

# **Effect of Health and Behavioral Health Managed Care for Child Welfare**

---

## **S U R V E Y R E P O R T**

Julie Collins

CHILD WELFARE LEAGUE OF AMERICA  
WASHINGTON, DC

The Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

© 2005 by the Child Welfare League of America, Inc. All rights reserved. Neither this publication nor any part may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, microfilming, and recording, or by any information storage and retrieval system, without permission in writing from the publisher. For information on this or other CWLA publications, contact the CWLA Publications Department at the address below.

CHILD WELFARE LEAGUE OF AMERICA, INC.  
HEADQUARTERS  
440 First Street, NW, Third Floor, Washington, DC 20001-2085  
E-mail: [books@cwla.org](mailto:books@cwla.org)

# C O N T E N T S

**Acknowledgments..... 4**

**Introduction..... 5**

## **PART 1:**

### **Perceptions About Physical and Behavioral Health Care Needs and the Effects of Managed Care**

**Behavioral Health Care Needs of the Child Welfare Population..... 9**

**Perceptions About Managed Care ..... 13**

**Education and Training ..... 22**

**Financing ..... 24**

**Effects of Managed Care Reforms on Access to Services ..... 26**

**Effects of Medicaid Managed Care Reforms on Services for Children  
in the Child Welfare System..... 29**

**Effects of Managed Care Reforms on Child Welfare Providers..... 32**

**Service and Interagency Coordination Resulting from Managed Care ..... 33**

**Link Between Child Welfare Initiatives and Behavioral  
Health Care Reforms..... 35**

## **PART 2:**

### **Summary and Conclusions**

**Summary..... 37**

**Conclusions ..... 42**

**References ..... 43**

## Acknowledgments

The Child Welfare League of America (CWLA) would like to express our appreciation to the Center for Health Care Strategies (CHCS), and in particular to Kamala Allan, CHCS Deputy Director, for their kind support of CWLA and our efforts to understand the effect of managed behavioral health care on the child welfare population.

We are grateful to the HCRTTP partners—Jan McCarthy, National Technical Assistance Center for Children’s Mental Health, Georgetown University’s Child Development Center; Beth Stroul, Management Training Innovations; Mary Armstrong, the Research and Training Center for Children’s Mental Health, University of South Florida; and Sheila Pires, Human Services Collaborative—for their ongoing coordination with us in tracking changes in children’s services and behavioral health managed care initiatives throughout the country. They and others of the project advisory board—Ronald Burd, Devereux Foundation; Fred Chaffee, Arizona’s Children Association; Rita Vandivort, formerly of the Office of Managed Care, Substance Abuse and Mental Health Services Administration; Susan Orr, Children’s Bureau; D. Richard Mauery, Center for Health Services Research and Policy; and Carlyse Giddins, Delaware Department of Services for Children, Youth and Their Families—helped shape the project. We also thank the state and local public agency staff who took the time to respond to the survey and answer “a few questions” (See Appendix B).<sup>1</sup> Without their support and cooperation, we would have no findings.

Special thanks go to Barbara Schmitt and Charlotte McCullough for their invaluable input to the survey and for making sure we had consistency with the original conceptualization of the project even though they had moved on from working at CWLA. Barbara was particularly helpful in getting the data system in place and fixing snags as I went along. Last but not least, special thanks go to Courtney Swartz, an intern with the Behavioral Health Division, and Tine Blanchette, Program Coordinator, both of whom helped with outreach efforts to the states to get the survey data submitted. Their persistent efforts yielded the data you see in this report.

—*Julie Collins*

---

<sup>1</sup> The states that indicated they had a managed care program were Arizona, California, Colorado, Connecticut, Delaware, Iowa, Maine, New Mexico, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, and Washington. The states that indicated they did not have a managed care program were Alabama, Kansas, Mississippi, North Carolina, New York, and Ohio.

# Introduction

## Background

CWLA is an association of approximately 900 public and nonprofit child welfare agencies. Since 1996, CWLA has conducted periodic surveys of the field to track and describe child welfare initiatives, identify emerging trends, and report changes in the management, financing, and contracting of child welfare and related services, with a focus on initiatives that incorporate tools and technologies common to managed care.

In 2000, CWLA was successful in obtaining a five-year grant from CHCS that enabled us to expand our efforts in three ways: (1) to broaden the scope of the survey to explore perceptions about the effect of managed behavioral health care on child welfare populations, (2) to publish and disseminate monographs that examine trends and issues in child welfare and public sector managed care plans as they relate to children in child welfare and their families, and (3) to collaborate more closely with two other related research projects partially funded by CHCS.<sup>2</sup> The funding allowed CWLA to forge a stronger partnership with the following two related projects:

The Health Care Reform Tracking Project (HCRTP), which was funded by the Substance Abuse and Mental Health Services Administration and the National Institute on Disability and Research, is a joint effort of the National Technical Assistance for Children's Mental Health at Georgetown University Child Development Center, the Research and Training Center for Children's Mental Health at the University of South Florida, and the Human Service Collaborative. For approximately 10 years, HCRTP has been studying the effect of public sector managed care reforms on children and adolescents with behavioral health (i.e., mental health and substance abuse) disorders and their families. The CHCS grant added a child welfare component to the five-year phase of the project's national state survey and the site visits. The Georgetown University Child Development Center took the lead on the child welfare component of the HCRTP activities.<sup>3</sup> Additional activities of HCRTP have been site visits; impact analysis reports of 18 states; the Promising Approaches Series, which is a series of thematic issue papers that highlights strategies; approaches and features in publicly funded managed care systems that promise effective service delivery for children with behavioral health treatment needs and their families, particularly for children with serious, complex disorders; and a consensus conference to develop a set of agreed-on recommendations for policy, practice, and research related to publicly financed center-managed care for children and adolescents with behavioral health disorders and their families. The following documents have resulted from the activities of the HCRTP: state survey reports by Stroul, Pires, and Armstrong (2001, 2004) and the impact analysis report by McCarthy and Valentine (2000).<sup>4</sup>

---

<sup>2</sup> The outcome of CWLA's activities are the first survey report (McCullough & Schmitt, 2003) and two monographs: *Highlights from the 2000–2001 CWLA Management, Finance, and Contracting Survey: Implications for Policy and Practice* by Julie Collins and *Financing and Contracting Practices in Child Welfare Initiatives and Medicaid Managed Care* by Charlotte McCullough, which can be found at <http://www.cwla.org/programs/bhd/mhpubs.htm>.

<sup>3</sup> Support for the child welfare component of the Tracking Project was provided by the David and Lucile Packard Foundation from 1996 to 1999. In 2000, CHCS in Princeton, New Jersey, began funding the child welfare component. Current support for the child welfare component comes through a cooperative agreement between the Child, Adolescent, and Family Branch of the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, and the Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services. This agreement provides funds to the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development to lead the child welfare component.

