,961.00	0.0%	35.7%	35.7%	\$ 72,215,315.76
Delaware	183,000	\$ 30,171,709.00	2.2%	20.0%	22.3%	\$ 6,717,665.50
District of Columbia	141,000	\$ 99,893,774.00	0.3%	22.7%	23.0%	\$ 22,926,770.16
Florida	3,646,000	\$ 424,766,984.00	0.6%	23.3%	23.9%	\$ 101,463,113.47
Georgia	2,079,000	\$ 215,686,041.00	7.3%	14.2%	21.5%	\$ 46,362,876.00
Idaho	346,000	\$ 37,152,000.00	0.6%	22.3%	22.9%	\$ 8,509,464.00
Illinois	3,407,000	\$ 1,830,818,036.00	6.2%	12.4%	18.6%	\$ 341,434,523.52
Indiana	1,591,000	\$ 316,285,783.00	0.2%	16.1%	16.3%	\$ 51,664,520.16
Iowa	849,000	\$ 162,389,629.00	15.3%	14.5%	29.8%	\$ 48,325,676.32
Kansas	750,000	\$ 127,280,610.00	10.0%	21.8%	31.7%	\$ 40,395,869.50
Kentucky	1,063,000	\$ 247,750,491.00	0.0%	22.2%	22.2%	\$ 55,093,611.63
Louisiana	1,283,000	\$ 176,143,728.00	9.7%	29.1%	38.8%	\$ 68,329,273.60
Maine	296,000	\$ 65,001,014.00	1.7%	32.6%	34.3%	\$ 22,293,608.43
Maryland	1,385,000	\$ 188,895,827.00	3.0%	25.5%	28.4%	\$ 53,740,439.04
Massachusetts	1,564,000	\$ 487,449,407.00	3.4%	21.8%	25.3%	\$ 123,192,287.33
Michigan	27,854,000	\$ 386,364,482.00	0.0%	40.7%	40.7%	\$ 157,443,316.64
Minnesota	1,359,000	\$ 344,315,453.00	12.1%	15.1%	27.2%	\$ 93,741,914.16
Mississippi	804,000	\$ 49,353,675.00	0.0%	20.6%	20.6%	\$ 10,182,563.49
Missouri	1,364,000	\$ 263,082,611.00	12.6%	19.2%	31.8%	\$ 83,753,512.73
Montana	251,000	\$ 28,974,839.00	18.5%	33.3%	51.8%	\$ 15,007,705.11
Nebraska	500,000	\$ 102,963,954.00	17.0%	19.8%	36.9%	\$ 37,955,908.64
Nevada	421,000	\$ 44,040,354.00	12.8%	9.6%	22.5%	\$ 9,888,842.60
New Hampshire	297,000	\$ 99,007,826.00	13.1%	21.0%	34.1%	\$ 33,757,185.60
New Jersey	2,073,000	\$ 434,654,523.00	7.1%	10.5%	17.5%	\$ 76,194,831.96
New Mexico	607,000	\$ 28,492,471.00	0.0%	24.0%	24.0%	\$ 6,835,204.26
New York	5,057,000	\$ 1,704,624,306.00	2.9%	40.4%	43.3%	\$ 738,364,086.44
North Carolina	1,742,000	\$ 162,154,210.00	0.0%	26.9%	26.9%	\$ 43,567,769.96
North Dakota	185,000	\$ 27,846,371.00	7.1%	33.6%	40.7%	\$ 11,321,447.13
Ohio	3,196,000	\$ 477,942,384.00	0.0%	37.4%	37.4%	\$ 178,815,773.25
Oklahoma	931,000	\$ 106,904,948.00	2.1%	16.0%	18.1%	\$ 19,371,431.80
Oregon	876,000	\$ 242,859,521.00	10.7%	13.4%	24.1%	\$ 58,598,236.02
Pennsylvania	3,145,000	\$ 991,068,000.00	0.5%	22.5%	23.0%	\$ 227,546,700.00
Rhode Island	237,000	\$ 92,414,790.00	28.4%	14.0%	42.4%	\$ 39,152,813.92
South Carolina	1,042,000	\$ 156,822,913.00	29.8%	12.5%	42.3%	\$ 66,260,069.11
South Dakota	222,000	\$ 24,794,512.00	8.7%	14.7%	23.4%	\$ 5,813,038.42
Tennessee	1,539,000	\$ 391,109,600.00	23.5%	11.5%	35.1%	\$ 137,099,690.00
Texas	5,857,000	\$ 473,595,200.00	6.8%	19.9%	26.8%	\$ 126,725,313.06
Utah	709,000	\$ 89,935,200.00	6.9%	14.8%	21.7%	\$ 19,502,956.00
Washington	1,502,000	\$ 209,541,738.00	12.1%	8.4%	20.4%	\$ 42,779,764.72
West Virginia	400,000	\$ 104,099,274.00	48.1%	8.6%	56.7%	\$ 59,063,642.16
Wisconsin	1,503,000	\$ 159,392,083.00	0.0%	3.8%	3.8%	\$ 6,070,563.76
Wyoming	145,000	\$ 23,595,275.00	6.8%	4.7%	11.5%	\$ 2,715,239.07
		\$14,292,526,475.00			27.5%	\$3,929,801,936.31

* Boots, Shelley, Rob Geen, Kain Tumlin, and Jacob Leaos-Urbel. *State Child Welfare Spending at a Glance: A Supplemental Report to the Costs of Protecting Vulnerable children* ((Assessing the New Federalism Urban Institute Occasional Paper Number 20 Supplemental Report, April 1999).

At the same time, states are faced with the challenge of developing record-keeping and cost allocation systems that distinguish between IV-E and Medicaid functions so that the worker on a day-to-day basis can focus on service delivery and does not have to make service decisions based upon funding source. In this environment, frontline practitioners must maintain case records that meet billing and audit requirements for both Title IV-E and Medicaid. These distinctions of whether an activity is a “breath” mint or a “candy” mint can become administratively complicated.

Because states’ efforts to secure federal financial participation have resulted in increased federal expenditures, both the Administration for Children and Families (ACF) and the Health Care Financing Administration (HCFA), as well as the U. S. Congress and Office of Management and the Budget (OMB), have placed such efforts – and the state plan amendments needed to implement changes – under increasing scrutiny.

That Title IV-E and Medicaid represent legitimate funding sources for some child welfare services is not an issue. How states can assure their systems comply with federal oversight and auditing responsibilities remains a significant issue, as this field is being developed.

Interest in applying managed care to child welfare at the same time that many states have sought to expand IV-E or Medicaid financial participation in their child welfare systems, some also have sought to restructure their financing and delivery systems through the use of managed care tools that have been applied in health care. Some of these tools include capitated payments to managed care organizations (MCO’s), who then contract with individual providers. Others involve capitated case rates applied directly to providers, pre-authorization of services and continuous review once services are authorized. In addition, providers generally are given more discretion over the specific services they provide in a managed care environment. They are allowed to provide services and supports that can assist in meeting treatment goals (presumably in a more cost-effective fashion) that are not provided under the state’s Medicaid fee-for-service system.¹³

A few states have sought waivers from HCFA to operate Medicaid-funded child welfare services under a managed care structure, through either an 1115 demonstration waiver or a 1915(b) managed care waiver. One of the rationales for this approach has been to provide more integrated services. The primary goal, however, generally has been for the state to share or transfer financial risk from the state (and Medicaid) to the entity who will be the managed care

¹³ In fact, this represents one of the rationales for moving to managed care that will be discussed in depth in this paper. See, also: Verdier, James. *Coordinating and Financing a Continuum of Services for Special Needs Populations in Medicaid Managed Care Programs*. Center for Health Care Strategies and Mathematica Policy Research, Inc.: Philadelphia, PA, 2000. What these broadened service parameters are represents one of the major unresolved issues with respect to the Iowa case study provided here.

organization.¹⁴ Managed care has been seen as a way to control the rapidly increasing costs that many states have experienced in their child welfare systems.

Issues in applying managed care to child welfare. The 1915(b) managed care waiver was developed by Congress with traditional medical services (physical and psychiatric) in mind and the growing use of private Health Maintenance Organizations (HMOs) and health insurers serving as gatekeepers to the provision of medical services. These medical services previously had been available on a fee-for-service basis, with the medical practitioner making the decision on the need for care and clients having a “freedom of choice” in choosing their medical care provider. Primarily, clients themselves seek out these medical services and voluntarily accept them. In a small number of cases, clients are ordered into treatment, usually through court-ordered commitment processes when, because they have a mental illness or developmental disability, they are unable to make those decisions themselves.

The 1915(b) managed care waiver was developed by HCFA to approve or disapprove such privately-administered managed care organizations for use in Medicaid. Because a managed care system imposes limitations on the choice of medical provider by introducing the managed care organization (MCO) as a gatekeeper to services, the managed care waiver was developed to insure that clients’ rights to treatment were protected. This was done in part through requirements for competitive bidding that would ensure some choice for clients in the selection of the MCO and in part through external reviews and grievance procedures related to the denial of care. In addition, since it was presumed that the MCO would be a private, for-profit entity, a demonstration of financial solvency also was required.

These requirements, however, do not have clear applicability to child welfare services, as the child welfare system can be distinguished from the traditional medical system of care in several ways.

First, the system itself is not usually a voluntary one. Clients generally do not seek services; they are identified through the child abuse and neglect process as needing services. In this respect, the state already is acting as service authorizer or gatekeeper to services, effectively serving as an MCO through its own system of handling cases and ordering services.¹⁵

¹⁴ In addition to sharing risk, managed care also provides an opportunity for some political insulation for state policy makers when the state is seeking to contain costs. If the state directly limited benefits, state policy makers would bear the brunt of the discontent and receive direct lobbying to restore those benefits. Contracting with a managed care entity, which then limits benefits, provides some insulation from state policy makers, as they no longer have direct control over the structure of those benefits.

¹⁵ While not a full analogy (as most gatekeepers in the medical world limit rather than insist upon services and the role of the state in child welfare is to provide all needed services to keep children safe), many states, including Iowa, do seek to fiscally manage their child welfare systems through the decisions they reach on the need for services. In Iowa, the state system has lived within its legislative appropriation for more than a decade, with the Division of Adult, Children, and Family

Second, while the state acts as gatekeeper, the state does not have sole authority over initial treatment and placement decisions. Though state laws vary, the courts have considerable authority, both informal and formal, in placement decisions and in ordering specific services. This adds an additional element of risk or uncertainty to contracting with an MCO or contracting directly with a provider.

Third, the state is more than a fiscal agent and performs some activities directly, including determination of child abuse, which may represent a determination of client service eligibility. Statutory requirements at the state level and IV-E requirements at the federal level, as well as constitutional requirements, do not allow the state to delegate such final determinations to another entity.

Fourth, the state also must deal with the federal Administration for Children and Families (ACF) and develop an agreed-upon methodology for determining IV-E participation on at least some of the same service areas that are incorporated into a 1915(b) waiver. Generally, ACF does not have either the same experience or statutory authorization to develop managed care systems of reimbursement as an alternative to a fee-for-service system. At a minimum, ACF is likely to require states to develop a corresponding, special demonstration waiver, particularly if a state seeks to develop contractual relationships based upon capitation or case rates.¹⁶

These four characteristics of the child welfare system present challenges to a state seeking to apply the 1915(b) waiver to Medicaid-funded child welfare services. At the same time, however, the 1915(b) waiver offers significant advantages to a fee-for-service approach. In particular, a waiver offers greater flexibility in service provision, a flexibility that may be very desirable from a client treatment perspective. For instance, while the Medicaid system is based upon serving individuals, the child welfare system often has its treatment focus upon families. While improving family functioning may be needed to achieve the child's rehabilitative treatment goals by providing safety and stability, parenting education or other services to improve this function usually will not be recognized as a child-focussed rehabilitative treatment. Under a managed care waiver, it is

Services establishing regional "targets" for expenditures that help insure that overall child welfare spending will not exceed the appropriated funds.

