

# Issues in Developing Comprehensive, Community-Based Service Systems

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## **Financing and Outcomes Accountability in Child Welfare An Assessment of the State of the Field**



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**Issues in Developing Comprehensive,  
Community-Based Service Systems**

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**by Charles Bruner**

## Preface

Everyone supports better results. Yet the sobering trends on many child outcomes – abuse and neglect, delinquency and violence, low birthweight, adolescent parenting – have led policy makers to call into question the effectiveness of current public services designed to address child issues and needs. Nowhere is the distrust in the effectiveness of a public system in meeting its outcome objectives greater than in the child welfare system.

This has given rise to a great deal of experimentation in child welfare in the use of outcomes to inform policy and practice. Increasingly, policy makers are calling for new forms of accountability for those providing services – on achieving results rather than adhering to processes. The question is how to provide greater outcome-accountability, while being fair to those service providers and not establishing unrealistic expectations.

This *Occasional Paper* was stimulated by broad-based, ongoing work in Iowa to develop more outcome-accountability in child welfare through a variety of activities, coupled with a new Iowa Department of Human Services' Action Plan based upon "purchasing results, not services," a plan that poses a radical departure from traditional ways of contracting with providers. The Appendix to the paper offers a critique of the pure approach to "purchasing results, not services," based upon a case example presented as an illustration of results-based case rates in the Action Plan.

As importantly, however, the presentation of this pure approach to "purchasing results" raised the question of how a state might best move toward greater outcome accountability in child welfare. That is the major theme of the paper.

The author would like to thank Victor Elias and Monica Cameron for assisting in the research for this paper. Jan McCarthy, Patrick McCarthy, and Carl Valentine all provided valuable comments to an earlier draft of this report. Participation on the Center for Health Care Strategies' Medicaid Managed Care Stakeholders Project and their support of related Child and Family Policy Center research contributed to this paper. The Annie E. Casey Foundation provided funding that supported completion of the paper. The author's experiences as Co-Chair of the legislatively-established Iowa Treatment Component of Child Welfare Services Work Group provided additional depth and understanding of the challenges and opportunities for child welfare reform within a federally-funded system. Despite these many influences, however, the conclusions and analysis in this paper are those of the author, and not necessarily any of the above-mentioned influences.

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# **Financing and Outcomes Accountability in Child Welfare – An Assessment of the State of the Field**

## **Introduction**

*Can child welfare systems, through performance-based approaches to provider contracting, get better results for children?*

*What other options can be pursued to achieve this goal?*

This occasional paper seeks to answer these questions, drawing upon the current state of the field in developing more outcome-based systems.

Currently, states are required to develop management information systems for child welfare that include outcome measures, particularly those related to permanency and safety – as measured by abuse and its reoccurrence and timely movement toward reunification or adoption.

Increasingly, states are exploring how to use these and other outcome measures to determine how they contract for services and monitor service performance. A few states have placed some portion of the child welfare service system under managed care-type contractual relationships. Others are examining how managed care tools and strategies can be incorporated into the way they manage their systems and contract with providers.

This report examines the state of the field in using outcomes as a management accountability tool – first in managed care generally and then for special populations, specifically the child welfare population. This includes both the use of outcomes in selecting providers and monitoring performance and in establishing specific payment systems based upon achieving results (“buying results, not services”).

The first section discusses the use of patient outcomes in the medical world and in managed care. The second section discusses the use of client outcomes in the child welfare world and when addressing special populations. The third section provides an assessment of the overall state of the field and suggests next steps within child welfare.

## **Managed Care and Outcomes in the Medical World**

*The operational dynamics of managed care entities and their connection to patient outcomes.* Most commonly, managed care entities have achieved their “economies” through concerted efforts to: reduce the use of high cost treatments; shorten lengths of stay within high-cost settings; aggressively negotiate with providers for discounts on their charges.

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These usually have not altered the general, fee-for-service system of reimbursement to providers, although they have altered what services (including scope, amount, and duration) will be purchased and the price that will be paid for them. Diagnostic related groups (DRGs) have provided case rates for specific presenting conditions, and other forms of case rates have been established, but these case rate systems are not tied to achieving specific patient outcomes.