<sup>4</sup> The Promising Approaches Series is available online at [www.gucdc.georgetown.edu](http://www.gucdc.georgetown.edu), or it can be ordered from [deaconm@georgetown.edu](mailto:deaconm@georgetown.edu); 202/687-5000.

- George Washington University studied contracting practices in publicly funded managed care reforms that are co-located with a child welfare initiative that introduces financial risk and new methods of delivering services. The purpose of the study was to describe promising contracting strategies that support improved coordination of resources and services for children and families who are enrolled in both child welfare and managed care plans (Mauery, Collins, McCarthy, McCullough, & Pires, 2003).

CHCS's funding enabled all three national projects to enhance their collaborative children welfare-related survey work, to join forces in conducting field studies, and to coordinate publication and dissemination efforts. In 2000, HCRTTP and CWLA began coordinating their survey activities. The HCRTTP and the CWLA surveys included similar questions to assess respondents' views regarding the effects of health and behavioral health managed care on children and families served by the child welfare system.

The respondents in the surveys conducted by CWLA in 2000–2001 and 2003–2004 were state and county child welfare administrators, whereas the HCRTTP state survey respondents were directors of children's mental health services in all 50 states and the District of Columbia. This report compares findings from the HCRTTP 2003 state survey with findings from this CWLA survey.

This survey by CWLA on the effect of managed behavioral health care on child welfare is the last in the series of collaborative activities funded by CHCS. Because Medicaid is the primary funding source for many of the physical and behavioral health services children and families in the child welfare system receive, these children are directly affected by public sector managed care initiatives.

The recent Child and Family Services Reviews, which require the state child welfare agencies to demonstrate they are meeting the physical and mental health needs of all children in the child welfare system, whether they are in out-of-home care or are still at home with their parents, has highlighted the need to examine the effect of managed care on the states' ability to meet this requirement.<sup>5</sup> Research has shown that children and families served by the child welfare system often have behavioral health needs that are intensive and complex and that require the use of extensive behavioral health services (Burns et al., 2004; McCullough & Schmitt, 2003). To meet these needs, it is essential for states to establish linkages across the various child- and family-serving systems, especially the health and behavioral health care system, in their efforts to meet the federal requirements for ensuring the well-being indicators as well as the child safety and permanency ones.

## Method

CWLA revised and expanded the 2003–2004 survey instrument from the instrument used in the previous survey period. Staff made revisions based on the experience of the previous researchers with the last survey (2000–2001) and the difficulties that they encountered in the data collection and analysis processes. The previous researchers believed that one of the reasons they ran into difficulties obtaining responses from the child welfare administrators and designees was that the survey instrument was too difficult to use, resulting in problems collecting the data and analyzing information from it.

The current researcher consolidated the set of questions regarding the perceptions of child welfare respondents regarding how well managed care systems were working to meet the physical and behavioral health care needs of children and families in the child welfare system and used it as an addendum to the survey instrument. She did this to facilitate ease of completion, as findings from the last survey were that generally, a

---

<sup>5</sup> In March 2000, regulations went into effect for the Child and Family Services Review process, a new approach to federal oversight of state child welfare programs. Overseen by the Children's Bureau of the Administration for Children and Families, the review process consists of statewide self-assessments as well as an onsite review in every state, conducted by a team of federal, state, and peer reviewers. Information gathered through the review is used to examine the states' success in meeting the major goals of the child welfare system—child safety, permanence, and well-being. When states do not achieve "substantial conformity" with a required outcome, they then develop a Program Improvement Plan to describe the changes they will make to reach substantial conformity.

different responder was required for this set of questions. The researcher hoped that this would increase the response rate.

In addition, the researcher modified the questions related to the perception of child welfare respondents regarding how well managed care programs were meeting the physical and behavioral health care needs of children and families in the child welfare system, and she added others to facilitate comparison with the HCRTP survey questions. She hoped this would increase the ability to compare data regarding the differences and similarities in the perceptions of the CWLA child welfare respondents and the HCRTP mental health respondents. Unfortunately, some unintended consequences may have occurred. Despite trying to facilitate ease of completion of the survey instrument by separating out the questions regarding the perceptions of the effect of managed care for child welfare, the survey instrument ended up being longer than intended.

The researcher tried to send out the HCRTP and CWLA survey instruments around the same time to facilitate comparison of results and report writing. Unfortunately, they were not able to do so. The CWLA survey went out after the HCRTP survey due to resource limitations and changes in staff working on this project. The survey went out in July 2003 to the 50 state and county recipients of the 2000–2001 survey. Despite attempts at following up to obtain increased responses, only 8 states' responses were obtained. Due to this limited response, the researcher did not have enough data for interpretation. This lack of response seemed to be due to a number of factors that are worthy of note:

- At the time, state- and county-level child welfare administrations were experiencing significant cuts in their budgets. Resulting reductions in staffing took place, thereby significantly impeding their ability to have the resources to complete the survey.
- The federal government was no longer granting Title IV-E waivers, so states and counties were not initiating any new projects.
- Many of the initiatives reported in the previous survey had already ended, and others were also conducting research targeting the same group of initiatives. It is unclear exactly what the reasons were for the lack of response, but the combination of these factors seem to contribute to the overall lack of response.

In the spring and early summer of 2004, with the help of a volunteer and in agreement with CHCS, CWLA once again sent out the survey instrument. This time, the researcher only sent out the addendum. This was the set of questions related to the effect of managed care on the physical and behavioral health needs of the children in child welfare. With this reduced focus and limited set of questions, combined with more resource staff to focus on encouraging states to complete and submit their survey responses, the study had an improved response rate. The researcher targeted follow-up efforts to those states in which the HCRTP respondents indicated they had some type of managed care program.

Although the response to the 2003–2004 CWLA survey was less than in 2000–2001 overall, the response rate to the set of questions in the addendum was about the same as for the set of questions addressing the same area in 2000–2001 survey. Twenty-two states responded in 2003–2004, and the study had about this same rate of response for most of the questions in the 2000–2001 CWLA survey. Of the 21 respondents, 7 indicated that they did not have a managed care program in their state.<sup>6</sup>

This report includes an extensive discussion of findings, linked to findings from HCRTP's 2003 state survey of state children's mental health directors (Stroul et al., 2004) as well as findings from the 2000–2001 CWLA survey (McCullough & Schmitt, 2003) and the HCRTP previous state surveys (Stroul et al., 2001). Throughout this report, the researcher highlights and compares findings of broad trends from both reports with comparisons to the results of the last surveys. Caution should be taken in comparing findings, as all the states that responded to the HCRTP study did not respond to the 2003–2004 CWLA survey.

---

<sup>6</sup> See Footnote 1.

Regardless of the difficulties, the intersection between the two national surveys provides some interesting findings that the field can use to guide future planning and for coordination efforts of the state child welfare administrators as they struggle to meet the CFSRs' requirements for safety, permanence, and well-being.

## **How the Report Is Organized**

Part 1 contains information from responses to questions about the physical and behavioral health care needs of the children and families involved with the child welfare system and the perceived effects of managed care on them. The researchers compare responses from the child welfare administrators or their designees responding to the CWLA survey and the children's mental health directors responding to a similar set of questions in the HCRTTP 2003 state survey. The report highlights key findings.