¹⁶ Providers of foster care and group services usually receive both Medicaid payments for treatment services and IV-E payments for maintenance costs during placement. They receive the IV-E payments only when the child is in placement, however. Strategies that may reduce placements through increased treatment services may produce overall cost savings, but the state or the provider may lose money as a result of lost IV-E participation. The only current option available to states to continue IV-E participation is through a special demonstration waiver, with Congress setting a limit on the number of such waivers. Further, these demonstration waivers require a strong research component and construction of a comparison group, so they cannot operate on a statewide basis. They are more like HCFA's 1115 waivers than they are 1915(b) waivers, making them much more complicated to obtain and administer and therefore less attractive as an option.

possible to extend the definition of allowable services to include at least some of this family counseling.

This discussion has outlined several significant issues in making use of the potential benefits of a 1915(b) HCFA waiver for Medicaid-funded child welfare services. Iowa's experiences in seeking to create a fit between these Medicaid requirements for managed care and state goals for addressing children's needs in the child welfare system is the major subject of the remaining sections of this paper.

Publicly Managed Care in Iowa – Case Study of a Vision

Iowa's efforts to incorporate Medicaid financial participation into child welfare services can be traced back seven years. Over the last three years, Iowa has sought an agreement with HCFA that would, in essence, capitate Iowa's Medicaid financial participation for child welfare rehabilitative treatment services in exchange for greater flexibility in service coverage. This has led Iowa to seek a 1915(b) waiver under a publicly-managed care framework. While Iowa's situation is, in many respects, a unique one, there are broader implications and lessons learned that can be drawn from it. The history of Iowa's efforts that are provided in this section is necessary for the discussion and implications sections to follow.

“Medicaiding” Iowa’s Child Welfare in System. In 1993, Iowa submitted a Medicaid Plan amendment to its regional HCFA office to include within its EPSDT services “rehabilitative treatment services” designed to “restore functioning that was lost or never gained as a result of abuse.” The Plan amendment described covered services to include both residential and non-residential services provided within Iowa's child welfare system – family-centered services, family preservation services, family foster care services, and group foster care services. The state proposed a new authorization process, a clinical assessment and consultation team (CACT) with clinical as well as social service expertise, to provide clinical oversight and authorize services. The CACT team included a “licensed practitioner of the healing arts.”

Iowa represented one of the pioneering states in seeking Medicaid financial participation for child welfare services, with a particularly broad scope of services covering nonresidential and well as residential services. Through negotiations with the regional HCFA office and through its own desires for fiscal management, Iowa chose to define family-centered and family foster care services within half-hour units of service, although both consultants and providers recommended a longer time frame for a unit of service.¹⁷

¹⁷ The state contracted with Peat Marwick to develop its Plan amendment. At the time, consultants recommended that the state retain as much flexibility as possible in its Plan amendment, as any detail incorporated into the Plan would be subject to audit. An DHS team that included one provider and the representative of the provider's association guided the effort,

Iowa received approval of the Plan amendment and began an extensive period of training providers in billing and documentation under Medicaid. Virtually all child welfare providers in the state were human service agencies that previously had had extremely limited contact with Medicaid and its eligibility and documentation requirements.

Iowa began billing Medicaid for child welfare services in 1994. The result was an additional \$25 million generated annually in federal Medicaid funding for Iowa's foster care and family-centered service budgets, at the time totaling approximately \$100 million in state funds and \$30 million in federal IV-B and IV-E funds. This additional funding was used to expand services and to increase provider reimbursement rates, particularly for group care. Virtually all services provided to Medicaid-eligible children were billed under the new rehabilitative treatment service provision.

While providing additional funding to the state child welfare system, the changes did not come without criticism from practitioners within Iowa. Providers were not accustomed to documentation at the level required under Medicaid, particularly for each half-hour unit of service provided. Department workers who previously had authorized services viewed the CACT process as a duplicative, unnecessary, level of oversight. The greater record-keeping and documentation requirements were seen as taking time away from direct work with the family. In addition, family centered service providers no longer could bill directly for collateral contacts. Costs associated with time spent working with schools, employers, and the courts or time expended in telephone contacts with children and families had to be built into the provider's rate as an indirect cost and recovered through the one-half hour unit payments.¹⁸

As importantly, the requirement that all Medicaid services be for "child-focused rehabilitative treatment" required providers to move away from a family-centered approach to counseling. Previously, much of the treatment provided in the child welfare system involved all family members and siblings and focused upon parenting issues and family dynamics. The move to a child-centered approach involved family-centered work only to the extent that family work specifically focused upon meeting the child's rehabilitative treatment needs.¹⁹

but changes were made to their final recommendation by an internal DHS group that substantially tightened the regulatory framework. Other states, which have "Medicaid" child welfare services may have retained much more flexibility than Iowa and therefore not be subject to the same auditing and documentation issues that Iowa has experienced.

¹⁸ This created a psychological as well as fiscal barrier against making those collateral contacts, as the premium was on providing one-half units of therapy and counseling. Longer units of service would have minimized this particular issue.

¹⁹ Iowa has been recognized as a leader in moving toward a family focus in child welfare services, an approach that has been rhetorically embraced in policy but is not always incorporated into practice. Many states have child welfare systems that are much less family focused and might not experience the disruptions that Iowa did, although using Medicaid as a funding source creates challenges to moving in the direction of more family-focused services. On a positive side, the introduction of clinical oversight through Medicaid occurred at a time when

At the same time, the regional HCFA office wanted assurances that the new practices met the requirements set out in Iowa's state Medicaid Plan. In the fall of 1995, HCFA visited Iowa and reviewed a select number of cases to determine Iowa's general compliance with HCFA requirements. That "policy audit" concluded that up to one-third of the state claims for Medicaid billing in those cases did not meet Medicaid requirements. While the policy audit report indicated that the services provided were reasonable ones, it concluded many did not meet the Medicaid definition of a "child-focussed rehabilitative treatment."²⁰

During this same period, Iowa also received approval from HCFA for a 1915(b) waiver for a capitated; behavioral health services managed care statewide contract, awarded in 1995 after competitive bidding to Merit Resources, a private MCO. The capitation was below existing state expenditures for mental health services, which had been rising dramatically. In addition to a goal of cost containment, Iowa sought to incorporate into the contract requirements, improvements in service proximity and availability, particularly for rural areas of the state.

HCFA was very supportive of Iowa's movement of behavioral health services into managed care and saw it as a major success. Creating the behavioral health managed care contract, however, did place some services (primarily psychiatric hospitalizations) into managed care that also were used by children in the child welfare system, creating a boundary issue regarding which system was responsible for paying for such services.

Meanwhile, while Iowa began corrective actions based upon the policy audit, HCFA continued to express concerns regarding the state's billing of rehabilitative treatment services (RTS) to Medicaid. HCFA notified the department of its intent to defer a portion of the state's claims (withhold payment for questionable claims), based upon the policy audit. The state negotiated with HCFA not to withhold payments, based upon the lack of representation of the case sample which had been the subject of the policy audit, but with a clear understanding from the regional HCFA office that this did not resolve their policy

children entering the child welfare system were increasingly displaying high acuity levels, were often prescribed multiple psychotropic medications with limited medical oversight, and increasingly required mental health as well as social service interventions. Use of Medicaid also can add a level of clinical expertise to serving children that can improve treatment effectiveness.²⁰ Kansas City Region, Health Care Financing Administration. *Final Report: Iowa Rehabilitative Treatment Services Program Review*. Conducted July 24-25, 1995. For instance, the use of RTS for parenting services was called into question. HCFA's clarification on this issue was as follows: "The delivery of services aimed at teaching or enhancing parenting skills and general age-appropriate training are not covered rehabilitation services regardless of how the specific needs of the child are documented in the case file. Only in situations where parents need to be educated about a child's special health needs or specific mental health behavioral condition is Medicaid rehabilitative services an appropriate funding source. Providing or enhancing parenting skills is a service of great value however, it is not an appropriate Medicaid expenditure." (p. 16)

concerns. The state then negotiated a set of policy changes and clarifications with HCFA designed to address these concerns.

In the summer of 1997, the Department of Human Services circulated for comment a draft RFP for continuation and expansion of the behavioral health managed care contract, now due for re-bidding. The expansion called for inclusion of substance abuse treatment services and greater coordination with child welfare services, including requirements that the contractor provide some administrative services to child welfare. After receiving comments, many of which were critical of the greater connection between the managed care contract and child welfare, the Department issued a second draft RFP in September. This RFP fully incorporated rehabilitative treatment services into the managed care contract, along with psychiatric medical institutions for children (PMICs), which primarily served child welfare children but received Medicaid funding as a medical institution.²¹

One of the rationales the Department offered for its incorporation of child welfare services into the RFP was that this constituted an acceptable resolution to Iowa's RTS billing issues. The Department claimed that the first RFP draft was not acceptable to the regional HCFA office in addressing HCFA's RTS billing concerns, but that the regional HCFA office found the second to be acceptable and agreed to use existing billing history as the basis for RTS capitation rates. Without this resolution, the Department stated that HCFA intended to audit Iowa's rehabilitative treatment system, and Iowa's exposure could be as high as \$20 million, when past claims were included.

In Iowa, there was widespread adverse reaction to the second draft RFP, both from the provider community and from local governments, which had received substantial authority from the state to manage child welfare services under a state "decategorization" law and felt the RFP would undermine their

²¹ Psychiatric medical institutions for children, or PMICs, represented Iowa's first actual "Medicaiding" of child welfare services. In 1989, the General Assembly enacted a new statute creating psychiatric medical institutions for children as dual-licensed facilities – which met both state child welfare regulations and requirements as residential treatment facilities and met additional requirements as PMICs, including accreditation by the joint commission on the accreditation of hospitals. The PMIC requirements in the new statute was worked out with the regional HCFA office to insure they met Medicaid requirements, which at the time were interpreted as requiring that facilities be medical institutions to be eligible for Medicaid funding. Although the legislation was designed simply to convert existing residential treatment beds into PMICs without changing their structure or purpose, and placed a limitation on the number of PMIC beds that could be created in the state (including requirements for any conversions to go through a certificate of need process), over time PMICs took on a life of their own. In particular, when the broader array of child welfare services were Medicaided, PMICs did not come under the CACT process but instead were authorized as a medical institution through the Iowa Foundation for Medical Care (IFMC). With the establishment of the behavioral health managed care waiver, the state had three separate authorization processes for child placements – CACT for foster care, IFMC for PMICs, and Merit for psychiatric hospitalizations. HCFA expressed substantial concern over this fragmentation, an issue that still remains to be resolved.

authority.²² The Legislative Council of the Iowa General Assembly convened a hearing in October to review the issue, with a representative from the regional HCFA office participating in the meeting and explaining HCFA's position. Her testimony confirmed the Department's statements regarding the second RFP as constituting an acceptable resolution of outstanding billing and auditing issues. Moreover, she testified that the policy audit issues regarding the provision of services that were not Medicaid-eligible would not be raised if those services were provided under the managed care contract, as the MCO would have the ability to provide such services as optional services.

Following that meeting, the Legislative Council established a 26-member Treatment Component of Child Welfare Services Work Group to provide recommendations to the General Assembly both on the short-term issue of whether to include rehabilitative treatment services into the behavioral health managed care contract and on the long-term issue of how to more effectively manage the child welfare system.

Work Group Actions and Recommendations. The Work Group included state representation from the Department of Human Services (including the Director, the Administrator of the Division of Medical Services, and the Administrator of the Division of Adult, Children, and Family Services, which includes child welfare), the Director of the Department of Management, the Director of the Department of Education, and a high-level administrator from Department of Public Health at the state level. It included local representation by county supervisors and DHS local office administrators. The Work Group also included representatives from juvenile court services and the provider community. The co-chairs were both citizens with strong interests in and knowledge of the child welfare system that were not financial stakeholders in the system. Representatives from the regional HCFA office and the regional ACF office also participated in an ex officio capacity.

The Work Group met four times for a total of six days between November 15th, 1997 and January 31st, 1998, an extraordinary number of meetings given the holiday season. The Work Group received additional testimony from several national experts both in Medicaid financing of child welfare services and in managed care.

²² Iowa's first "decategorization" legislation was enacted in 1989, providing two Iowa counties with the authority to pool over thirty separate child welfare funding streams or service categories and redirect resources to develop more integrated and community-based services that would rely less on remote, institutional, and out-of-home care. As an incentive, counties could retain any savings achieved from this redirection to fund other services. The decategorization project was a finalist for the prestigious Ford Foundation's Innovation in Government Award in 1993. Decategorization has since been expanded, with 98 of Iowa's 99 counties opting to operate under that framework. The local department of human services office, the juvenile court with jurisdiction in the decategorization area, and the county board of supervisors must jointly request decategorization status. For further information on Iowa's decategorization initiative, see: Bruner, Charles. *Improving Children's Welfare: Learning from Iowa*. National Conference of State Legislatures: Denver, CO, 1991).