Reductions in the use of high cost treatments and shortening lengths of stay most commonly have been achieved through pre-authorization and continuous review policies. Managed care entities employ protocols for different presenting conditions/diagnoses that establish expectations for care generally well below those in practice before managed care. In Iowa under the IA Plan (a private managed care contract to provide behavioral health and substance abuse treatment services for Medicaid recipients), for instance, the average length of stay for the inpatient psychiatric hospitalization for children was reduced from over twenty days to four-and-one-half days, although the payment system to hospitals for psychiatric inpatient care itself was not changed to a case rate or capitated payment. Alternatively, office visits for psychiatric services under the IA Plan are not subject to pre-authorization or continuous review (unless they exceed a large number per year) and cost is “controlled” through a payment structure that is well below market.

The pre-authorization and continuous review policies and protocols developed within managed care generally are based upon evidence (or lack of clear evidence to the contrary) that higher cost treatments or more extensive lengths of stay do not produce better outcomes.

There may be a common perception that the medical community operates based largely upon scientific evidence and proven clinical pathways for different medical conditions. In fact, however, in the medical (physical and behavioral health) world, there are wide variations in practice patterns, with patients with similar symptoms and diagnoses receiving different treatment regimens depending upon the individual clinical judgement of their health professional and with a lack of medical consensus on the most effective clinical pathway. Managed care entities, in essence, seek to employ the least costly (and usually least invasive) treatment in such instances, selecting the lowest cost clinical pathway as at least the treatment of first choice and the basis for protocol development. Managed care entities do not seek to employ ineffective treatments, but their emphasis is upon finding the lowest cost clinical pathway that will address the patient’s treatment need.

A managed care entity’s definition of satisfactory patient outcomes also is likely to be below what might be viewed by patients as optimal. Again, while there are some measures of patient outcomes – such as mortality rates, survival curves, post-operative morbidity (including iatrogenic, or treatment-produced illness), and subsequent medical care utilization for the same condition – that can be quantified with a fair degree of ease, “quality of life” and even “level of functioning” indicators are much more difficult to develop on a patient-by-patient basis.

*Resulting applications of outcome-based management within managed care.* Managed care entities do develop clinical pathways and treatment protocols that are based, to the extent evidence is available or can be gathered, on patient outcomes and treatment effectiveness (although these pathways are likely to be based upon minimal rather than optimal definitions of outcomes). This is one major way that managed care entities employ outcomes. Further, there is a good rationale that, in the absence of better information to the contrary, one should minimize the scope and duration of a treatment intervention, as invasive treatments involve some patient risk and some potential negative side effects.

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In addition, managed care entities may develop provider profiles that can help them select preferred providers. These profiles may, in part, be based upon patient outcome experiences. Hospitals with high post-operative morbidity or mortality rates for certain procedures, for instance, might be avoided. Similarly, higher cost hospitals which can demonstrate no clear advantage in terms of patient outcomes might be avoided. As with the development of clinical pathways, however, provider profiling based upon patient outcomes is in an early developmental stage.

Finally, managed care entities may have some outcome measures built into their management information systems to aid in developing outcome-based clinical pathways and protocols and assessing individual provider treatment effectiveness. These can include baseline information on the severity of condition at the time of intervention, as well as the post intervention results.

Managed care entities also often collect patient reports in terms of “consumer satisfaction” surveys, which represent a relatively low-cost additional check upon quality of care and treatment outcomes from a patient perspective. In some instances, contracts with managed care entities require such surveys and reports, as well as data tracking systems, as a means of accountability.

In summary, in the medical world, managed care entities have used outcomes to guide their contracting relationships with providers primarily in the following ways:

- ◆ developing treatment protocols for pre-authorization and continuous review
- ◆ provider profiling
- ◆ consumer satisfaction reports and surveys

Any of these approaches can be employed and developed independent of a managed care entity or contract. In fact, the Federal Agency for Health Care Policy and Research has devoted substantial attention and effort to medical treatment effectiveness research and developing researched-based and expert-consensus-based protocols for a variety of medical diagnoses. Among many other state efforts in this area, the Iowa Health Data Commission began with a goal of constructing a data system for medical providers that would have outcome measures. Paul Ellwood has emphasized the potential for using data systems from medical records and their patient outcomes as a population-based tool for determining the effectiveness of alternative treatments for similar conditions.