Part 2 offers a commentary and summary of the findings and concludes with an identification of the key issues that would be beneficial to address through future research studies

# P A R T 1: PERCEPTIONS ABOUT PHYSICAL AND BEHAVIORAL HEALTH CARE NEEDS AND THE EFFECTS OF MANAGED CARE

## **Behavioral Health Care Needs of the Child Welfare Population**

This section summarizes findings from the 2003–2004 CWLA survey related to the perceptions of child welfare respondents regarding the health care needs of the child welfare population and the effect of managed care on them. It also provides discussion regarding the HCRTP 2003 state survey responses regarding the child welfare population. When helpful, it cites findings from previous CWLA and HCRTP surveys and impact analyses for comparison.

As was highlighted in the 2000–2001 CWLA survey report, children and families served by the children welfare system need intensive physical and behavioral health care services (McCullough & Schmitt, 2003, p. 71). More recent research (Burns et al., 2004) indicates that children involved with the child welfare system in out-of-home care continue to have high rates of emotional and behavioral problems. Nearly half (47%) of youth ages 2 to 14 with completed child welfare investigations had clinically significant emotional and behavioral health problems. Only one-quarter of the youth showing a mental health need in the clinical range received any specialty mental health care during the previous 12 months (Burns et al., 2004).

As mentioned previously, the CFSR process also highlights the needs of the children and families in the child welfare system for physical and behavioral health services to meet their safety and well-being outcomes. The continued, tightened time frames created by the changes in ASFA, along with the child welfare reforms taking place in individual states, make for a compelling reason for ensuring that the needed physical and behavioral health care services are available for this specialized population.

The results of the HCRTP 2003 state survey demonstrate increasing responsiveness by managed care programs to address the special needs of the child welfare population by having more services available that meet their needs (Stroul et al., 2004, p. 133). Unfortunately, the HCRTP 2003 state survey results of managed care systems covering the child welfare population indicate a decline from 91% in 2000 to 74% in 2003 (Stroul et al., 2004, p. 133). Nonetheless, 74% of the managed care programs continue to cover this population, so it is important to find out how these programs are doing and whether child welfare respondents believe they are meeting the needs for physical and behavioral health services of this vulnerable population of children and families.

### **Ability to Assess, Track, and Report the Mental Health Needs of Child Welfare Populations**

***Finding:** Few states continue to have the capacity to assess, track, and report the percentage of children and adolescents served by the child welfare system that have a serious and complex behavioral health need.*

The researcher asked respondents if they have the ability to assess, track, and report on the percentage of children and adolescents served by the child welfare system who have a serious and complex behavioral health need. Although these questions received a greater response rate than in the 2000–2001 CWLA survey, most child welfare respondents continue to not be able to assess, track, or report on these issues or to not know if they

can. Slightly fewer child welfare respondents reported they are able to assess, track, and report on the percentage of children served by the child welfare system with a serious and complex behavioral health need than were able in the 2000–2001 survey 33.3% vs. 36%; (McCullough & Schmitt, 2003, p. 72).

Also as with the 2000–2001 survey, only 4 (27%) of the child welfare respondents could estimate the percentage of children in the child welfare system with a *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994, 4th ed.; *DSM-IV*) diagnosis. Of those child welfare respondents who could estimate the percentage of children with a mental health diagnosis, they estimated the percentage ranged from a low of 27% to a high of 50%. Of these four respondents, only one reported that there was an increase in the prevalence of mental health problems among the child welfare population over the past five years. For the rest of the respondents to this question, 20% reported that the estimated number has remained the same, whereas the remaining 67% did not know the estimated percentage or did not answer.

In the 2000–2001 survey, child welfare respondents estimated the percentage of children with a *DSM-IV* diagnosis ranged from a low of 17% to a high of 60% (McCullough & Schmitt, 2003, p. 72). Given that so few respondents overall are able to assess, track, and report on the prevalence, it is hard to draw any real conclusions from the differences in the range from the 2000–2001 survey results to the 2003–2004 survey results.

The survey also asked child welfare respondents if they had the capacity to identify the mental or emotional disorders that are most common in the children they serve. Only 33% indicated that they could, 47% could not, and 20% did not know or did not answer. This was a new question, but the child welfare respondents' overall lack of ability to collect data shows a continuing trend for ongoing difficulties in assessing, tracking, and reporting on the mental health diagnosis of the children and adolescents they serve.

The researcher asked child welfare respondents if they were able to report on their ability to assess, track, and report on the substance abuse diagnosis for the children and adolescents in the child welfare system. It would appear the states had an even more difficult time assessing, tracking, and reporting on substance abuse diagnosis of the children and adolescents they serve. Only one state (7%) out of the 15 respondents reported that they were able to do this. The rest of the respondents either did not know or did not answer. The one state's respondent who indicated he or she was able to assess, track, and report indicated that approximately 14% of the children in the system had a substance abuse diagnosis. Three states (20%), although not able to assess, track, or report, estimated that over the past five years, the number of youth with a substance abuse diagnosis had increased, whereas the rest did not know or did not answer.

As with prior survey results, this survey shows that child welfare respondents continue to lack the ability to assess, track, and report on the mental health and substance abuse needs of the children in child welfare. This ongoing lack of data collection capability would appear to make it difficult for state child welfare systems to ensure the children they are involved with are receiving the services to meet their needs.

This is an area of concern, especially as each state struggles to meet the CFSR Well-Being Indicator regarding making sure that each child it is involved with has his or her mental health needs addressed. How can states know that they are meeting the need if they are not even able to track if the child has a diagnosis that requires referral for assessment or treatment? It also makes it very difficult for the child welfare system to be able to advocate for the services these children need and to work with managed care plans to make sure that specialized services are available for the population of children they serve. As the states move forward with implementing their Program Improvement Plans (PIPs) to address CFSR areas in which they did not meet the performance requirements and initiate planning for the upcoming second round of CFSRs, the ability to assess, track, and report will become even more important to facilitate meeting children's mental health needs. These data are crucial to assisting them in reaching out to the Medicaid managed care programs in their area or state to collaborate to ensure the state child welfare system is able to meet this performance requirement.

## Prevalence of Behavioral Health Problems in the Parents of Children in the Child Welfare System

**Finding:** *Slightly more than half the child welfare respondents (53%) were not able to assess the degree to which parental behavioral (mental health or substance abuse) problems are a primary reason for the initial referral or placement of children in out-of-home care. About a third were able to differentiate the needs or assess the prevalence of parental behavioral health problems and estimate the percentage of cases in which the primary reason for the referral or placement of children directly related to parental behavioral health problems.*

As reported in the previous CWLA survey report parental mental health and substance abuse problems are key risk factors for children to become involved in the child welfare system (McCullough & Schmitt, 2003, pp. 72–73). Despite this, very few states are able to assess and report on the prevalence of parental mental health or substance abuse problems as a reason for the initial referral. Only 33% of respondents said they could assess the degree to which parental mental health or substance abuse problems are a primary reason for the initial referral or placement of children in out-of-home care. Of the 15 respondents, 8 (53%) could not, and 2 (14%) said they did not know or left the question blank. The response rate to this question was also low in the 2000–2001 CWLA survey (32% reported that they could), pointing to the continued challenges the states have in this area (McCullough & Schmitt, 2003, pp. 72–73).