**Table Two:
Long-Term Goals that Should Be Addressed in Making a Linkage Recommendation**

The long-term goal for a system is one that is:

Community designed and managed

- ❖ In partnership between the state and its communities
- ❖ Building upon decategorization
- ❖ With attendant capacity to manage complex system
- ❖ Identifying and establishing statewide standards to insure both quality and quantity of services are available on a statewide basis
- ❖ Re-engaging the entire community to achieve the goal of child well-being, drawing upon both formal and informal systems of support
- ❖ Placing emphasis upon finding means to fund and support long-term prevention efforts without diverting funds from needed early intervention and treatment services

An integrated and holistic system of services and supports

- ❖ Involving an array of treatment services needed by children coming into contact with the child welfare and juvenile justice system
- ❖ Creating a more seamless system of services that provides continuity in care, treatment, education, and case management
- ❖ Supporting more bundled and packaged service concepts
- ❖ Fully integrating the service systems and funding streams

Administered flexibly

- ❖ Reducing process accountability paperwork
- ❖ Allowing for individualized plans
- ❖ Drawing in natural supporting networks as well as professional systems of care
- ❖ Ending duplicative administrative efforts, including licensing, audits, and inspections

With clear accountability based upon results

- ❖ Establishing quality assurance system through use of performance objectives
- ❖ Achieving fundamental goals of child welfare and juvenile justice systems – safety, permanence, best interests of the child, least restrictive environment, child health and well-being, and reasonable efforts
- ❖ Contributing to achieving cross-system goals for child well-being in health, mental health, substance abuse, and education and special education – inclusion, normalization, primary care

Drawing upon best fiscal management practices to insure managing within finite resources

- ❖ Utilizing appropriate managed care technology to achieve goals
- ❖ Appropriately sharing risk, including financial risk, and assuring the system is managed within resources
- ❖ Addressing issues relating to authority and responsibility of court to carry out the law
- ❖ Coordinating and complementing other city, county, and school funding sources
- ❖ Recognizing the state's responsibility to adequately fund the system

In partnership with the federal government and its funding sources

- ❖ Using Title XIX and Title IV-E effectively to support system goals
- ❖ Maximizing federal participation and other funding support without allowing funding consideration to drive the system

Involving consumers throughout the system

- ❖ Insuring that consumer views and perspectives are part of the accountability and quality improvement system
- ❖ Insuring that consumers help design their own system of care
- ❖ Recognizing that foster parents and adoptive parents sometimes act in the role of consumers and sometimes in the role of caregivers

**Table Three:
Managed Care Tools and Strategies**

The term “managed care” refers to a variety of mechanisms designed to control the utilization and costs of services or to improve the quality of care or both. It does not define any particular model of service delivery. Managed care’s defining characteristics is that it specializes in using certain techniques to manage the utilization of resources. Specifically, managed care is the systematic application of:

Gatekeeping and prospective authorization (preauthorization) through:

- ❖ Twenty-four hour availability
- ❖ Protocols for making authorization decisions

Concurrent utilization review through:

- ❖ Ongoing monitoring of active treatment plans
- ❖ Data management systems tied to treatment plans
- ❖ Red flag reviews

Creating of financial risk and incentives for providers to be cost effective through one or more of the following:

- ❖ Limitations on benefit packages
- ❖ Capitation or case rates
- ❖ Negotiated discounts
- ❖ Performance contracts or incentives
- ❖ Rewards for achieving reductions in lengths of stay or restrictiveness of setting

Coordinated management of services to reduce duplication or service fragmentation through:

- ❖ Integrated case management
- ❖ Local provider networks providing continuum of services
- ❖ Streamlined administrative procedures and oversight

Provider profiling and selective provider contracting through:

- ❖ Evidence-based assessment of provider ability to perform work
- ❖ Assessment and selection of cost-effective providers

Use of practice guidelines and treatment protocols through:

- ❖ Incentives for reducing high cost services/duration of treatment/re-entry into care
- ❖ Flexibility to draw upon nontraditional/nonprofessional systems of support

Outcome-based accountability through:

- ❖ Consumer feedback and satisfaction surveys
- ❖ Outcome-based management information system

Grievance procedures/dispute resolution mechanism through:

- ❖ Administrative process
- ❖ Ombudsmen services

Risk adjustment and control capacity through:

- ❖ Actuarial data to assess costs for capitation purposes
- ❖ Controls to limit uncertainty
- ❖ Risk pools and risk corridors
- ❖ Indemnification/insolvency protection/reinsurance

Table adapted from the following sources:

Center for Health Care Strategies, Inc. Managed Care Terms: Medicaid Managed Care Program State Readiness Assessment Process. Handout: Princeton, NJ 1997

Iowa Department of Human Services. Functions and Requirements of a Managed Healthcare Organization. Handout: Des Moines, IA 1997

Lutz, Lorrie. “Managed Care is the Systematic Application of.” and subsequent overheads. Open Minds Presentation to the Treatment Component of Child Welfare Services Work Group, December 11th, 1997 mtg.

Scallet, Leslie, Cindy Brach, and Elizabeth Steel, eds. Managed Care: Challenges for Children and Family Services. Policy Research Center and the Annie E Casey Foundation: Baltimore, MD: 1997

The Work Group first established a consensus list of long-term goals for the child welfare system, shown in Table Two. Coupled with this list was another consensus list of managed care “tools” that the Work Group believed should be incorporated into that system, shown in Table Three.²³ The Work Group recognized that some of these tools would have to be developed for the child welfare system, whether the Department continued to manage the child welfare system itself or contracted with another entity.

The Work Group recommended to the General Assembly that the state not include rehabilitative treatment services within the behavioral health managed care contract. Instead, the Work Group recommended the state seek alternative approaches to addressing Iowa’s audit exposure. These alternative approaches included restructuring Iowa’s rehabilitative treatment service system by establishing a “publicly managed care” waiver, with the state in essence agreeing to capitation of rehabilitative treatment services.

The regional HCFA office indicated it would work with the state on a resolution to the overbilling concerns and would not initiate an audit, provided the state made reasonable progress in producing that resolution. The regional HCFA office, however, expressed skepticism over the ability, within federal guidelines, for the state to develop a structure by which it could operate as a public, managed care entity.

The Work Group immediately established several different Planning Groups – including one on developing a waiver and one on developing an outcome-based management information system – and later established other committees to deal with specific issues and concerns. Over the next two and one-half years, over four hundred Iowans participated in Work Group sponsored meetings, and there were over fifty full days of meeting time by the Work Group or its Planning Groups. This level of activity was made possible by support from the Annie E. Casey Foundation to the Child and Family Policy Center, which staffed the Work Group, as well as a legislative appropriation of \$50,000 per year, to cover meeting and travel expenses and printing and other out-of-pocket costs.

In February, 1998 then-Associate Regional Administrator Richard Brummel met with the Work Group co-chairs and the Department Director to discuss next steps. Brummel offered the state the option of developing “bundled services” as a bridge to publicly-managed care, which would provide the state additional time to define publicly-managed care and develop a waiver.²⁴ The

²³ These two Tables were included in the initial report to the Iowa General Assembly: Treatment Component of Child Welfare Services Work Group Co-Chairs’ letter to Legislative Leadership and Office of the Governor, February 2, 1998.

²⁴ Letter from Associate Regional Administrator of Region VII Health Care Financing Administration to Iowa Department of Human Services Director Charles Palmer, February 18, 1998. The letter stated: “HCFA previously suggested capitation as a means of resolving some of the Medicaid issues noted in our 1995 review of the RTS program. Last week I discussed at some length another avenue: a blended rate/bundled services approach. ... I emphasized that

Medicaid share of participation in bundled services could be developed through case reviews and applied prospectively, thereby rendering an audit of Iowa's existing system moot.

The Work Group then pursued two paths simultaneously – developing bundled services as a more integrated approach to service delivery and seeking additional clarification from the regional HCFA office on the issues involved in developing a managed care waiver, with a division of state government as the managed care entity.

In developing bundled services, the Work Group conducted several meetings with groups of field level practitioners from the Department, the juvenile court, and the provider community. The Work Group also reviewed real cases to assess how they would fit into a bundled service framework.

These meetings and case reviews showed a strong desire at the field level for greater flexibility in service delivery, with documentation based upon good case record-keeping rather than traditional Medicaid-eligibility documentation for each unit of rehabilitative treatment service provided. Particularly in family-centered services and family foster care services, frontline practitioners strongly favored greater flexibility and less attention to Medicaid-related documentation. In fact, workers stated that the traditional Medicaid documentation requirements created case records that were not particularly useful from a case planning perspective, as they had to be written in a way that activities always related back to specific child-focused rehabilitative treatment issues.²⁵

Bundled services were developed to correct these perceived problems, both by extending the unit of service from one-half hour to one month and by incorporating non-Medicaid services within the service bundle. Following extensive discussion with regional HCFA officials, the state filed a Medicaid Plan amendment in September, 1998 to implement bundled services. Under the Plan amendment, while at least one hour of child-focused rehabilitative treatment service had to be documented to receive payment for each billed monthly unit of service, good case records were considered as sufficient overall documentation. Among the services that were bundled were Medicaid-eligible child-focused rehabilitative treatment services, but also non-Medicaid-eligible family-centered services, supports, and supervision. HCFA and the state agreed that the Medicaid level of participation in the bundled service would be based upon a case

HCFA was not requiring either approach, but was offering both as acceptable to us. The understanding that I left our meeting with was that by the time the Iowa legislature adjourns this spring the Work Group will select its method for revising the RTS and will notify HCFA of that decision as well as of a date certain by which revisions to the Medicaid state Plan will be submitted to HCFA for review.”

²⁵ Documentation required that, for each one-half unit of service delivered, records show the date of service, client name, nature and extent of unit of service (include relationship to treatment plan objectives and actual minutes of service), name of agency, and location of service. Not only did this documentation take substantial time, workers also indicated that they felt including other important aspects of their work which might not be considered “rehabilitative” would jeopardize claiming – and therefore their records were incomplete.

review of a select number of existing cases and their mix of Medicaid and non-Medicaid funded services. The percentage of the total expended funds from the case review that were determined to be Medicaid-eligible funds would then be applied prospectively as the Medicaid participation level in bundled services. HCFA, through administrative claiming, participated in fifty percent of the cost of the case record review to determine these Medicaid participation rates, which occurred in October and November, 1998.

Table Four
Family Centered-Services Example

Mary has three children, 3, 6, and 8. She lives in a trailer court. The school has made several referrals to DHS, as the school-aged children often are late to school and occasionally absent, sometimes inappropriately dressed for the weather, and dirty. The 6 year-old is aggressive in class and difficult to manage. Upon investigation/assessment, it is found that Mary, 24, works at Burger King during the days and leaves her younger child with a neighbor. She often has trouble getting up in the morning, is generally depressed, and "has no energy." She sometimes goes out at night with friends, with her mother in charge of the children, who is too frail to provide such supervision.

The child protective service worker determines that there is evidence of neglect, but not serious enough to warrant placement on the registry. Mary is receptive to receiving help in the form of current "family-centered services," which the CPS worker recommends.

The CACT process determines that the middle child, age 6, is experiencing behavior-related problems that qualify for RTS services. CACT orders ten half-hours of treatment services over the next three months for the child and family, and ten half-hours of skill building to help Mary address these behavioral needs.

The treatment services consist of counseling sessions every other week with the 6 year-old, and then Mary, to work on the child's anger management and impulse control. The skill-building services are provided in the home, working on general parenting support as it relates to addressing the 6 year-olds needs. The child protective service worker also seeks to arrange for homemaker services to help Mary manage housekeeping and provides a referral for mental health services to deal with Mary's depression.

At the end of the initial service period, the family is still intact. Mary finds the contact and support and listening ear from the different meetings helpful, although "they add an additional thing I have to do." Mary has stopped leaving her children with her mother and is doing somewhat better at getting her kids to school, although much of this may be due to the increased supervision Mary feels she has with the visits and her fear of losing her children to CPS. The CPS worker recommends additional family-centered services.