Generally, however, medical managed care has not developed “results-based” contracts with providers. Health care providers are not paid more when their patients “get better” or paid only if their treatment was successful. The medical world has not adopted a “purchasing results, not services” approach, recognizing that achieving positive results is not the result of the medical treatment alone, and that most medical treatments are not successful with every patient with the same presenting condition or diagnosis. The incentives provided to providers under managed care in the medical world generally have been to use less costly levels of care than would be the case under a provider-determined treatment regimen and not to improve patient results, let alone to “purchase results, not services.”

## **Managed Care and Outcomes Use in Child Welfare and with Other Special/Vulnerable Populations**

*Current studies in the field on managed care for special populations. The preceding*

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section discussed managed care and outcomes in the context of general medical care for the overall population. Several organizations or consortia of organizations have begun to examine the application of managed care to special needs populations, including children's behavior health and child welfare. Congress has recognized that managed care applied under Medicaid to special populations provides new challenges that may require the purchaser (government) to insist on additional protections. A provision in the 1997 Balanced Budget Act specifically required the United States Secretary of Health and Human Services to study and report to Congress concerning "safeguards, if any, that may be needed to ensure that the health care needs of individuals with special health and chronic conditions that are enrolled with Medicaid managed care organizations are adequately met."

The Center for Health Care Strategies (CHCS), among other organizations, has begun to examine the impact and applicability of managed care contracting, as it has been applied to a general patient population base for physical health services, and when it is applied to special or vulnerable populations, particularly those which are the public's responsibility to protect and serve.

Under the direction of the Medicaid Managed Care Stakeholders Project of CHCS, James Verdier of Mathematica Policy Research, Inc., produced a report, *Coordinating and Financing a Continuum of Services for Special Needs Populations in Medicaid Managed Care Programs* (2000).

The Verdier report examined state experiences in providing managed care to several specific "special needs" populations: behavioral health managed care programs for children and for adults, managed care programs for persons with physical disabilities and chronic illnesses, home and community-based waiver programs for persons with mental retardation and developmental disabilities and the elderly, and managed care programs for dual Medicaid and Medicare eligibles.

The report concluded that substantially more protections need to be built into managed care contracts to adequately serve these populations, with funding based upon capitation often problematic. Such "special needs" populations frequently have long-term and chronic health needs that are not easy to estimate based upon historical utilization, particularly for populations that have not received special attention under the fee-for-service system. The report concluded that:

- ◆ States should assume that managed care for special needs populations will in most cases not produce short-term savings and will require major design and implementation efforts;
- ◆ States should assure that needed resources for care coordination are available and appropriately funded; and
- ◆ States should recognize that many of the services provided to special needs populations have not previously been provided under managed care or FFS Medicaid, and may, therefore, require some special efforts to incorporate into managed care, especially non-medical services needed to achieve health objectives cost-effectively.

While this report did not discuss the use of client outcomes in service or MCO contracting relationships specifically, it emphasized the need to move forward very carefully in imposing traditional managed care utilization controls on special needs populations. It also indicated that subcontractual arrangements between the managed care entity and providers based

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upon capitated or case rates could be even more problematic than capitated relationships between the purchaser and the managed care entity.

The Health Care Reform Tracking Project (involving a consortia of the University of Southern Florida, the Human Service Collaborative, and Georgetown University) has produced a 1997-98 State Survey and a 1997 Impact Analysis report on state behavioral health managed care initiatives in its *Tracking State Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families* series. In general, the two reports found very few instances in which capitation payments to MCOs or BHOs were subcapitated for providers, with providers still mainly being reimbursed on a fee-for-service basis. While survey respondents pointed to the potential benefit of moving to subcapitation, they noted that providers serving the public sector populations typically are unaccustomed to risk-based contracting and do not have the financial resources to bear much risk. They emphasized the need for a "go slow" approach to capitating providers.