To better understand the specific behavioral health needs of the parents, the survey then asked respondents to estimate the percentage of referrals and placements of children in three separate areas: (1) parental mental health problems, (2) substance abuse problems, and (3) co-occurring mental health and substance abuse problems. Only one of the respondents could estimate the percentage of referrals and placements due to parental mental health problems (which he or she estimated at 30%), whereas three respondents (20%) could estimate the percentage of referrals and placements due to parental substance abuse problems, which ranged from 85% to 18%. Two of the respondents (20%) indicated that the prevalence of the primary referrals and placements for children because of co-occurring mental health and substance abuse problems ranged from 30% to 65%. Only one state could actually provide an estimate on the percentage of primary referrals and placements because of parental problems across all three areas.

These results again raise concerns about the states' ability to track what is going on with parents and to provide services and follow-up for both parents and children to address the effects of these issues. As with the previous survey results, these findings indicate states continue to be challenged regarding having effective data systems for planning, service delivery, and follow-up.

## Practice of Relinquishing Custody to Obtain Services

**Finding:** *Of the respondents, 67% acknowledged that parents relinquish custody of their child to obtain behavioral health services for them. Only 20% could indicate how often this practice was taking place. Slightly more than half (53%) of the states responding indicated that they do not see that the managed care programs have had any effect on this preexisting practice.*

A report addressing this practice highlighted the need for states to better track and report on it (*Child Welfare*, 2003). The report called on the child welfare and juvenile justice systems to improve coordination and more effectively address tracking and reporting. As had been reported in the 2000–2001 CWLA survey, states could report that the practice was taking place, but only one of the respondents could report how often it was taking place (McCullough & Schmitt, 2003, p. 74).

In the 2003–2004 survey responses, although the ability to report that the practice was happening increased, only three (20%) of the states could report how often it was taking place. Slightly more than half the states (53%) responding indicated that they believe that managed care programs have had no effect on the issue of parental relinquishment. Only 13% indicated that they believe that managed care programs have made this practice

worse, whereas 27% of the respondents indicated that they did not know what the effect of managed care was on this practice.

According to the HCRTP 2003 state survey report:

The findings for both 2000 and 2003 indicated that managed care systems have had no effect on the pre-existing practice of families having to relinquish custody in order to access behavioral health services for their children in most systems (83% in 2000, 81% in 2003). (Stroul et al., 2004, p. 143)

This percentage was much greater than what the child welfare respondents indicated (53%). As with the CWLA 2003–2004 survey results, the HCRTP 2003 state survey found that in only one or two systems has managed care reportedly made the practice of relinquishing custody to receive services worse (Stroul et al., 2004, p. 143). Although the HCRTP 2003 state survey respondents indicated that in a small percentage of the systems (13% in 2000, 16% in 2003), managed care reportedly has improved the practice of relinquishing custody to receive mental health services, no child welfare respondents reported that managed care made any improvements in this practice (Stroul et al., 2004, p. 143).

## Perceptions About Managed Care

The researchers continued to be interested in the child welfare respondents' perceptions of the effect of managed care programs on the children and families served by the child welfare system. They made some changes to the survey questions and deleted others that were no longer relevant.

**Finding:** *Most respondents indicated that managed care programs affect the provision of physical and behavioral health services to children in the child welfare system.*

To get a better understanding of the child welfare respondents' perceptions of the effect of managed care programs on the children in the child welfare system, the researchers asked if managed care programs affect the physical and behavioral health needs of the children in the child welfare system. Most respondents (73%) indicated that managed care programs provided physical health services as well as behavioral health services. Of the respondents, 27% indicated managed care programs did not affect the provision of physical health services, whereas only one state reported that the provision of behavioral health services was not affected, and three (20%) did not answer.

### The Effects of Managed Care on the Provision of Physical and Behavioral Health Care Services

**Finding:** *There was a mixed response by child welfare respondents as to whether the managed care programs made it more difficult or easier to obtain services.*

Slightly more respondents indicated it is easier versus more difficult to obtain physical health services while the respondents were equally split on whether it was easier or more difficult to obtain behavioral health services. If the respondent indicated that it was more difficult to obtain services for children, then they generally indicated this for both physical and behavioral health services. If they indicated that it was easier to obtain services, then it was generally easier for both the physical health and behavioral health services.

If the child welfare respondents indicated that the managed care programs affected the provision of services, then the survey asked them to indicate the effect: made it easier, made it more difficult, or had little effect for child welfare to obtain needed physical and behavioral health services for children. Of states that indicated that managed care did affect child welfare workers obtaining needed physical health services for the children, 40% indicated that the managed care plan made it easier, whereas 26.7% indicated that it made it more difficult. The respondents were equally split as to how the managed care program made it easier (33.3%) and more difficult (33.3%) to obtain behavioral health services. The survey received a limited response to this question, so is unclear what the driving force is that would make the provision of services easier or more difficult.

The results from the 2000–2001 survey were mixed as well, although it had a higher rate of response. In that survey, the respondents were asked about the effect on obtaining health care services. Slightly more respondents believed that the managed care program made it more difficult (33.3%) than easier (28.6%) to obtain services. In the 2000–2001 survey, 19% of respondents indicated that managed care had no effect on obtaining services, whereas in the 2003–2004 CWLA survey, no respondents indicated that there was no effect on obtaining physical or behavioral health services (McCullough & Schmitt, 2003, pp. 76–77).

### Prevalence of Children in the Child Welfare System in Managed Health Care Plans

**Finding:** *Most respondents (80%) indicated that the Medicaid managed care program includes Medicaid-eligible children and families served by child welfare agencies.*

The 2003–2004 CWLA survey asked child welfare respondents to indicate whether the Medicaid managed care program covered the Medicaid-eligible children and families served by child welfare agencies. This question varies somewhat from the question asked in the 2000–2001 survey, as it included families. The respondents to the new survey question indicated a higher percentage were covered—80% versus 61.8% in the 2000–2001

CWLA survey (McCullough & Schmitt, 2003, p. 77). This higher percentage might reflect the inclusion of families in the question. It is unclear why the differences existed, and it is not possible to draw any real conclusions about trends over time, as the previous survey question did not ask respondents if families were included. Also, it appears that the 61.8% in the 2000–2001 CWLA survey was only for physical health managed care programs, whereas the 2003–2004 CWLA survey was reporting on the physical and behavioral health programs, which might explain the difference (McCullough & Schmitt, 2003, p. 77).