Bundled Services

The pre-authorization process determines that, because of the rehabilitation needs of the 6 year-old, the family qualifies for Medicaid coverage under the family-centered service bundle.

The pre-authorization process orders the bundle for three months (priced equivalent to ten half-hours of treatment services and ten half-hours of skill-building).

The provider conducts a problem solving (family unity) meeting with Mary, her neighbor and best friend, her mother and sister, and a representative from the school. They focus upon getting the children to school and maintaining adequate supervision of the children when Mary goes out at night. They also discuss how Mary can better manage the six year-old. The result is a plan for the next three months that enables Mary to go out once a week, with her sister as well as mother coming to look after the children. The neighbor agrees to call Mary at 7:00 a.m. each morning and to come over, if needed, to make sure the kids get off to school. The neighbor also will look after the children while Mary goes to a counseling session on parenting, and later a parenting class and support group. In addition to providing the counseling and parenting class, the provider agrees to "check-in" on Mary by phone at least three times a week, at a designated time, to see how things are going. The provider pays the neighbor for the baby-sitting she provides during counseling and for the morning help. The school agrees to update the provider, as well as Mary, on how the six year-old is doing, and adapt its schedule around Mary's for parent-child meetings, with Mary also bringing her neighbor.

Each month, the provider also meets with Mary and her 6 year-old for a face-to-face session that focuses upon the child's behavior and reviews progress the child is making in his anger management and impulse control. These represent the only "treatment" or "skill-building" services to Mary and her family that can specifically be designated as "rehabilitative treatment" services.

At the end of three months, a new routine has been established, and Mary feels much more "in control." The trailer is much neater, and all the kids feel they get more attention from Mary. The behavioral problems at school have decreased, and Mary notes that the teachers view her children a lot better.

Contrasted with the current service authorization, many fewer clinically-directed "treatment" or "skill-building" sessions occurred. The focus was redirected more to Mary's needs as a parent than to the behavioral needs of the 6 year-old. Much of the contact was by telephone rather than face-to-face. Altogether, however, the provider expended the same amount of resources as in the current system.

**Table Five
Group Care Example**

Robert, age eleven, and his family have been involved in the child welfare system, off-and-on, for six years, including the provision on several occasions of family-centered services. Robert's parents, Don and Carrel, have two other children, fourteen and six, who have not been the subject of investigation. According to them, Robert is "a difficult child," with DSMs of AD/HD, conduct disorder, and intermittent explosive disorder. He had two founded abuse reports as a young child, the result of excessive discipline and an occasion where Carrel indicated she "lost it." Robert is in special education as a BD student as well as being substantially below grade-level in reading and mathematics, and was picked up by the police twice in the past month, the first for assault on a classmate (resulting in further DHS involvement and family-centered services) and the second for fire-setting (resulting in a delinquency petition and appearance in juvenile court). Both Don and Carrel now feel Robert is beyond their ability to control.

The juvenile court judge, with recommendations from the juvenile court officer and the child protective service worker, orders out-of-home placement in a community residential program (no family foster homes available and willing to take Robert) located in a community thirty miles away.

Current Service System

Robert receives CACT authorization for RTS at the community residential program level of care. He participates in both group and individual activities under RTS related to dealing with his aggression, impulse control, and anger management. His educational progress is closely monitored, and he is making up some ground in both math and reading. His parents are invited to participate in some activities, and do visit him regularly, although they admit to substantial relief and better control in their household now that he is not there. Their other children are "doing much better" and are less "anxious" because Robert is not around. Robert, himself, says he misses his parents and siblings and tears well in his eyes when he talks about them. His interactions with others in the facility are okay, but he says he holds back from making friends because he's likely not to be there long, anyway.

After seven months in the facility, and with the completion of the school year, the plan is for Robert to return to his home. Don and Carrel are pleased to see some changes in Robert, but they also are uneasy that he may begin displaying old behaviors and disrupt their now calm household.

Bundled Service System

The juvenile court and the pre-authorization process approve a seven-month level one bundle for group care. For a program that includes aftercare in the bundle, this authorization includes an expectation for four months of residential treatment and three months of aftercare.

The provider immediately engages Don and Carrel and the other children in their work with Robert, starting with intensive sessions right after placement. Staff arrange for nightly telephone calls between Robert and his family, and they also connect with Robert's home school to prepare for Robert's return to class midway through the semester. They do some up-front reunification planning, describing what Robert needs to change to live at home and how the family needs to change to provide support to Robert. Within one month, they arrange for weekend returns home for Robert. They connect Don and Carrel with a support group for parents of children with AD/HD.

The staff person with whom Robert has made the most connection agrees to visit Robert periodically when he returns home and to call him at the same time three days each week to see how he is doing. Prior to reunification, Robert and his family are counseled on the likelihood of a "row" occurring sometime after Robert returns home and how that gives them an opportunity to respond differently to the tensions that exist. The provider agrees to make staff available to address that "row." In the end, Robert's stay in the program is less than three months, with less "separation" ever occurring that has to be addressed later in Robert's treatment. By the end of the fifth month, the provider requires only minimal involvement with Robert and his family.

Again, the level of resources expended has been equivalent to that in the current system, although more has been devoted to the up-front period.

The development of bundled services in Iowa, involving a broad range of stakeholders, highlighted long-standing complaints about the current system and created some level of commitment and acceptance from both providers and departmental staff to fundamental service delivery changes, even while recognizing that setting reimbursement rates for bundled services would be challenging. While constructed to address immediate audit concerns, bundled services also represented a move to a "wrap-around" service philosophy that also was envisioned to provide the service delivery aspects of publicly-managed care. Two case examples of how bundled services would operate differently than the RTS system were constructed to illustrate the approach and are shown in Tables Four and Five

Meanwhile, the Work Group worked to develop a more detailed concept of a publicly managed child welfare system. It commissioned a paper outlining the minimum conditions Iowa would have to meet in operating under a 1915(b) waiver. In October, 1998, the Work Group submitted this concept paper regarding publicly managed care to the regional HCFA office and requested comments on a number of issues. The Work Group sought to determine the minimum set of activities the Division of Adult, Children, and Family Services would have to perform to serve as the managed care organization for rehabilitative treatment services. This commissioned paper drew from HCFA regulations and other states' waivers in defining both the competencies the division would need to display and the specific activities the division would need to undertake, contrasting these with what the division currently was doing.²⁶

The regional HCFA response to this query raised two fundamental issues that HCFA indicated would have to be resolved even before it could determine whether the Division had the capacity to operate as an MCO:

- * The issue of separation. Essentially, the Division of Medical Services would contract with the Division of Adult, Children, and Family Services within the same state Department. With both Divisions located within a single Department, HCFA questioned whether there was sufficient separation of authority that one could effectively monitor and oversee the other.
- * The issue of sole sourcing. The concept paper presumed that the Division of Adult, Children, and Family Services would serve as the MCO, without a competitive bidding process. HCFA questioned whether this would violate the requirements for competitive bidding to insure freedom of choice.

HCFA did not say that a waiver would be denied that did not include greater separation or did not involve competitive bidding, but HCFA did indicate that strong justification would have to be made for them.²⁷ The Work Group searched for precedents in other regions on these specific issues, while pursuing the bundled services approach, as well.

The movement to implementing bundled services was virtually halted in April, 1999, both due to changes in personnel at the regional office and Congressional concerns raised at the federal level. Richard Brummel, who offered the bundled services option to the state, left his position at the regional office and the state liaison from the regional office also changed. The new Associate Regional Administrator, Tom Lenz, and the new state liaison had not been involved in the negotiations with the state on designing bundled services and placed a much stronger interest in the audit and overbilling issues in their negotiations with the state.

²⁶ Lutz, Lorrie. *Shifting Iowa's Child Welfare System to a "Public Managed Care Entity."* Paper prepared for the Treatment Component of Child Welfare Services Work Group, October, 1998.

²⁷ Letter from Associate Regional Administrator for Medicaid and State Operations of Region VII Health Care Financing Administration, Thomas Lenz, to Treatment Component of Child Welfare Services Work Group Co-Chairs, Date stamped December 15, 1998.

Further, at the federal level, Congress conducted special hearings on bundled services as they applied to school health services. Congress was concerned that bundled services were being used for generating revenue from the federal government that displaced state or local funding and providing lucrative consulting contracts with private vendors. A number of states had contracted with private consulting firms to secure Medicaid financial participation for school health and special education services, employing bundled services as an accounting mechanism. In response to this Congressional concern and HCFA's own concern, Sally Richardson, the Director of the Division of Medicaid at the federal level, issued a memorandum barring the use of bundled services for school health, requiring states already employing this methodology to begin to redesign their billing arrangements.²⁸

While Iowa's bundled services proposed for child welfare were different from those structured for school health services, Iowa's plan amendment was seen as possibly creating precedent in this area. The regional HCFA office asked the state to withdraw its proposed Medicaid Plan amendment, or it would be denied, while the federal office further reviewed the issue.

An Iowa delegation of state legislators and Work Group members, including the Director of the Department of Human Services and the Administrator of the Division of Medical Services, requested a meeting in Baltimore to present Iowa's case to both federal and regional HCFA officials. The meeting was held in the federal HCFA offices in Baltimore in May, 1999. The result was that federal officials indicated they better understood Iowa's approach and the use of bundled services as a bridge to publicly managed care and pledged to continue to work with the state.

Congress, HCFA, and OMB all had major concerns that bundled services in school health represented a potentially huge federal fiscal liability. Although HCFA recognized that Iowa's use of bundled services was in a different context and did not present this liability, HCFA was still concerned that approval of Iowa's child welfare bundled services could be used as precedent for the use of bundled services to expand Medicaid use in other states.²⁹

²⁸ "Dear State Medicaid Director" memorandum from Director of Center for Medicaid and State Operations of the Health Care Financing Administration Sally Richardson, date stamped May 21, 1999. The memorandum states: "A number of States have been paying for school-based services using a "bundled rate" methodology. ... Effective immediately, HCFA will no longer recognize bundled school-based health service rates as acceptable for purposes of claiming Federal financial participation (FFP). States that are currently paying bundled rates for school-based health services pursuant to an approved State plan amendment must develop and prospectively implement an alternative reimbursement methodology. We will be convening a meeting with a group from the States and the Department of Education to discuss options that are available. Also, States will be given time to work with the HCFA regional offices which will assist in the development and implementation of a non-bundled reimbursement methodology."

²⁹ The HCFA memorandum regarding bundled services raised a number of objections from state Medicaid directors, and the federal HCFA office later established a Work Group which included State Medicaid Directors to establish a framework for covering school health services under Medicaid. Don Herman, then-Administrator of the Division of Medical Services in Iowa, chaired

A second major issue that HCFA expressed with the bundled services approach presented by Iowa for child welfare services was that the bundles included non-Medicaid eligible services. The bundling of Medicaid and non-Medicaid services could mean that Medicaid would be paying, at least in some instances, for services that were not Medicaid-eligible, which would threaten the “integrity of the funding streams.” This concern represented a departure from earlier positions of the regional HCFA office, which had agreed that Medicaid and non-Medicaid services would be bundled and a blended rate prospectively established through a case review process.³⁰

At the May meeting, both the federal and regional offices indicated that going directly for a waiver would eliminate the specific concerns related to bundled services and that bundled services could become the service delivery option under a managed care waiver. Given Congressional involvement on bundled school health services, HCFA also indicated it might be more expeditious to pursue a waiver than to seek approval of a Plan amendment involving bundled services. The Work Group previously had agreed with HCFA that a Plan amendment was a quicker alternative, but now recognized that the political environment had changed and began putting together a framework for a waiver. HCFA also agreed to respond in writing, within two months, to Iowa regarding the key issues around bundled services and the options HCFA believed were available to the state (the actual, written response was not provided until May of the next year).

Throughout this period, the Work Group and the state maintained regular discussions with the regional ACF office. Both regional HCFA and ACF staff attended many of the planning and design development meetings. ACF’s participation was critical in designing a financing structure that could be used as a means for determining IV-E financial participation as well as Medicaid financial participation. IV-E contributes to the financing of both family foster care and group care by matching state expenditures for maintenance costs (costs associated with placement, such as foster care payments to foster parents and facility and food costs related to group care). Like Medicaid, IV-E funds could only be used for specific purposes, and a record-keeping and accounting system had to be maintained which tracked expenditures billed as IV-E eligible, to the satisfaction of ACF.