These reports also emphasized that the child welfare system had additional stakeholders, particularly the courts, who played a major role in decisions regarding placement and service, compounding the challenges of establishing rates for managed care entities based upon capitation or rates for providers based upon cases. They further found some evidence of cost-shifting from behavioral health to child welfare, particularly in providing "placement step-down services." Finally, they noted that some incentives to providers that might be offered under Medicaid to reduce placement duration had other potentially off-setting consequences. Specifically, federal IV-E funding for maintenance in foster placement could be lost, so the total federal funding available in reducing placement duration might be less, even though the amount available under Medicaid remained the same.

Explicitly with respect to outcomes, they found increased emphasis upon reporting on outcomes, including the use of consumer satisfaction surveys and the development of management information systems that could better track client encounter data and some functional assessment information. They found, however, little extension of this outcomes information to specific contractual incentives or performance-based payment structures.

The Health Care Reform Tracking Project also produced a special analysis from the 1997-8 state survey, *Child Welfare Managed Care Reform Initiatives*. This report categorized the twenty-five identified initiatives into four broad approaches: (1) a fairly comprehensive managed care approach (13 of 25 sites), (2) managed care for the provision of mental health services only (4 of 25 sites), (3) privatization (3 of 25 sites), and (4) multi-system initiatives (7 of 25 sites). The report found very broad differences across the sites, both in the approaches taken to managing care and the specific populations targeted for service.

The report concluded both with initial positive findings and initial concerns, based upon observations in one or more of the sites they examined. These represent potential benefits and possible negative aspects that should be considered in developing approaches:

- ◆ Initial positive findings that managed care reforms in child welfare can:
  - secure greater flexibility for child welfare system and opportunities to leverage child welfare funds in new ways
  - promote greater concern about accountability to the public and decision makers
  - increase attention to achieving more concrete outcomes for the child welfare system and the children and families they serve
  - promote a more efficient service delivery system and influence providers to

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- offer a greater array of home and community-based services
  - provide opportunities for child welfare agencies to work in partnership with a broader group of child-serving agencies, promoting a greater sense of shared responsibility among agencies to serve children and their families
  - increase access to services for children and families
  - may reduce the practice of relinquishing custody of children in order to obtain services
  - reduce reliance on out-of-home care
- ◆ Initial concerns about child welfare managed care initiatives include:
- insufficient tracking mechanisms to determine outcomes and possible cost shifting among child welfare and mental health agencies
  - insufficient family involvement in design planning and program implementation
  - concern that case rates may be too low
  - no special (higher) case rates for children with serious behavioral problems
  - loss of control in decision-making
  - changing role for child welfare staff – from service provider/manager to monitor
  - fear of accepting or sharing risk.

A subsequent draft report (“Special Analysis – Child Welfare” by Jan McCarthy and Carl Valentine) for the Tracking Project, based upon additional and more recent state reviews, found additional work and activity in the states to incorporate managed care technologies into child welfare systems. While most managed care entities operated within a full-risk environment through capitation, providers continued to be paid principally on a fee-for-service basis. Designing appropriate capitation levels continued to be a challenge within states. Dealing with extended care needs of children presented different challenges to utilization management systems traditionally used in managed care.

With respect to outcomes, the report concluded that “measurable systems for clinical and functional outcomes for children’s behavioral health” were at a very early stage of development, and these often were not connected to specific child welfare indicators.

The Child Welfare League of America’s Managed Care Institute coordinated its work with the Tracking Project and also has completed a report, based upon surveys of state and county efforts to implement managed care or privatization in child welfare, *CWLA Managed Care & Privatization Child Welfare Tracking Project: 1998 State and County Survey Results*.

The CWLA report found more risk-based contracting with providers in child welfare than in behavioral health. The report found this risk-based contracting more likely with nonprofit agencies than for-profit providers, with the most common arrangement a case rate, with risk adjustments to limit losses and profits. This may have been due to the relative power of the state in determining reimbursement systems for providers who essentially do not have other sources than the state for their clients.

Variability in the rates proposed for similar initiatives suggested how difficult it is to accurately price capitated or case rates in child welfare. The report found that case rates for similar populations and services in different states varied by more than \$1,200 per child per month. Some experiences have proved to be disastrous for service providers, and others have seemed to overcompensate them for their work.