The HCRTP 2003 state survey found that 74% of systems reportedly cover children served by the child welfare system. This represented a 17% decrease from the number of systems that reported covering the same group of children in the HCRTP 2000 state survey (Stroul et al., 2004, p. 133). Since 2000:

The field has reported a decline in coverage of Medicaid populations that can be expected to use more and costlier services, including children involved in the child welfare and juvenile justice systems and children eligible for Supplemental Security Income. This decline appears to be driven largely by decreases in the coverage of these populations of children by managed care systems with integrated designs; 80% of the carve outs cover children in the child welfare system, whereas only 38% of the integrated systems do so. (Stroul et al., 2004, p. 133)

This trend did not occur in the 2003–2004 CWLA survey as only two respondents indicated that their state had a behavioral health carve outs, and they did not respond to the question about whether the Medicaid managed care program covered the Medicaid-eligible children and families served by child welfare agencies.

It is interesting that 80% of child welfare respondents indicated that the Medicaid managed care program includes Medicaid-eligible children and families served by child welfare agencies, which is the same rate as indicated by the carve out programs.

## **Child Welfare Populations Included in Health Care Plans**

***Finding:*** Both the CWLA and HCRTP surveys found approximately the same percentage of managed care programs (66.7% and 66%, respectively) cover children in the child welfare system who are in state custody.

The researchers modified the question regarding the types of child welfare populations covered by managed care programs in the 2003–2004 CWLA survey in an attempt to be able to more accurately reflect the types of populations that are part of the child welfare system as well as to improve the ability to compare the responses between the CWLA and HCRTP respondents. Unfortunately, the CWLA respondents only provided this information for the physical and behavioral health Medicaid managed care programs. Three respondents did not answer the question, and of these, two indicated that their Medicaid managed care program was focused on behavioral health only.

Given that the question was modified from the CWLA 2000–2001 survey, it is hard to compare the current results with the previous survey. In 2000–2001, respondents indicated that about 60% of physical health managed care programs covered children in the child welfare system, whereas children in the child welfare system were covered by 51% of the managed behavioral health care plans (McCullough & Schmitt, 2003, pp. 77–78). In the 2003–2004 CWLA survey, respondents indicated that 66.7% of physical and behavioral health managed care programs covered children in the custody of the child welfare system, 66.7% covered children in child welfare who were not in state custody but were receiving voluntary services, 58% covered children and families identified as at risk but prior to formal involvement with the child welfare system, and 58% covered children who were part of child welfare who were also involved with the juvenile justice system (see Table 1). The researchers included an “other” category, and respondents indicated numerous other categories that are covered, such as:

- child or family must be Medicaid eligible,
- services are voluntary and child is in a residential facility,

- services are voluntary and child is involved with juvenile justice and child welfare when Medicaid eligible in a different category,
- child must be in custody only in nonpaid out-of-home care, or
- child is in child welfare in county custody.

**Table 1**

**Child Welfare Populations Included in Health Care Plans (n = 12)**

Subset of Child Welfare Population	n (%)
Children in child welfare who are in state custody	8 (66.7)
Children in child welfare who are not in state custody but receive voluntary services	8 (66.7)
Children and their families identified as at risk but only prior to formal involvement with the child welfare system	7 (58)
Children who are part of child welfare who are also involved with the juvenile justice system	7 (58)

HCRTTP also gathered additional information about the coverage of the subset of the children in the child welfare system who are in the custody of a child welfare agency. The results show that 66% of managed care plans cover them (Stroul et al., 2004, p. 133). This is almost exactly what the child welfare respondents indicated (66.7%).

It is of interest that the report found that in most of the managed care systems (90% of those covering children in state custody), enrollment of children in state custody is mandatory (Stroul et al., 2004, p. 133). In only 10% of the managed care plans, is enrollment of children in state custody voluntary rather than mandatory. In these systems, the child welfare agency may choose to keep children in state custody outside the public managed care system when workers believe or at least fear that the managed care system cannot meet the unique needs of children in custody. For these children, behavioral health services are frequently offered through a fee-for-service arrangement (Stroul et al., 2004, p. 133).

The CWLA survey did not address the issue of enrollment and so it is not possible to compare the findings from HCRTTP or to address trends over time. Despite the reported decline in the numbers of managed care programs that cover the child welfare population as reported by the HCRTTP 2003 state survey, the child welfare workers and their mental health counterparts appear to be in agreement on the percentage of programs that cover child in the child welfare system that are in state custody.

**Child Welfare Populations Excluded from the Health Care Plans**

**Finding:** *As reported in the previous surveys, both the 2003–2004 CWLA survey and the HCRTTP 2003 state survey respondents continue to see a trend toward placement type affecting coverage by the managed care programs.*

Most child welfare respondents (74%) reported that certain placement types would affect coverage in the managed care program. This is a significant increase over what was reported in the 2000–2001 survey results (43%; McCullough & Schmitt, 2003, p. 80). It would appear this practice of restricting eligibility based on placement is increasing. The types of placement that the child welfare respondents indicated will typically make children ineligible for services from the managed care program are detention or incarceration, out-of-county or out-of-state placement, and paid out-of-home care, which includes foster care or therapeutic care. In addition, one state indicated that a child would lose coverage if he or she was placed in a residential facility, and one state

indicated the child would lose eligibility if he or she entered a state hospital. The list of types of placements varies from the previous survey results somewhat (McCullough & Schmitt, 2003, p. 80).

As indicated in the HCRTTP 2003 state survey report, respondents in the 2000 and 2003 state surveys indicated that approximately three-quarters of the managed care systems (73% in 2000, 79% in 2003) indicated that some placements result in loss of access to services through the managed care system (Stroul et al., 2004, p. 134). This is roughly the same percentage as child welfare respondents reported. The HCRTTP 2003 state survey reported that the types of placements that typically make children ineligible for services are detention, incarceration, and placement in state-operated facilities. Ten percent of the systems responded that children are ineligible for the managed care system if they are in residential treatment facilities, and one state indicated that when a child enters foster care, he or she loses eligibility for managed care (Stroul et al., 2004, p. 134). Two states described geographic reasons for losing eligibility, such as if a child moves to an area of the state not covered by a managed care plan. One state identified private institutions that use seclusion and restraint and nursing homes as placements that cause children to lose eligibility for managed care (Stroul et al., 2004, p. 134). This list varies somewhat from what child welfare respondents reported, as indicated in the previous paragraph.

Although the placement types might vary, this specific practice raises concerns that children in the child welfare system will experience disruptions in coverage based on the type of placement they are moved to. This practice makes it very difficult for child welfare agencies to maintain consistency of service delivery and providers as well as to ensure that the child's needs are met. Strategies such as this lead to further disruptions and potential trauma for these children, when they have already experienced trauma resulting from child abuse or neglect. This practice and the subsequent implications demonstrate the need for better policies and practices that would minimize these disruptions and enhance service delivery for this vulnerable population of children.