The possible establishment of case rates for providers under a capitated system itself presents specific challenges. While managed care organizations in behavioral health have been able to achieve cost savings by reducing lengths of stay in hospital settings, reductions in lengths of stay in group or family foster care provide cost savings in IV-E maintenance payments that are separate and

that Work Group, which issued a set of recommendations, although action on these recommendations has not yet been taken.

³⁰ The term “integrity of the funding streams” was not raised by HCFA in the initial development of bundled services and prior to the transition in Regional HCFA office leadership, but was used frequently by regional HCFA staff in discussions with the Work Group thereafter and became a very prominent part of the negotiations.

distinct from the payments for services. Particularly if reducing lengths of stay is achieved through expanding aftercare services or intensifying efforts at reunification during a stay through additional counseling and treatment, the service costs may be greater under a case rate system, even though the overall costs (maintenance plus service costs) are lower.

Both providers and departmental staff believed that lengths of stay could be reduced for some children through more extensive initial work with the family in reunification planning and through aftercare services after the child was returned home. Under its current structure, however, once the child returned home, IV-E financial participation through maintenance payments stopped. While case rates might be established for providers for services covered under Medicaid for children in care, providers would not receive a corresponding maintenance payment based upon a case rate rather than a per diem in placement. Since managed care waivers under Medicaid must have an upper payment limit of no more than what expenditures would have been incurred under the prior system, without changes in IV-E funding relationships, providers would have little incentive to intensify service efforts and costs in order to reduce placement costs.

The Work Group explored with ACF to determine how Iowa might make use of ACF demonstration waivers in this respect, although the ACF demonstration waivers were more like 1115 Medicaid waivers than 1915(b) waivers, requiring a control group and a strong research component. Iowa wanted to go statewide with its proposed Medicaid 1915(b) waiver. HCFA had repeatedly indicated to Iowa that a 1915(b) waiver was much more straightforward and required much less work than an 1115 waiver.

Iowa thus pursued developing a publicly managed care 1915(b) waiver, recognizing that there remained a great deal of work to do with ACF if the waiver was to take full advantage of the flexibility it offered regarding Medicaid services. Since agreement on the basic structure of a publicly managed care waiver had not been reached with HCFA, however, the Work Group first devoted its attention to developing a waiver for submission to HCFA.

The Work Group recognized that HCFA would not respond to Iowa, in any specific detail, regarding what was allowable within a waiver prior to a waiver submission – but would respond to a waiver request with a set of questions that would need to be addressed. For that reason, and to continue to fulfill its commitment to HCFA to make reasonable progress toward the development of a new financing structure, the Work Group proceeded to develop a 1915(b) waiver request.

In September, 1999, the Work Group reached general consensus on the structure of a publicly managed care system and contracted with an outside consultant to draft the state's 1915(b) waiver proposal.

Somewhat later, at the Work Group's direction, the Department directed the accounting firm with which it contracted to develop an actuarial study that would use historical claims for Medicaid funding for rehabilitative treatment services to establish capitation rates for those services under the waiver.

Under the draft waiver, the Division of Adult, Children, and Family Services served as the managed care organization. The Division of Medical Services was responsible for contracting with the Division of Adult, Children, and Family Services and enforcing the contract. The waiver justified the sole sourcing of the contract on two grounds:

- * Iowa was not moving from a freedom of choice, fee-for-service system to a gatekeeper system, as the child welfare system already had a gatekeeper through the child abuse investigation and service determination process. One of the rationales for competitive bidding was to provide a "freedom of choice" to clients, which was not relevant with respect to child welfare services. Another of the rationales for competitive bidding was to insure that services would not profit excessively from the contract. The state was not a profit-making entity, and the state would agree to a "maintenance of effort" with respect to its funding, which would represent an equivalent guarantee.
- * By statute, the state was responsible for determining service need. The Division of Adult, Children, and Family Services currently operated as a managed care organization. Further, the courts ultimately made placement decisions, which created uncertainty for any managed care organization in operating under a capitated payment system. The state was in the best fiscal position to deal with this uncertainty.

Several states had established managed care waivers for part or all of the Medicaid-funded child welfare services they provided.³¹ Iowa's approach was different from these waivers, however, because the current managers of the child welfare system, the state Division of Adult, Children, and Family Services, would retain that role and assume the financial risk of operating under a capitated federal payment.

The Work Group explored other risk-bearing arrangements, including local governmental units receiving the capitation or opening the process to provider networks and private managed care organizations. While the Work Group agreed that, over time, it might be possible to develop subcontracts with local

³¹ For two reviews of state activities in this area, see: McCullough, Charlotte and Barbara Schmidt. *Managed Care and Privatization Child Welfare Tracking Project*. Child Welfare League of America Managed Care Institute, Washington, D.C., 1999; and Shulzinger, Rhoda, Jan McCarthy, Judith Meyers, Marisa de la Cruz Irvine, and Paul Vincent.. *Special Analysis: Child Welfare Managed Care Reform Initiatives: The 1997/98 State Survey*. Health Care Reform Tracking Project of the Research and Training Center for Children's Mental Health, the Human Services Collaborative, and the National Technical Assistance Center for Children's Mental Health, Tampa, FL: 1999.

governmental units or providers to operate under a capitated payment or with case rates, the Work Group concluded that local governments and providers were not in a position to accept risk at that time. In many respects, the state already operated as an MCO under a legislative appropriation that represented a capitation on state funding. The Work Group agreed that any movement by the state to share risk should not be imposed by the state.

The draft waiver defined mandatory services in identical language to the child focused rehabilitative treatment services included in the state's existing approved Medicaid Plan. The draft waiver incorporated the non-Medicaid services in the bundles as optional services (including non-rehabilitative family-centered services and a variety of other services and supports generally considered as "wrap-around" services³²).

The draft waiver also committed the state to a strong "outcome focus," with the establishment of benchmarks and a management information and quality assurance system based upon the child welfare objectives of safety, permanency, and well-being, with a particular emphasis upon addressing the child's rehabilitative treatment needs.

The draft waiver also included other general requirements for a 1915(b) waiver, including an external audit, a grievance process, and a strong emphasis upon consumer involvement, including the development and use of consumer satisfaction surveys or other tools to determine consumer satisfaction.

In essence, the draft waiver committed the state to developing, over the course of the three-year waiver period, the types of managed care tools outlined in Table Three. The draft waiver represented these as system enhancements made possible through the waiver.

An initial draft of the waiver was completed in February, 2000. As ex officio members of the Work Group, regional HCFA staff received a copy of that initial draft.

After substantial additional committee work in amending and revising the draft waiver, the Work Group approved a near-final version and recommended that the Department of Human Services submit it to HCFA in May, 2000. The only missing element was the actuarial data, with the actuarial study nearing completion.³³

³² "Wrap around" services are defined as or whatever additional services or supports can be "wrapped around" the child and family that contribute to efficiently achieving treatment plan goals, whether medically-based or not. Many of the new services described in the case examples in Tables Four and Five represent "wrap around" services.

³³ The state and HCFA agreed that there needed to be a resolution to the audit issues on appropriate state claiming for RTS services and that this resolution needed to be incorporated into the capitation rate. A variety of separate negotiations between the state and the regional HCFA office occurred during this period, with the recognition that a resolution of this issue would be reflected in an adjustment to the overall actuarially-established capitation structure included in

Meanwhile, the regional HCFA office had shared the earlier draft of the waiver with the Baltimore HCFA office. It was at this time that HCFA issued a written response to the state presentation and requests for interpretation of the May, 1999 meeting.

That response rejected the option of pursuing bundled services as a bridge to publicly managed care. The response listed three options the state might pursue as an alternative: (1) continuing the present system; (2) incorporating rehabilitative treatment services into the behavioral health managed care contract (which the Work Group and the state had previously rejected); and (3) seeking a 1915(b) or 1115 waiver.

On the last alternative, HCFA's federal response included a page outlining some general concerns related to Iowa's approach, indicating that interagency agreements (let alone intra-agency agreements) were not acceptable but that the Department could contract with other governmental bodies under explicit guidelines and that sole source contracts would have to have very substantial justification establishing the unfeasibility of another approach.³⁴

The Work Group's own legislative authorization expired at the end of the state fiscal year, on June 30, 2000. The Work Group co-chairs issued their final report, which provided the General Assembly several options regarding continued oversight. As of December, 2000, a waiver request had not been submitted.

Both the Iowa Department of Human Services and the General Assembly are considering options, including but not limited to whether to submit the waiver in its current form (with strong likelihood of disapproval) or submit a waiver that involves risk-based contracting with provider networks, which the Work Group did not recommend.

any waiver submission. The actions involved in resolving this issue are central to Iowa's receiving approval of a waiver, but are tangential to the major policy and practice issues regarding Medicaid financing of child welfare services discussed here. Currently, the regional HCFA office and the Department have agreed to continued monitoring of RTS claiming, with a year of "clean claiming" by the state required before negotiation of a capitation rate with HCFA.³⁴ Letter from Center for Medicaid and State Operations Director Timothy Westmoreland to Iowa Department of Human Services Director Jessie Rasmussen, date stamped May 8, 2000. The Guiding Principles reiterated regulations that "all procurement transactions shall be conducted in a manner to provide, to the maximum extent practical, open and free competition" but did note "there have been certain situations in the past where a State has justified that open competition was not practical. In such instances, the Secretary of the Department of Health and Human Services has final, discretionary authority to approve waivers implementing Medicaid managed care programs that involve non-competitively procured contracts."

Observations on the Iowa Experience and Lessons Learned

Iowa's experience in pursuing a publicly managed care waiver from HCFA has many unique aspects, and the exact experiences and issues that Iowa faced may not apply to other state efforts. Still, there are a number of issues raised and lessons learned that can inform other efforts to improve child welfare systems. These are described under two categories – those related to the content issues that were encountered and those related to the process issues that arose.

Content Issues. Although they sometimes serve the same children, historically the Medicaid and child welfare systems have been viewed as distinct and discrete. The providers generally are different, and the regulations and language and approach are different as well. In fact, however, achieving desired results in either system is likely to require much more integrated approaches, not just because of the boundary issues in financing and fiscal responsibility. For instance, mental health counseling under Medicaid should have goals and expectations consistent with those in the child welfare system's treatment plan. The step-down from a psychiatric hospitalization under Medicaid should be connected to the follow-up services and supports in a child welfare residential treatment setting. The following six findings can be drawn from Iowa's experiences on this issue of greater integration of services and strategies across child welfare and Medicaid.

1. *A significant portion of the services provided in the child welfare system represent Medicaid-eligible services to Medicaid eligible children. Medicaid represents a legitimate and significant funding partner in child welfare.*

While some use of Medicaid funds for child welfare services was being contested with respect to Iowa's RTS system, the regional and federal HCFA staff both agreed that child-focused rehabilitative treatment represents a Medicaid-eligible service, that most children have rehabilitative needs as a result of abuse or neglect, and that many of the services provided by child welfare constitute those child-focused rehabilitative services. States continue to push the boundaries for what is Medicaid-eligible and what is not, but even the non-contested share of Iowa's Medicaid reimbursement for rehabilitative treatment services represents a significant part of Iowa's overall child welfare spending (at least ten percent).

States should explore and make use of Medicaid funding for child welfare services, both under rehabilitation options within EPSDT and under targeted case management.³⁵ As much as is possible, however, states should seek to

³⁵ States have the option to finance certain aspects of their case management by Medicaid, an option taken by a half dozen states. The increased federal reimbursement to the state can be significant. Taking this approach also offers states the opportunity to restructure their case management systems to make better use of managed care tools, although to date this has not been the driving force behind state efforts in this area.

construct their reimbursement systems in ways that minimize impacts upon how services are delivered.

2. *Especially in child welfare, the distinctions between child-focused treatment and services designed to create the environment needed to make that treatment effective are difficult to draw and the distinctions drawn can be artificial. Treating Medicaid-eligible services as discrete from family-focused activities can create significant problems, although this may be necessary to preserve “the integrity of the Medicaid funding stream.”*

Although Iowa received valuable additional funding support for child welfare services as a result of securing Medicaid participation in its child welfare services, this also resulted in at least three negative “side effects” – discussed below under the subheadings “bias,” “documentation,” and “increased administrative and accounting cost.” The issue of “Medicaiding” a service without unduly “medicalizing” it is sometimes given limited attention by states seeking to enhance federal financial participation, which can result in the issues Iowa ultimately faced with its incorporation of rehabilitative treatment services into Medicaid.