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Public agencies also reported a range of quality assurance mechanisms and reporting requirement to ensure clients have access to needed care and contracts are accountable to achieving results consistent with legal mandates regarding safety and permanence. There has been some limited risk-sharing based upon achieving outcomes, usually in the form of financial bonuses or penalties linked to performance in key outcome areas, primarily related to system outcomes of permanency but sometimes tied to consumer satisfaction, as well.

CWLA found increasing experimentation and innovation in risk-based contracting and outcomes reporting and accountability, with both in early development stages and often developed on largely parallel paths. With respect to performance-based contracting, CWLA found that most incentives being provided were fairly small and more in the nature of bonuses than sanctions.

A Hennepin County, Minnesota, study of its hundred highest cost families showed that most of these families were involved in the deeper end of the child welfare system, although they incurred costs in other systems (TANF, other income support systems, juvenile justice, and mental health) as well. While a very small minority of all families, they consumed a great proportion of public costs and the coordination of their care across systems often was nearly non-existent. All had costs to the system in excess of \$200,000 over a five-year period, with many having costs in excess of \$1,000,000 over that period. The annual costs of these families, however, fluctuated dramatically over the years, with a great deal of uncertainty in predicting immediate future costs on the basis of prior year expenditures. This report provides real-life data that illustrates the challenge of establishing case rates on a small sample or individual basis.

Finally, the Annie E. Casey Foundation's Outcomes and Decision Making Project is developing a series of service protocols or pathways for families who come into contact with the child welfare system, in order to bring greater consistency to frontline practice, based upon field experience and research. These include protocols for families with: sexual abuse; physical neglect; failure to thrive; medical neglect; physical abuse; and the presence of domestic violence, as well as, abuse or neglect. These are further broken down into sub-categories, with assessment strategies and recommended pathways to follow for each. For instance, for physical abuse there are different protocols and pathways depending upon whether the physical abuse falls into three patterns: violence as a way of life; excessive discipline; or inability to cope.

*General Conclusions from Reports on State and County Activities.* Taken together, these reports and the research underway indicate the following:

- ◆ designing risk-bearing contracts, at either the MCO or provider level, within child welfare is more complicated than for many other populations, due to the following:
  - the contracts must deal with extended as well as acute care situations
  - other decision-makers outside the managed care entity's or provider's control, particularly the juvenile court, can determine placement and service cost
  - child welfare providers generally have less history with data-based management and have fewer outside resources to manage risk than medical providers
  - managing risk on a case rate basis is likely to require spreading that risk

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across large populations, but the child welfare population itself is relatively small, particularly when looking at specific sub-populations within that population or when individual providers are expected to assume that risk for the individuals they serve

- considerable cost-shifting is possible across systems, and financing systems for child welfare (e.g. IV-E) can run counter to efforts to develop case rates based upon reducing lengths of placement
- ◆ moving to outcome-based accountability within child welfare is in an early developmental stage, for the following reasons:
  - clinical pathways and protocols have not been developed and must take into account substantially more conditions (e.g. the family and home and neighborhood environment) than the child's condition/diagnosis alone
  - in the human service world, where trust and the relationship between provider and consumer are so critical to achieving results, clinical pathways and protocols alone may be insufficient to assess what constitutes an effective treatment strategy
  - management information systems do not provide the longitudinal and cohort data tracking capacity needed to begin using even the systems outcome information that currently exists in systems
  - moving beyond systems outcomes (re-occurrence of abuse, re-entry into care, recidivism, length of placement, time to permanency/adoption) to child well-being indicators requires substantial additional data collection efforts
  - child welfare staff in public agencies and service providers have limited experience in, or a mindset toward, outcome-based monitoring and accountability, particularly as it applies to case-specific monitoring.

## Summary

There is general consensus on the value in shifting to a more outcome-based focus and accountability structure in child welfare. There is also general agreement that managed care tools and strategies can assist in this development. Finally, there is general agreement that the current "state of the field" suggests that states proceed carefully in developing financing systems based upon outcomes.

In developing a more outcome-based system, however, it is important to start with a clear identification of the problems in the system before posing specific solutions. Many of these problems may stem from the absence of information in the system about children and families and their needs or clear experiences of successful practices with different populations – problems that need to be addressed prior to establishing provider contracting expectations with respect to results.