## Services for Family Members

***Finding:*** *More than half of child welfare respondents (60%) report that if only the child is eligible, managed care programs will not cover behavioral health services for families. This is a significant increase in lack of coverage over what was reported in the 2000–2001 survey (37.5%; McCullough & Schmitt, 2003, p. 81).*

Although results from the previous 2000–2001 CWLA survey indicated that for 37.5% of managed care programs (McCullough & Schmitt, 2003, p. 81), family members would not have their behavioral health services covered if only the child was eligible, the 2003–2004 CWLA survey findings indicate that the gap is increasing. The respondents to the new survey indicated that in 60% of managed care programs, family members would not have their behavioral health services covered if only the child was eligible. This apparent increase is very concerning. To successfully return children to their families and avoid reentry into child welfare, it is imperative that family members obtain services for their behavioral health needs. This has two potential consequences: The child might be potentially returned to an unstable living situation, or the family's ability to be reunified might be negatively affected. Although the child welfare respondents indicated that for 33.3% of managed care programs, family members would have their behavioral health services covered, this still raises concerns for the rest of the children whose families are not covered.

As was reported in 2000, the findings from the HCRTTP 2003 state survey indicated that about half of managed care programs pay for services to family members, even if only the identified child is covered (Stroul et al., 2004, p. 142). This is higher than the 33.3% reported by their child welfare counterparts.

The 2003–2004 CWLA survey asked child welfare respondents which agency was primarily responsible for and had the funding to provide behavioral health services to parents of children in child welfare. The respondents indicated that the most common agency to have the behavioral health dollars for services to parents was the public mental health system (67%). The other systems that had funding were the public substance abuse system (47%), the public child welfare system (40%), the Medicaid managed behavioral health contractor (40%), other systems (33%), the private contractor under the child welfare initiative (13%), and the Medicaid managed physical health contractor (13%). Only one respondent indicated he or she did not know (see Table 2).

**Table 2**

**Agency Primarily Responsible for Providing Services to Parents (n = 15)**

Agency	n (%)
Public mental health system	10 (67)
Public substance abuse system	7 (47)
Public welfare system	6 (40)
Medicaid managed behavioral health contractor	6 (40)
Other systems	5 (33)
Private contractor under the child welfare initiative	2 (13)
Medicaid managed physical health contractor	2 (13)
Don't know	1 (6.7)

**Involvement of Child Welfare Stakeholders in Planning, Implementing and Refining Managed Care Reforms**

**Finding:** *The child welfare respondents reported a greater level of involvement in the planning, implementing, and refining of the Medicaid managed care programs than did their mental health counterparts. Half of the state child welfare respondents reported significant involvement in the planning, implementing, and refining of the Medicaid managed care programs compared with the 21% reported by their mental health counterparts.*

The researcher tried to make the question consistent for both sets of survey respondents and did not break out the differences between the physical health managed care programs and the behavioral health managed care programs as in the previous child welfare survey. This question was not answered by states that indicated the managed care program had only a behavioral health focus. To get a better understanding of the areas in which the child welfare stakeholders were more involved, the survey question required the respondents to indicate the level of involvement for the planning, implementing, and refining. Of the child welfare respondents, 67% reported the same level of involvement across all three phases. If there was any variation in involvement across the three phases, it was in the implementation phase, but there were too few responses to make it possible to draw conclusions about the variation. Half (50%) of the child welfare respondents report a significant level of involvement across all three phases: planning, implementing, and refining of Medicaid managed care programs. This is an increase from what they reported in the prior survey, in which the rate of significant involvement was only 14.3% for the physical health managed care programs and 25% for the behavioral health programs.

The results from the HCRTTP 2003 state survey show an actual decrease in the reported level of involvement. Although respondents reported a significant level of involvement of 46% in the planning, implementing, and refining of the behavioral health managed care systems in 2000, they only reported 21% in 2003. The most common level of involvement was “some involvement,” which was up slightly to 50% from what was reported in 2000 (43%). There was also a reported increase in the level of no involvement from 11% in 2000 to 29% in 2003 (Stroul et al., 2004, p. 134; see Table 3). It is unclear why the mental health respondents would report decreasing levels of involvement of child welfare stakeholders, whereas child welfare respondents reported increasing levels of involvement.

**Table 3**

**Rate of Involvement of Child Welfare Stakeholders in the Refining, Planning, and Implementing of Managed Care Reforms—Child Welfare League of America (n = 12)**

<i>Rate of Involvement</i>	<i>Significant</i>	<i>Some</i>	<i>None</i>
	<i>n (%)</i>	<i>n (%)</i>	<i>n (%)</i>
Planning	6 (67)	3 (25)	3 (25)
Implementing	6 (67)	2 (17)	4 (33)
Refining	6 (67)	4 (33)	2 (17)

The HCRTTP 2003 state survey report suggested that the decrease that was being reported in their survey:

. . . could be the result of fewer managed care systems covering children in the child welfare system; however, it also might be related to the greater maturity of managed care systems, an acceptance of managed care as “business as usual,” familiarity with how it works, and less concern about molding, crafting, and changing the system. (Stroul et al., 2004, p. 134)

Although this might be true, it does not necessarily explain the apparent increased involvement being reported by the child welfare respondents to the CWLA 2003–2004 survey (see Table 4).

**Table 4**

**Child Welfare Stakeholder Involvement in Planning, Refining, and Implementing (in percentages)--Health Care Reform Tracking Project**

<i>Survey</i>	<i>None</i>	<i>Some</i>	<i>Significant</i>
1997–1998 State Survey	7	56	37
2000 State Survey	11	43	46
2003 State Survey	29	50	21

Note: Adapted from Stroul et al. (2004, p. 134).

**Discrete Planning for Children in the Child Welfare System**

**Finding:** *The CWLA and HCRTTP respondents differ in their perception of whether managed care programs have a discrete planning process for the child welfare population. Only 33.3% of the child welfare respondents report a discrete planning process for child welfare, whereas 47% of HCRTTP respondents reported that it takes place.*

The child welfare respondents reported an increasing trend in managed care programs toward not having a discreet planning process is supported by their mental health counterparts, who reported an increasing trend for more managed care programs to not have a discreet planning process for the child welfare population.

In the 2003–2004 survey, 53.3% of child welfare respondents reported that generally no discrete planning process existed for children in the child welfare system, compared with fewer than half of the respondents in 2000–2001 (McCullough & Schmitt, 2003, p. 83). This appears to be a small increase in perceived lack of discrete planning across the survey years. On the other hand, the HCRTTP 2003 state survey found 25% fewer systems reporting that they are engaged in a discrete planning process for children in the child welfare system. Although the planning process had actually increased between 1997–1998 and 2000, the percentage of managed care systems with a discrete planning process dropped to 47% in 2003 (Stroul et al., 2004, p. 134). This level is almost equal to the 1997–1998 level, in which 48% of systems reported discrete planning for the child welfare population (Stroul et al., 2004, p. 134). This 47% reported in 2003 is still considerably higher than the 33.3% of managed care programs with a discreet planning process for children in the child welfare system reported by the

child welfare respondents. The child welfare respondents still perceive there to be a much lower percentage of managed care programs with a discreet planning process in place than what the Medicaid managed care programs report. It is unclear why this perceived difference would exist, and it is important to look at what is driving it.