Bias. Medicaid funding caused the state to create a new pre-authorization process for services (CACT) that resulted in a treatment bias toward Medicaid-eligible treatment services. Ideally, there would be a “front room” where decisions on the safety, permanency, and treatment needs of the child were identified and service plans developed and implemented, and a “back room” where those that were Medicaid-eligible were identified and billed to Medicaid. In practice, however, the pre-authorization process tended to direct service provision toward child-focused rehabilitative treatment issues, even where other non-rehabilitative treatment services might have been more appropriate. This “medicalizing” of child welfare services made sense from a state fiscal perspective (as the Medicaid funds derived were substantial), but it did not always make sense from an overall fiscal perspective – as it tended to move in the direction of more expensive discrete services and less comprehensive overall service plans.

Documentation. Iowa’s use of small (1/2 hour) units of service created significant documentation problems. Each one-half hour unit had to be thoroughly documented – who provided the service, what qualifications that individual had to provide the service, where and when the service was provided, and how the service directly fit into the child’s rehabilitative treatment plan. Particularly in highly structured settings that involved group counseling (some of Iowa’s day treatment programs), this created a great deal of paperwork on the part of staff and the resultant opportunity for audit exceptions. Using monthly units of service would have created fewer documentation problems (although it would have required more work in setting rates). In addition, under Medicaid rules some related work, such as collateral contacts or general counseling of families, did not fall within the definition of a unit of service and providers could not recover those costs directly, although they were essential from a treatment

perspective.³⁶ A longer unit of service would still require documentation, but would enable some of the costs for these related services implicitly to be incorporated into the rate.

Workers also complained that the method of documentation not only was cumbersome, but required terminology that did not convey what was actually happening and made their case records less useful for treatment purposes. This represented a particular challenge when more than one worker was involved with a case or when workers changed during the course of care and treatment, as the case records provided the history and context for the work with the child and family.

Increased administrative and accounting costs. Compared with the prior documentation requirements, Medicaid reporting requirements, at least as required under Iowa's system, greatly increased administrative time both at the provider level and at the state level, as well as increasing the amount of training that had to be conducted to familiarize providers and departmental field staff of the documentation requirements. These requirements also changed over time, in part as a result of HCFA requests to the state for increased or different forms of verification regarding Medicaid-eligible services.

While it is much easier said than done, states should not first raise the question, "What will Medicaid permit us to do?" but rather ask the question, "What do we want to do?" and then seek to pursue Medicaid funding in a way that requires the least deviation from the overall treatment strategies they believe will be most effective as is possible.³⁷

3. *A more holistic approach makes sense, and, once the level of Medicaid participation can be established, managed care waivers offer an opportunity for flexibility and a holistic approach that a fee-for-service system cannot. Current federal regulations regarding managed care waivers, however, were not written with the child welfare system in mind, nor did they envision the state as being interested in assuming full risk under a publicly managed rather than privately managed system.*

Specifically, managed care waivers presume that there will be a new gatekeeping or pre-authorization process prior to the delivery of a professional service, where one previously did not exist. In child welfare, however, the state

³⁶ Providers also could bill for "general counseling of families" as a direct service, as long as these were authorized by the worker as a "non-rehabilitative service" that did not draw down a Medicaid match. Decisions must be made on how many RTS and how many non-RTS services should be authorized, however, and providers then have to track these separately, adding considerable complications both in authorizing the most appropriate services and in billing for them – and creating a more fragmented system. See also the discussion around footnote ten.

³⁷ Some deviation from the most cost effective treatment strategy may still make sense, from a state fiscal perspective. For a state with a matching rate of 50% from Medicaid, it is cost effective from a state perspective to nearly double the cost of care when Medicaid participation can be secured, although from an overall governmental (state plus federal) perspective, this does not make sense.

already manages and has a gatekeeping system through its child abuse investigation and assessment system. Moreover, this gatekeeping generally is established by statute and responsibility cannot be transferred. Therefore, the requirements for competitive bidding and (possibly) multiple contracts are designed to continue to provide individuals with some choice in providers. In the case of child welfare, however, there already exist restrictions on that choice, and publicly managing the system under a waiver would not change the existing system in this respect.

In addition, the imposition of a Medicaid upper limit (a limitation on federal financial responsibility to no more than what exists under the current system) is designed to provide a protection to HCFA against a state's approval of contractual agreements and capitated payments that end up being more expensive than the current system. In the case of the state serving as the managed care organization, however, a capitation with the state fully protects HCFA, whether or not state spending increases as a result.

Logically, once a capitation rate is set, HCFA's liability is established. A state that is willing to spend more to achieve better results should be given the opportunity to do so, as HCFA will not be responsible for sharing in any of that additional spending. A more relevant requirement than an overall upper payment limit would be an upper payment limit to the state coupled with a requirement for a state maintenance of effort.

HCFA's 1915(b) waiver, however, was not developed with public system management in mind. It also was not written with the unique features of the child welfare system in mind – the nature of the population served and its often long-term system involvement³⁸, the overall goals that exist for services (safety and permanence in addition to well-being), the current legal gatekeeping structure and the involuntary nature of most services, and the level of uncertainty in determining costs and the degree to which providers have the capacity to assume risk.

4. Most of the managed care tools developed for physical and behavioral health – pre-authorization and continuous review, management information systems that focus upon outcomes, clinical pathways and protocols, provider profiling, fiscal incentives to providers for cost effective care, and consumer feedback – represent management practices that could and should be adapted for and incorporated into the child welfare system. This should happen whether or not there are any changes in individual responsibilities within the system (e.g. moves to different contractual and risk-bearing relationships with providers, private managed care organizations, or the state or its political subdivisions).

³⁸ Special considerations that apply to Medicaid managed care for chronic and long-term populations is discussed in some detail in: Verdier, James, *op.cit.*

The development of such tools in child welfare, however, has not proceeded as far as it has in the physical health and behavioral health fields. As importantly, the child welfare system virtually always involves issues around the child's immediate ecology that must be addressed (and usually are the reason for the entry into the system), which results in greater complexity and uncertainty in diagnosis, treatment, monitoring, and assessment of results. While managed care tools can be useful to child welfare, in many instances they will need to be adapted from the manner in which they are applied in the medical world to apply to child welfare services. They also must recognize that the child welfare system has a much smaller research and knowledge base than the medical field and often must address much more complex and interdependent issues and concerns. A number of different managed care tools and their applicability to child welfare are discussed below.

Preauthorization and continuous review. There is a pre-authorization process within child welfare, through the child abuse investigation and assessment process, where abuse or neglect is established and recommendations for services may be made. The degree of continuous review in most managed care organizations, however, extends well beyond that found in the child welfare world. In part, this is because addressing acute care medical needs is of a generally short-term duration that has very significant costs during that period. In child welfare, the duration of treatment often is an extended one, including long lengths of placement in higher cost group care and residential facilities. Once the initial, difficult decision to place a child has been made, the child welfare system often moves onto other cases and does not seriously review progress toward, or work aggressively to achieve, permanency plan goals, until near the time a court review is scheduled, generally three months from that placement time.

There is some, but limited, research on imposing shorter time frames for such reviews that suggests lengths-of-stay can be shortened without compromising safety or well-being. The development of review protocols for different presenting conditions and concerns within child welfare, however, could substantially improve system management. A managed care approach could speed the development of such review protocols and insure their application.³⁹

Management information systems that focus upon outcomes. At the federal level, ACF has required states to develop management information systems that can track important child welfare "outcomes," such as re-occurrence

³⁹ There has been a long-standing concern in child welfare about "foster care drift" – that children placed in care remain in care for much longer periods than necessary. Many of the reforms to child welfare, dating back to the Adoption Assistance and Foster Care Act of 1972 (PL 92-272), have worked to prevent this "drift," through the imposition of permanency planning and required court hearings. The recent Adoption and Safe Families Act of 1998 has imposed new requirements upon states to reduce the length of time that children wait to achieve permanency through aggressive time frames and incentives for adoption. The federal administration also has imposed new requirements for states to track specific child outcomes in the system – with several directly related to length of time in placement, as the next subheading discusses.

of abuse, length of stay in out-of-home care, and timely proceeding to adoption.⁴⁰ Through AFCARS and SACWIS, the federal government has provided financial support and direction to states in developing such data systems.⁴¹

Still, few states have systems that provide for longitudinal tracking of children in the system or track both children and families with respect to abuse. Analyses based upon the data – such as cohort analyses related to lengths of stay and unplanned movements from one placement to another, or analyses of particular subgroups in the population for their general profiles of service use (and variations in service use much like variations in medical practice identified through small area analysis) – generally have been performed only as part of special research projects or foundation-supported initiatives.⁴² In addition, such analyses generally are limited to the specific child welfare goals of permanence and safety (with permanence itself being related to system costs), and not to child well-being, particularly child well-being as measured by rehabilitative progress.

Constructing, and then using, such management information systems to guide practice and establish protocols is one key element for moving toward a more outcome-based management system. Entry into managed care may be able to speed this process, either through states directly improving their management information systems or contracting for that system development and management (under a partial administrative services only, or ASO, contract). Within state government, it often is difficult to directly secure additional “management” resources to perform such planning tasks, and operating under a managed care waiver could provide the flexibility and support for developing this infrastructure.⁴³

⁴⁰ See note three. These outcomes do not speak to “well-being,” however, let alone progress toward “regaining a function that was lost or never gained as a result of abuse,” e.g. rehabilitation.

⁴¹ The Adoption and Foster Care Analysis and Reporting System (AFCARS) is a federally mandated data collection system. All states are required to collect specific data concerning children in foster care and adoptive children placed by the state (or private agencies contracting with the state). The Statewide Automated Child Welfare Information System (SACWIS) is designed to serve as a case management system which can be used by workers to input and retrieve individual case information, which must be able to collect and report the AFCARS data. The development of both systems has been supported by the federal Administration for Children and Families.

⁴² Bob Goerge and Fred Wulcyn at Chapin Hall at the University of Chicago and Lynn Usher at the University of North Carolina have been pioneers in constructing cohort data from administrative data that can be used for longitudinal analysis..

⁴³ Many state computer systems are now archaic mainframes designed primarily for fiscal management and billing. They are not geared for client tracking and case planning, nor amenable for statistical analysis, particularly related to longitudinal data. Moreover, child welfare systems may have difficulty internally establishing alternative management information systems, given the overall commitment to a unified mainframe system, as well as the purchasing requirements established within state government. ASO contracts may be a more expeditious way of developing management information systems that can be used for research and client tracking purposes.

Child welfare faces an additional challenge in developing outcome-based systems, however, and that is the clear determination of successful, versus unsuccessful, outcomes. While this is sometimes an issue in medical care, it very often is one in child welfare, where different system “outcomes” may need to be weighed against one another. Returning a child to the child’s home from a placement may reduce the trauma of separation and allow for healing of family relationships or resolution of issues needed for the child’s sense of identity, but it also may result in less supervision and educational progress in school than would occur in a more structured environment. Moreover, for one child, returning home may help gain a sense of belonging and self-identity; for another child, placement in an environment away from family may be needed to sever destructive relationships and begin to build positive relationships with others.

In the end, the indicators currently most frequently used to measure child welfare outcomes – length of stay in placement or toward permanency, reoccurrence of abuse, re-entry into placement, and disruption of placement -- are measures more related to system response (and system cost) than they are to child psychological and emotional well-being and behavior.⁴⁴

Clinical pathways and protocols. The child welfare system is at a much earlier developmental stage in developing clinical pathways and treatment protocols than the medical world. While the medical field is still developing those clinical pathways and establishing medical treatment effectiveness protocols (with large variations in practice currently existing in the treatment of a wide variety of health conditions), child welfare is only beginning to develop those pathways and protocols. Further, the amount of funding for research in the child welfare field specifically, and the social services world generally, is miniscule compared with the funding in the medical field.⁴⁵

⁴⁴ Absent contrary evidence in the medical field, it has been argued that less intervention and invasive action is preferable to more intervention and invasive action (because of potential negative, or iatrogenic, effects of intervention). This formed the rationale for some of the practice changes that resulted from small area analysis showing wide variations in physician practice.