There are several parallel, but complementary, approaches to making greater use of

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outcomes in child welfare that all deserve further development:

1. *Developing data management systems that track, on a longitudinal and cohort basis, at least basic systems outcomes related to safety and permanency.* These data systems are essential to identifying outliers for further “red flag” reviews and defining specific population groups (children or families in the child welfare system with similar presenting conditions) around which there are wide variations in systems outcomes and therefore the need for service pathway development.
2. *Building service pathways and protocols.* Whether through pilot programs, drawing upon national evidence, or both, evidenced-based pathways and protocols for specific population groups need to be developed, much as work in the medical treatment effectiveness research field has developed.
3. *Developing provider profiling capacities related to measurable outcomes.* Since successful work is so dependent upon the ability of the provider to develop a trusting relationship with the child and family and then proceed with persistent and creative problem-solving, it is not simply service pathways or protocols that are likely to determine success. Instead, the capacity of the provider to make those connections, regardless of the specific treatment regimen adopted, is critical to success. It is important to determine which providers work best with which types of children and families.
4. *Testing the effectiveness of fiscal incentives in changing provider practice.* These are most likely to pertain to systems outcomes, particularly as these relate to reducing reliance upon high cost services and meeting permanency goals more quickly, where both fiscal benefits and client benefits are seen to be in reasonable alignment. They must be developed in ways in which providers are not exposed to greater risk than they can manage.
5. *Incorporating consumer perspectives in assessing treatment effectiveness.* Again, particularly in the human service world, the measure of success is always somewhat subjective, and consumer satisfaction surveys and intensive case review and monitoring processes can help gauge the impact of treatments on the client level.

In short, moving to outcome-based accountability does not necessarily mean dramatically altering provider contractual relationships nor changing the financing structure or incentives. That is only one possible tool. Moving to outcome-based accountability requires much more attention to clearly defining outcome objectives and determining what strategies can produce those outcome objectives with the highest probability of success.

Unless there is some clear understanding and evidenced-based experience of what can realistically be achieved, expecting the individual provider to produce at a high level of success in achieving results simply because fiscal incentives have been put into place is likely to be unrealistic, however desirable it might be.

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## **Appendix**

### **Results-Based Case Rates: A Case Illustration and Attendant Caveats**

To date, states and counties have taken very small steps in moving to a financing system for child welfare that would “purchase results, not services.” This is particularly true when getting beyond systems outcomes to measures related to child functioning and development.

At a conceptual level, the Iowa Department of Human Services is exploring a much bolder approach, which is referred to as “stratified” or “results-based base rates.”

The following represents the most detailed description of this approach, as applied to a representative case:

#### **Results-Based Case Rate Example**

Customer: 13 year-old, high risk, with history of:

- Multiple failed placements
- Post traumatic stress disorder
- Broken home
- Physical aggression and running behaviors
- At risk of psychiatric hospitalization
- Not engaged in school or treatment
- Grandparents are viable permanency plan

Case rate: \$35,000 annually based upon:

- historical practice: 24 hr. inpatient, residential treatment @\$45,000 per year
- best practice: rapid stabilization, intensive family support, counseling, educational support @ \$30,000

“Results-Based” Payments to Provider based upon achieving following:

- Stabilized and treatment engaged - \$ 5,000
- Continued, stable integration within home - \$ 15,000
- Education engaged - \$ 5,000
- Practicing safe and healthy behaviors - \$ 5,000

Clearly, this is an illustration rather than an actual case, but it is sufficiently detailed to provide a basis for discussion of the potential challenges to “buying results, not services” through a results-based case rate approach. Moreover, unless a results-based case rate is established for each individual served, it is sufficiently detailed to be representative of a group of cases for which a results-based case rate would be created. The following raises some fairly basic issues regarding such an approach.