## Special Provisions for Children in the Child Welfare System

**Finding:** Both the CWLA and HCRTTP surveys asked questions about the inclusion of special provisions for children in the child welfare system. Although both survey results indicate that states continue to report the inclusion of special provisions, the percentage of managed care programs that are including them are less in the HCRTTP results, whereas there appears to have been a perceived increase by the child welfare respondents. Despite this perceived difference, the results from the 2003–2004 CWLA survey are more in keeping with the findings from the HCRTTP 2003 state survey.

In the 2003–2004 CWLA survey, child welfare respondents generally reported increases in special provisions by the managed care programs for children who had serious and complex needs and who were part of the child welfare system (see Table 5). This is in contrast to the findings from the mental health respondents, who reported that although most managed care systems incorporate special provisions for children and adolescents in the child welfare system, the percentage actually dropped from 87% in 2000 to 63% in 2003 (Stroul et al., 2004, p. 134; see Table 6). The special provisions reported most frequently for children in the child welfare system by both surveys (see Tables 5 and 6) were interagency treatment and service planning, intensive case management, expanded service arrays, and the wraparound process. Only 33% of both sets of respondents reported offering family support services for families involved in the child welfare system. Also, only 15% of respondents to the HCRTTP 2003 state survey and 13.3% of CWLA 2003–2004 respondents identified higher capitation or case rates as a special provision (Stroul et al., 2004, p. 135).

**Table 5**

### Percentage of Systems with Special Provisions for Children in Child Welfare by CWLA Respondents (in percentages)

<i>Special Provision</i>	<i>2000–2001</i>	<i>2003–2004</i>
Interagency treatment/service planning	31.3	60
Intensive case management	43.8	53.3
Expanded service array	25	40
Therapeutic foster care	Not asked	40
Wraparound process	37.5	33.3
Family support services	12.5	33.3
Higher capitation or case rate	25	13.3
Flexible service dollars	Not asked	20
Catastrophic cap	Not asked	Only one respondent
Risk adjustment	Not asked	Only one respondent

Note: The 2000–2001 data are from McCullough & Schmitt (2003, p. 85).

In the HCRTTP survey findings, although managed care programs might be providing special provisions, the rate at which they provide them has decreased except for higher capitation or case rates, which increased from 11% in 2000 to 15% in 2003 (Stroul et al., 2004, p. 135; see Table 6). On the other hand, the CWLA survey findings indicate overall increases in the percentages of systems that are providing special provisions (see Table 5). The only decreases are in the area of higher capitation or case rates (37.5% in 2000–2001 to 33.3% in

2003–2004) and wraparound (25% in 2000–2001 to 13.3% in 2003–2004; McCullough & Schmitt, 2003, p. 85). Only one child welfare respondent reported that there were no special provisions included for children in the child welfare system with serious and complex behavioral health needs.

**Table 6**

**Percentage of Systems with Special Provisions for Children in Child Welfare by Health Care Reform Tracking Project Respondents (in percentages)**

Special Provision	2000	2003
Interagency treatment/service planning	67	51
Intensive case management	53	51
Expanded service array	63	46
Wraparound process	57	46
Family support services	43	33
Higher capitation or case rate	11	15
Flexible service dollars	Not asked	26
Other	11	5

Note: The 2000 data are from McCullough & Schmitt (2003, p. 85); the 2003 data are from Stroul et al. (2004, p. 135).

Family support services was the only area in which both sets of respondents reported the same rate (33%) of managed care systems providing this special provision. This was actually a decrease for the HCRTP 2000 survey (43%) and an increase from the CWLA 2000–2001 survey (12.5%; McCullough & Schmitt, 2003, p. 85; Stroul et al., 2004, p. 135). If the managed care programs are going to be able to support the number of families with children who have specialized needs, this rate of inclusion seems low. New this year was the service category of flexible service dollars. A small percentage of respondents reported inclusion of this special provision. The HCRTP respondents reported higher rates of inclusion than their child welfare counterparts (26% vs. 20%; Stroul et al., 2004, p. 135).

The overall findings still raise concerns as to how the managed care programs will be able to meet the specialized needs of this vulnerable population of children and families. It is critical for these special provisions to be made available for these children to be served successfully in their communities. Although it is encouraging that child welfare respondents see an increase in what was reported in the previous survey findings, it is still of concern that the HCRTP survey respondents report significant decreases in the inclusion of these services. This will make it more difficult for children and families to be successful and for the child welfare system to be able to meet the CFSR performance requirement regarding the well-being indicator for addressing the physical and mental health needs of the children they are involved with. In addition, it is unclear why the CWLA findings show an increase, but it would appear that at least the findings are more in keeping with what was reported by the managed care system in the HCRTP 2003 state survey.

**Mental Health Screening for Children Entering Child Welfare Custody**

Both surveys asked a number of questions regarding mental health screening. The researcher asked child welfare respondents whether the Medicaid managed care program is responsible for screening children in the child welfare system who enter custody to identify mental health problems and treatment needs. Of the child welfare respondents, 33% responded yes. The HCRTP 2003 state survey explored the same question, and almost half of the systems (43%) reported that they are responsible for screening these children (Stroul et al., 2004, p. 135). It is unclear why the child welfare respondents would indicate that only 33% of the managed care programs are responsible for the screening, but perhaps this is an indication that they are not aware of this requirement.

The surveys asked how often children actually received mental health screenings. The child welfare respondents reported that only 40% of the time do most children obtain a mental health screening in the managed care programs that are responsible for the mental health screening. The HCRTP 2003 state survey indicated that the mental health screening takes place for most of the children 77% of the time (Stroul et al., 2004, p. 136). In addition, the child welfare respondents reported that 27% of the time, some children are screened, whereas the HCRTP 2003 state survey reported 15% (Stroul et al., 2004, p. 136). None of the child welfare respondents reported that few children are screened, whereas HCRTP found that few children are screened 8% of the time (Stroul et al., 2004, p. 136). None of the managed care systems in the HCRTP 2003 state survey indicated that no children entering custody are screened (Stroul et al., 2004, p. 136). Child welfare participants did not respond to this category in the 2003–2004 CWLA survey. Due to the low response rate by the child welfare respondents to this question, it is difficult to draw any meaningful conclusions. As has often been the case in responses to previous survey questions, the mental health respondents perceive a higher percentage of screenings taking place by the managed care systems than child welfare respondents perceived. This is an important area to examine further, as screening for mental health issues for children is important so that the child welfare system is able to meet CFSR requirements for it.