In child welfare, there is a requirement to impose the “least restrictive alternative” possible in making decisions regarding placement, and the same argument related to well-being can be applied (e.g. absent other evidence to the contrary, less intervention is better than more intervention).

The fact remains, however, that these are “systems” outcomes and not direct client outcomes. In the medical field, “outcome” measurement involves “clinical outcomes” (e.g. the eradication of a specific disease); “functional outcomes” (e.g. the patient’s functional status and ability to perform tasks), “patient satisfaction,” (e.g. the patient’s belief that the intervention has helped), and “systems outcomes” (e.g. the cost of care). All four should be incorporated into an analysis of treatment effects. In child welfare, there is seldom much critical examination of the “systems outcomes” side, let alone the other three.

⁴⁵ For instance, the federal government provided \$ 1 million each to two separate research efforts to determine the effectiveness of family preservation services and family support programs in producing results for the children and families served – and these were considered major investments in the child welfare area. These represent tiny investments, however, in contrast with the research into treatment effectiveness and outcomes financed by the National Institute of Health and other federal agencies dealing with medical health services.

In short, there is much less field experience, let alone research, in applying clinical pathways and treatment protocols in child welfare. Further, the ability to diagnose the specific causes of a child's behavior that then can be treated is much less subject to clinical diagnostic tests and much more to individual therapeutic judgement in child welfare, as it must address the child's environment (family and other social and emotional ties) as well as the child.

This does not mean that much better diagnostic and categorizing tools cannot be developed for child welfare which can begin to establish recommended courses of care and treatment, including lengths of placement. In fact, the discipline of managed care can make this more likely to occur and to proceed more quickly.

In some respects, however, the current state of the field presents a case for keeping the development of such understanding in the public domain, rather than on a proprietary basis. In fact, one major emphasis of the Work Group's activities in Iowa was to provide significantly greater attention upon outcomes in order to begin to develop protocols regarding specific subpopulations within child welfare (such as conduct-disordered thirteen to fifteen year-old males, which represent a significant portion of the child welfare population and an even greater portion of its costs, but whose range of treatments and services varies substantially). Under the state's existing management information system, however, such subpopulations cannot be identified, much less their courses of care, placement, and treatment described over time. Population-based studies require a substantially more sophisticated data base than exists in most, if not all, child welfare management information systems.⁴⁶

Provider profiling. Unlike medical care and treatment, which often involves direct physiological changes through medication or surgery, most of the interventions in child welfare to address rehabilitative needs rely primarily upon some form of therapeutic relationship. While "bedside manner" plays a role in treatment in medical care, it is the principal treatment in child welfare, with the key to successful treatment being the trusting relationship the provider is able to develop with the child and family. Research has shown that some practitioners do better than others in this respect, and some do better with some types of children and families while others do better with others.

For this reason, in the long term, provided it is possible to identify more completely the presenting issues and underlying conditions of children and the desired results of care and treatment, provider profiling may play an even greater relative role in child welfare than in medical care. Again, however, the state of the child welfare field is such that it is likely that only significant "outliers" (providers whose results are at great variance with other providers in the field) are likely to be worth profiling, and then for subsequent examination of whether there is a reason for their "outlier" status.

⁴⁶ Ellwood, Paul, "Shattuck Lecture: Outcomes Management: A Technology and Patient Experience," *New England Journal of Medicine* 318, pp. 1549-1557, 1988.

*Fiscal incentives to providers for cost effective treatment.*⁴⁷ Over the last five years, a number of states, or their political subdivisions, have experimented with new financing arrangements with child welfare service providers, particularly related to children placed in residential care. Reducing lengths of stay in residential care (or eliminating placement altogether) have been considered as the most significant ways to contain system costs. Fiscal incentives have been provided in the form of case rates which give providers an incentive to return children home sooner (presumably through greater emphasis upon reunification efforts both prior to and after reunification). Incentives also have been offered in the form of performance-based contracts that provide some, usually limited, bonuses to providers who achieve certain benchmarks, again usually around placement or movement to permanency. The results from these efforts show some successes in reducing lengths of stay, although these also are dependent upon insuring that IV-E placement funds are retained (in order for the state to derive a fiscal benefit). To a much lesser extent, case rates have been applied to in-home treatment, in exchange for flexibility in treatment design, sometimes with the rationale that wrap-around services may be substituted for treatment services and will produce improved results for children and families.

These contractual relationships generally impose some level of risk on providers. In most states, the provider community is composed of nonprofit organizations that differ from hospitals and medical providers in their capacity to assume financial risk. Most have few, if any, other payers for their services, so they cannot spread any additional costs they might accrue to another funding source. In short, child welfare providers in many states, although they are not employees of the public system, do all their business with the state. Therefore, their ability to accept risk is much less in the child welfare community than in the medical field.⁴⁸ Further, pricing “case rates” has proved to be challenging, and, in at least one jurisdiction (Kansas), led to provider insolvency, although a technology is developing in this field. These issues need to be recognized in developing risk-based provider contracts.

As described in Table Three, the Work Group recognized the value of applying managed care tools to child welfare, with or without development of a formal managed care structure and financing relationship with HCFA. At the same time, these tools require adaptation for child welfare, as well as development of a research base for the populations that child welfare serves.

Consumer feedback. In child welfare in Iowa, regulations require case treatment plans to be developed with the involvement of the child and family, unless doing so would be inadvisable from a treatment perspective. In practice,

⁴⁷ For a more extensive discussion of this issue, and references to several national surveys of state and community efforts to employ managed care financial tools in child welfare and behavioral health, see: Bruner, Charles. *Financing and Outcomes Accountability in Child Welfare: An Assessment of the State of the Field*. National Center for Service Integration and Child and Family Policy Center: Des Moines, IA, 2000.

⁴⁸ E.g. There is not an opportunity for “cost shifting” to the private sector.

however, family involvement in treatment planning often does not occur or is conducted superficially, through obtaining a parent's sign-off after the provider has developed the treatment plan.

At the same time, a growing body of literature and a growing number of reform efforts in child welfare stress the need for such involvement. Some initial studies and reports on promising practices⁴⁹ suggests that family group decision-making, family meetings, and individualized courses of action developed with or by the family are more effective than professionally-driven treatment plans, with limited or no family involvement.⁵⁰ Because of its flexibility, managed care provides opportunities for such family-based treatment planning to be covered as an optional service, with a rationale that more cost-effective treatments would result.⁵¹

In addition, managed care organizations typically include consumer surveys as a means of providing some level of feedback on service quality. This approach has been much less used in child welfare and could have useful applications. Many of who could be considered the "consumers" in child welfare, the parents or guardians of the child, are involuntary ones, however, who may have strong disagreements with departmental, or court actions. For this reason, interpreting a survey regarding satisfaction with services can be more problematic than with medical services. In addition, mail surveys are unlikely to be effective in obtaining feedback from the child "consumer" (even when an older youth) and also could be seen as compromising the child, if the child is still living at home.⁵²

Again, however, by beginning to develop and use consumer satisfaction surveys in child welfare, baselines can be established and more sophisticated data analysis of the results developed. As with many other managed care tools discussed in this section, the child welfare field is most likely to advance with a "learn by doing" approach.

⁴⁹ See, for example, the materials prepared by the Annie E. Casey Foundation on its Family-to-Family Initiative and the work of the American Humane Association, among others, on adaptations in the United States of the Family Group Decision-Making model from New Zealand.

⁵⁰ These improved outcomes relate to both systems outcomes (quicker closing of cases and reduced utilization and cost of services) and consumer satisfaction outcomes.

⁵¹ Iowa's draft waiver allows such family case planning models and "wrap-around" services as optional services – with required services constituting current "child focused rehabilitative treatment services." While individuals cannot be denied required services that they need, the optional services can eliminate the need for an otherwise required service, as is shown in the illustrations in Tables Four and Five.

⁵² Kansas has been a pioneer in using consumer satisfaction surveys, and Iowa has conducted several surveys of families who have been the subjects of child protection services. Most recently, Iowa conducted a survey of adoptive parents of special needs children. For a discussion of the findings from that survey, see: Bruner, Charles *Beyond Adoption: Supporting Adoptive Families of Children with Special Needs*. National Center for Service Integration Clearinghouse and Child and Family Policy Center: Des Moines, IA, 2000.

5. *The categorical nature of both Medicaid and Title IV-E make it difficult for states to easily draw down their legitimate share of federal funding and create the frontline practice that makes the most sense. Not only are the goals for the systems somewhat different (Title IV-E – safety and permanence; Medicaid – rehabilitation), their regulations and documentation requirements make it problematic for states to fit the two together in more seamless ways, particularly as this requires agreements from two different federal agencies.*

Aligning the regulations that govern Medicaid and IV-E represents a major challenge to states seeking to use both funding sources and develop an integrated system of child welfare services. This includes direct administrative challenges in documenting services, the indirect impact that eligibility determinations can play on selection of services and treatments, and the lack of flexibility or fungibility of services across, and sometimes within, those systems. Some of the difficulties Iowa experienced with respect to Medicaid were discussed earlier (under point two), but the effort to interface Medicaid with IV-E creates additional challenges.

The administrative challenges start with the client eligibility determination process, with Medicaid and IV-E having different definitions of eligibility. This requires states to incorporate two methodologies for eligibility determination within their child welfare system, at significant administrative expense both for determinations and ongoing tracking.

These administrative challenges extend to the manner in which the services that are provided have to be defined and documented. At a minimum, when Medicaid funding is incorporated into the child welfare system, staff and providers have to substantially expand their expertise regarding issues related to eligibility and documentation. At the same time, those workers in most cases have their primary responsibilities and training in direct service provision or service monitoring that does not correspond to Medicaid clinical documentation requirements.

In addition, while there are fine distinctions between supervising (IV-E) and treating (Medicaid) children, states must draw and record these distinctions. Each is subject to separate auditing provisions, so disqualification for eligibility for payment under one system does not necessarily mean that the payment will simply be transferred to the other system. Different methods of cost accounting – from billable units of service to random moment time studies – may apply to the different systems, compounding accounting challenges for the state. The result is that states may have to develop quite complex accounting systems for apportioning responsibilities for payment between the Medicaid and IV-E. This increases the opportunity for errors as well as taking additional time and expense, often on the part of frontline staff whose primary role should be providing supervision or treatment.

Process Issues. In many respects, Iowa undertook an unprecedented level of activity and involvement with federal agencies in seeking to develop an

approach that seemed to Iowa stakeholders the best way of achieving desired results. This approach also required significant thinking outside traditional lines. Although the success of this two and one-half year concentrated effort in achieving its goals is still uncertain, there are three process issues and lessons from Iowa that may be relevant to other state or county reform efforts involving federal funding streams, whether or not they focus upon the particular issue of publicly managed care for Medicaid-funded child welfare services. These are discussed below.

1. *Despite Iowa's efforts to work with federal agencies and those agencies' efforts to work with Iowa, there are no structures that really enable federal agencies to partner with states in seeking innovative solutions. This placed Iowa in a difficult position of having ground-rules changed as it worked for solutions, as there was no authority given to federal agencies to support Iowa in "drawing outside the lines."*

When the Iowa Legislative Council established the Work Group, it included representation from the regional HCFA and ACF offices. Further, Iowa's Governor and two U.S. Senators wrote to Department of Health and Human Services Secretary Donna Shalala to urge her to make travel resources available for regional staff to participate in the Work Group's deliberations, as the regional offices had indicated they had no travel funds enabling them to come to Iowa. As a result of this request and Secretary Shalala's response, HCFA and ACF were able to be directly involved with the Work Group.⁵³ Representative from both agencies participated in more than twenty full-day work sessions of the Work Group or its Planning Groups in designing bundled services, and later the waiver.

Throughout, however, HCFA and ACF staff primarily raised concerns or responded to questions regarding whether Iowa's approach met existing federal requirements. In particular, HCFA staff primarily monitored Iowa's work to determine whether the state was making progress toward changing its RTS system. Regional staff, and later federal staff, took the role of interpreting existing federal regulations and boundaries, but not of assessing whether these made sense when applied to Iowa's approach. With the exception of Associate Director Richard Brummel's letter indicating that moving to "bundled services" represented an acceptable option, HCFA did not participate in any "brainstorming" regarding how the current system might be modified.