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First, to implement such a system would require that one estimate the likelihood of success and incorporate that into the payment structure. As purchaser, the state probably would be very pleased if two-thirds of these outcomes were met for a group of children under this payment structure. If this is the expected success rate, however, the pricing for achieving these successes would need to be that corresponding percentage above the costs, as the provider is not paid for, but will still have incurred costs, for all the children under contract who do not achieve these results. In this instance, it would probably mean that the state would have to pay in excess of the \$45,000 it expends today on residential treatment for those children. As an empirical illustration, if two-thirds of youth succeed fully but one-third never could be placed outside the residential setting, the provider's expenses would be  $\$30,000 * 2/3 + \$45,000 * 1/3$  or \$45,000. The provider can recover that cost only for the two-thirds of children who succeed, however, would require a payment of  $\$45,000 / 2/3$  or \$60,000 per child for the provider to break even. If the state sets a potential payment level above current costs to account for this fact, however, providers are incited to spend more per child in some instances where that will achieve higher success. This would result in a more costly system than currently exists. While this may be desirable from an outcome perspective, is not the premise upon which this case example was based – which one of revenue neutrality.

Second, particularly when dealing with small numbers of cases, this approach is subject to substantial uncertainty for the provider. For nonprofit providers, this level of uncertainty and risk is likely to be great relative to potential benefits (particularly since, as nonprofit entities, providers are not motivated by the potential of making a profit and have no private paying clients from which to recoup uncovered costs).

Third, from a case perspective, the consequences of not succeeding likely are to revert back to a higher-level cost of care (e.g. \$45,000). Presumably, the provider would have to bear this cost, without any compensation. This adds to the level of risk described above.

Fourth, both establishing the specific results that trigger payments and constructing billing and payments structures to fairly provide those payments when they are achieved and not provide them when they are not is no small or costless task. It will require substantially more work than under current billing practices in a fee-for-service system. Further, it likely will invite substantially more negotiations and appeals of decisions based upon differences in interpretation between provider and payer.

Fifth, there likely are to be some "exceptional circumstances" that would require adjustments to this system, particularly because of the level of financial risk the provider bears. The grandmother becomes ill, needs surgery, and no longer can provide care. The youth is arrested for breaking and entering and the juvenile court orders a restrictive placement in a boot camp. The youth is diagnosed with a severe learning disability that requires special attention and disrupts the child's educational attendance and makes the educational outcomes irrelevant. If these are not taken as "exceptional circumstances," the expected success rates would need to be lowered substantially in calculating payment rates for results. If they are treated as "exceptional," criteria would need to be spelled out to treat them as "exceptional," including a negotiation process regarding them and an alternative payment mechanism defined.

Sixth, this illustration represents only one of many different presenting scenarios for which results-based case rates would have to be established. Developing a series of results-based case rates to cover the majority of children in the system would require some identification of the current service pathways for each sub-population (and their costs) and identification of a service pathway that could be expected to produce better results (and its costs). This work has yet to be completed and represents a major challenge, even apart

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from developing a financing system based upon it. If these pathways are developed, there also are alternatives to results-based case rates to reimburse providers for following those pathways and monitoring them to insure they do.

Seventh, there may be some trade-offs between different outcomes. It may be easier to achieve school attendance and educational development outcomes in a more controlled setting (e.g. group care), but the child's attachment to a permanent home will not be achieved. In addition to the technical tasks involved in establishing a results-based reimbursement methodology, value issues also must be addressed.

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These are a few of the issues that must be resolved in moving from a conceptual level to a practical application. Further, they must be resolved in a way that does not create a system so complex that the costs of managing it (from both the purchaser and provider perspectives) negate any possible benefits it might have.

Such "results-based case rates" go well beyond the case rates now in developmental use in child welfare. Case rates have proved to be difficult enough to develop, although, for case scenarios like the one here, they do offer fiscal incentives to providers to move toward the "best practices" service strategy, without the additional encumbrances and risks that pure "results-based contracting" bring.

As Iowa and other states explore moving from a conceptual to a practical level, it will be important to recognize that the goal is for better results for children within the context of finite resources – and "results-based case rates" represent only one possible strategy to achieve that end. It is important not to equate "results-based financing" with "results-based accountability."

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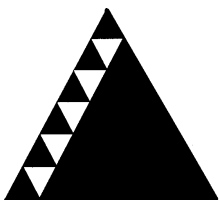
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National Center for Service Integration Clearinghouse  
Child and Family Policy Center  
218 Sixth Avenue, Suite 1021  
Des Moines, IA 50309-4006

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