Although it may have been due to policy changes at the federal level, HCFA also responded differently when Iowa submitted a formal proposal than when Iowa sought guidance on regulations and boundaries. The questions raised in submission of the Plan amendment to implement bundled services, for

⁵³ Letter from Governor Terry Branstad, U.S. Senator Charles Grassley, U.S. Senator Tom Harkin, Iowa House of Representatives Speaker Ron Corbett, Iowa House of Representatives Minority Leader David Shrader, Iowa Senate Majority Leader Stewart Iverson, and Iowa Senate Minority Leader Michael Gronstal to United States Department of Health and Human Services Secretary Donna Shalala, November 7, 1997.

instance, raised a wide variety of issues that had not been raised in prior discussions with HCFA, during the period bundled services were designed and the Plan amendment was being drafted.

In short, as participants on the Work Group, both HCFA and ACF⁵⁴ played the role of clarifiers of the boundaries within which new systems might be designed, rather than as partners in designing a new system.

2. Iowa was able to proceed as far as it did in developing consensus on some fundamental shifts in its child welfare system precisely because there was a broad perception that “the status quo was no longer tenable” and there were resources available to support an intensive and broad-based planning process.

The changes in service delivery posed by adopting bundled services and the changes in managing the system posed by securing a waiver represent dramatic departures from prior practice. They involve major changes in the manner in which frontline workers in the department of human services and the juvenile court do their work and the way service providers develop and implement service plans. They call for fundamental changes in the manner in which services are priced and providers are held accountable for implementing them.

It is highly unlikely that gaining consensus on these changes from representatives of the department, the court, and the provider community would have occurred were not the current system, “the status quo,” regarded as no longer tenable. Once there was general agreement that the system had to change, this agreement kept interests at the table willing to negotiate and compromise to develop a new system.

The belief that the status quo was no longer tenable was the result of the financial risk to providers and the state posed by a federal audit. Reiterations of HCFA’s position that the state must make reasonable progress in moving to a new system in order to render moot a federal audit of the existing system created a sense of urgency in the state. Over time, the impetus for change also stemmed from a recognition that the current system could not lead the state in the direction it wanted to go and was, in itself, “broken” from both a management and a service delivery perspective. Moreover, there was a strong sense, at least from the provider and the local government community, that the Work Group was their best opportunity for participation in the design and decision-making regarding system changes. If the Work Group ceased to move forward, many

⁵⁴ At the same time the state pursued new structures for Medicaid involvement in funding child welfare services, the state also sought additional Title IV-E participation in funding specific child welfare and juvenile justice services, particularly with respect to covering some juvenile court officer activities and covering some community-based provider services. ACF took the role of clarifiers of boundaries within which a new system might be designed. The issue of the integrity of the Title IV-E funding stream was raised in the same manner that the integrity of the Medicaid funding stream was raised by HCFA with respect to bundled services.

reasoned, decisions would be made elsewhere, either by federal action or unilateral department action.

Maintaining this sense of urgency, however, required that forward momentum be maintained. During the first year of the Work Group's effort (during the time of the development of bundled services and initial mapping out of the parameters for a 1915(b) waiver), this occurred. The next year's work, however, consisted primarily of negotiations with the regional and federal HCFA offices over the acceptability of Iowa's approach – both regarding a bundled services plan amendment and a 1915(b) waiver. This suspended involvement by many stakeholders in Iowa in the next phase of the planned work – orientation and training for implementation at the field level – and raised questions as to whether, in fact, there would be any change. Some momentum for change was lost, as Iowa was held in limbo awaiting federal responses. Since the delays were the result of federal deliberations, the sense of urgency in order to forestall an audit also was placed in question.

Whether this momentum can be re-established, the engagement of the field in the same positive, shaping direction, and the scope of reforms sustained – even if a waiver is approved that enables Iowa to develop a more flexible and holistic service delivery structure – has yet to be determined. At a minimum, it is likely to require significant leadership and concerted activity to re-establish that momentum for significant change.

3. Iowa chose a more cooperative path with HCFA than many states choose to take. Iowa made only limited and largely non-confrontational use of political avenues through its congressional delegation and did not challenge HCFA's interpretations through court actions. Strategically, Congressional activity may have proved to be a more successful path – particularly when pressing the boundaries of conventional practice and seeking innovative approaches.

Throughout the Work Group's tenure, Iowa sought to work with HCFA and ACF to produce change, keeping both agencies involved in the process. The Work Group explored its Congressional options, as well, but generally only in the context of facilitating HCFA and ACF involvement.

Iowa's Senate delegation, in particular, is well-positioned on these issues, with Senator Grassley a high ranking majority party member of the Senate Finance committee and Senator Harkin a former chair and now the ranking minority member of the appropriations subcommittee dealing with HCFA's and ACF's appropriation.

Both Iowa's United States Senators, Chuck Grassley and Tom Harkin, intervened at strategic points to facilitate interactions with HCFA, although this involvement stopped short of seeking Congressional authorization to enable Iowa to adopt a particular plan. Under counsel from the Work Group and the

department, both Grassley and Harkin sought to use their influence within a collaborative and congenial approach with HCFA.

First, Senators Harkin and Grassley joined Governor Branstad in petitioning Secretary Shalala to allow her regional staff to participate on the Work Group itself. Later, Senator Harkin requested a federal meeting for Iowa with HCFA to explain Iowa's approach to bundled services and publicly managed care, succeeding in getting the May, 1999 meeting scheduled. At that time, Senator Grassley provided a statement to the Senate hearings on bundled services for school health that supported Iowa's position with respect to child welfare.⁵⁵ Senator Harkin discussed Iowa's bundled services proposal with HCFA Director Nancy Ann Min-DeParle and drafted language for the Senate committee report on the appropriations bill encouraging HCFA to support Iowa's approach.⁵⁶ A response to the state from HCFA indicated that HCFA had reviewed and approved that language for inclusion in the report⁵⁷ (which Senator Harkin believed represented an agreement with HCFA that Iowa would allow Iowa to receive approval for its bundled services plan amendment).⁵⁸

Iowa stopped short, however, of seeking specific Congressional authorization through an amendment attached to an appropriations or a finance committee bill. In large measure, Iowa has not pursued such a Congressional solution. The Department of Human Services Director and the Administrator of the Division of Medical Services, in particular, expressed their desire to maintain an ongoing, collegial relationship with the regional office with respect all Medicaid issues and did not want this specific issue to disrupt other actions with the regional office.

The Work Group did seek legal counsel from others who worked and lobbied at the federal legislative level on behalf of states, however. This counsel indicated that seeking Congressional authorization effectively eliminates the

⁵⁵ Statement by Senator Charles E. Grassley to the Committee on Finance Hearing – Medicaid and School-Based Services, Thursday, June 7, 1999. Senator Grassley's statement was accompanied by written Testimony from the Iowa Department of Human Services Director and the Treatment Component of Child Welfare Services Work Group Co-Chairs.

⁵⁶ Senate Committee Report on the 2000 Health and Human Services Appropriations bill. The language read: "In order to provide the most effective services to abused and neglected children in our child welfare system, it is important to ensure providers have the flexibility they need. ... The State of Iowa has submitted a proposal to HCFA to restructure services in order to increase flexibility, ease administrative burdens and encourage innovation in service selection and delivery. The Iowa proposal would utilize existing Medicaid resources and does not require additional appropriations. The committee encourages HCFA, pending agreement on a final plan, to consider approving the Iowa proposal as a two-year project to demonstrate the efficacy for this service approach." (p. 197-198)

⁵⁷ Letter to Iowa Department of Human Services Director Jessie K. Rasmussen from Deputy Director of the Center for Medicaid and State Operations of the Health Care Financing Administration Rachel Block, date stamped September 9, 1999. The letter states: "I know you will be interested to learn that we recently reviewed and sent forward Senator Harkin's proposed language for inclusion in the Senate Committee on Appropriations report in support of Iowa's (RTS) proposal as a congressional demonstration project.

⁵⁸ Author's telephone discussions with Senator Harkin staff.

option of seeking HCFA approval without authorization – representing a “burn the bridges” approach. States are in the best position for securing congressional authorization when they can document a history of futility in their efforts to work through HCFA channels. When taking this route, the authorization sought should be sufficiently specific that it waives all regulations that might stand in the way of HCFA approval. Counsel also stated that state experiences have been that seeking such authorization does not make it more difficult to negotiate on other issues with HCFA regional offices.

In its final report to the General Assembly, the Work Group recommended that serious consideration be given to seeking such Congressional authorization for a demonstration – one which enables Iowa flexibility in the service design and delivery of rehabilitative treatment services, in exchange for a capitated federal financial Medicaid commitment to the state with an agreement for a state maintenance of effort in its own financial support.⁵⁹

Conclusion – Final Observations and Proximate Solutions

Iowa’s experiences speak to a variety of important issues regarding system management and service delivery of child welfare services funded by Medicaid and operated within a publicly managed care environment. They suggest both the potential for adapting managed care tools and incorporating them into state child welfare systems and the specific reasons that adaptation of these tools is needed.

These issues cannot all be addressed through one new approach, nor will they be addressed in the abstract, however long and intensive a planning process may be. They represent important issues that do need to be addressed,

⁵⁹ Letter from Treatment Component of Child Welfare Services Work Group Co-Chairs to Members of Iowa Legislative Council and Joint Appropriations Subcommittee on Human Services, June 22, 2000. The letter states: “Our work has convinced us that the state should continue to pursue an alternative method for financing child welfare services that continues to draw down federal funds but provides substantially more flexibility in developing and implementing treatment plans. This may require special Congressional authorization and certainly will require a waiver from existing HCFA standards.” This is particularly crucial if HCFA contends that optional services provided under a managed care waiver still must justify themselves as being treatment-oriented, rather than social or educational, in nature. According to Carl Valentine, this may be the current battleground in such waivers: “Is the waiver driven by outcomes or must there be the same degree of process recording and accountability as there is under fee for service. Medicaid managed care increasingly is requiring activities to be tied back to the Medicaid program through encounter data reporting which uses standardized behavior health procedure codes with limited tolerance for use of state only procedure codes.” (December 4, 2000 memo to author from Carl Valentine). In Iowa’s extensive work in developing bundled services as a bridge to a managed care waiver, HCFA’s representatives indicated that moving to outcomes was viewed very positively and would create flexibility and a waiver would enable Iowa to take a broadened approach to services beyond what it could do under a fee-for-service system. This propelled Iowa to moving toward publicly managed care – but this is precisely the area that Valentine indicated represented the current battleground regarding managed care waivers.

however, if management and frontline practice in child welfare is to improve while federal financial participation through Medicaid and IV-E is maintained.

Based upon the Iowa experience, it is the author's view that they will be addressed most expeditiously if states and communities are provided the opportunity and encouragement to "learn by doing." In this context, the federal government may have "to lead, follow, *and* get out of the way."

Both Medicaid and IV-E, as well as other federal funding streams, have categorical requirements that can make needed innovation difficult. The following three actions at the Congressional level could enable some risk-taking states, like Iowa, to explore and experiment with more integrated strategies that respond more holistically to children and families in order to achieve better results. These could eliminate some of the barriers and hoops that Iowa experienced as a result of existing federal regulations governing both Medicaid and IV-E.

1. Restructuring HCFA's managed care waiver requirements with publicly managed systems in mind, particularly through providing for direct capitation to the state and using maintenance of effort rather than an upper payment limit as the criterion for approval, while enabling blending of funding streams within a single regulatory policy that focuses upon results.
2. Establishing cross-departmental waiver options that permit states different ways to blend Medicaid and IV-E (and potentially TANF, and other federal program) funding, again with maintenance of effort protections.
3. Providing greater direct support for the adaptation and incorporation of managed care tools within child welfare, through federal funding (and/or foundation support) – in order to build a broader base for the field – with or without any changes or modifications to federal funding streams.

In the end, Iowa's approach was most innovative in its management design and service delivery aspects – not in its fiscal arrangements with HCFA and IV-E (those fiscal arrangements, however, are too significant for a state to ignore). The lessons learned from implementation of either bundled services or a publicly managed care waiver would be in the areas of developing more outcome-based system management tools in the context of more holistic and individualized treatment plans. Especially when a state is willing to assume risk, through capitation of a federal funding stream that constitutes an open-ended federal funding responsibility, federal restrictions based upon the "integrity of federal funding streams" should not provide insurmountable barriers to reform.