## Education and Training

In the 2003–2004 CWLA survey, child welfare respondents reported that only 33.3% of Medicaid managed care programs provided education and training about the goals and operation of the managed care program to the child welfare staff. Only 26.7% of the child welfare respondents reported that child welfare staff provided education and training to the managed care organization (MCO) about the needs of the child welfare population. These percentages appear to be significantly lower than those reported in the 2000–2001 CWLA survey. The previous survey showed that 43% of managed care programs provided education and training on managed care operations, whereas 68% of the child welfare respondents provided training to MCOs on the needs of the child welfare population (McCullough & Schmitt, 2003, p. 85; see Table 7). This reported potential trend of less education and training is of concern as it leads to potential miscommunication, children’s and families’ needs not being understood, the special types of services that they need not being available, problems with access and payment, and lack of knowledge about what services are available and any limits on them, to name a few.

**Table 7**

**Education and Training on Managed Care Provided to Child-Serving System by Child Welfare League of America Respondents (in percentages)**

<i>Medicaid Managed Care System</i>	<i>2000–2001 Survey (n = 16)</i>	<i>2003–2004 Survey (n = 15)</i>
Provided education and training about the goals and operation of the managed care system to child welfare staff	43.8	33.3
Provided education and training to the managed care organization on the needs of the child welfare population	68.8	26.7

The HCRTP 2003 state survey found that education and training about the goals and operations of the managed care system reportedly are being provided for the child welfare system in a higher percentage of the systems (61%; Stroul et al., 2004, p. 136). The HCRTP survey also found a decrease in education and training of child welfare and other key stakeholders on the goals and operations of managed care systems from 2000. Less education and training seems to have occurred since 2000 with respect to almost all stakeholder groups (Stroul et al., 2004, p. 136). Table 8 demonstrates this.

**Table 8**

**Percentage Receiving Education and Training on Managed Care Provided to Child-Serving Systems by Health Care Reform Tracking Project Respondents (in percentages)**

<i>Child-Serving System</i>	<i>1997–1998</i>	<i>2000</i>	<i>2003</i>
Child welfare	67	72	61
Juvenile justice	Not asked	63	58
Other child-serving group	64	72	45

As noted in the HCRTTP report, “decreased education and training on managed care may be related to the fact that most managed care systems are no longer in early implementation stages, and that child-serving systems have greater familiarity with their goals and operation” (Stroul et al., 2004, p. 136). Although this might be true, other factors might well be at play here.

Unlike the 2003–2004 CWLA survey findings, the HCRTTP 2003 state survey found that:

There has been a slight increase in training and education provided to MCOs in order to increase their knowledge base related to serving children and adolescents in the child welfare system (a 5% increase from 52% of the systems in 2000 to 57% of the systems in 2003). This is consistent with an increase in training for MCOs regarding other populations of children served. However, training about other populations reportedly increased more significantly. For example, training about children with serious emotional disorders increased by 16% to 71% of the systems, and training related to youth in the juvenile justice system increased by 15% to 51% of the systems. (Stroul et al., 2004, p. 137)

# Financing

As in the previous surveys, both CWLA and the HCRTTP partners included a set of questions that addressed the funding of the managed care programs and whether cost shifting is taking place between child-serving systems and managed care.

## Funding Sources

The HCRTTP 2003 state survey has consistently found that over time, the child welfare agencies contribute financing to a relatively small proportion of managed care systems. According to the survey results, “the percentage of managed care systems that include child welfare funds increased slightly from 21% in 2000 to 29% in 2003. This is still less than the proportion of systems (32%) that included child welfare funds in 1997–1998” (Stroul et al., 2004, p. 138).

The 2000–2001 CWLA survey results indicated that 25% of child welfare systems contribute money to the managed care program (McCullough & Schmitt, 2003, p. 86). The result in the 2003–2004 survey indicates a decrease—only 7% of the child welfare systems contributed dollars to the managed care programs. It is unclear why such a significant decrease occurred since the last reporting period and why such a significant discrepancy exists between the results reported in the HCRTTP report and those reported by child welfare respondents. This raises questions as to whether this is just a data issue or one of lack of knowledge of exactly what the child welfare system contributes to and pays for.

## Access to Medicaid Funds Outside the Managed Care Program

The 2003–2004 CWLA survey found that in 73% of managed care programs, child welfare is able to access and use Medicaid funds for behavioral health services that are outside the Medicaid managed care program. This is higher than the approximately 50% reported in the previous CWLA survey (McCullough & Schmitt, 2003, p. 87) and consistent with the 72% reported by the HCRTTP 2003 state survey and in 2000 (Stroul et al., 2004, p. 138).

Although the child welfare system contributes some dollars to the Medicaid managed care system, it has Medicaid funds available in its own system to draw on as needed to meet behavioral health treatment needs beyond what is provided through the managed care programs. The child welfare system generally will use the Medicaid funds under its control and other resources to provide services to meet the needs of children that fall outside the managed care program. This practice has the potential to contribute to cost shifting, confusion about who should pay for what, and fragmentation of service delivery for children and families. Although it is nice for the child welfare system to have access to additional resources to meet the needs of the children and families it is serving, this does potentially create other problems. On the other hand, given the identified trend of a decrease in the special provisions for children with specialized needs, it is a potential safety net for the child welfare system to have the option to access Medicaid dollars outside of the Medicaid managed care programs to facilitate ensuring this vulnerable group of children gets their treatment needs met.

## Cost Shifting

The 2003–2004 CWLA survey showed an increase in the child welfare respondents’ ability to track whether cost shifting is taking place between child welfare and the Medicaid managed care program. Forty percent reported that they are able to track whether cost shifting is taking place. This is an increase from the 19% reported in the last CWLA survey (McCullough & Schmitt, 2003, p. 87). The rest of the respondents either were not able to track cost shifting (33%) or did not respond (27%; see Table 9).

**Table 9**

**Ability to Track Cost Shifting**

	<i>Child Welfare League of America Survey</i>		<i>Health Care Reform Tracking Project Survey</i>	
	2000-2001	2003-2004	2000	2003
Percentage able to track cost shifting	19	40	16	11

Although CWLA respondents reported a perceived increase in their ability to track cost shifting, HCRTTP found a decrease in the percentage of managed care systems that actually track or monitor cost shifting among child-serving agencies from 16% in 2000 to only 11% in 2003 (Stroul et al., 2004, p. 139).

Perceptions about the direction of cost shifting remained almost consistent for HCRTTP between the 2000 and 2003 survey findings (see Table 9). Cost shifting is perceived by mental health respondents to flow both ways—from the managed care system to other child-serving systems (36% in 2000, 38% in 2003) and from other child-serving systems into managed care systems (43% in 2000, 44% in 2003; Stroul et al., 2004, p. 139).

Findings from the 2003–2004 CWLA survey are mixed, and it is unclear how child welfare respondents view the direction of the cost shifting taking place. Of the 40% who indicated that they have mechanisms in place to track whether cost shifting is taking place, 26% reported that they did not believe that cost shifting was taking place whereas 13% believed that cost shifting was taking place from the managed care program to the child welfare system. Only one respondent believed that cost shifting was taking place from the child welfare system to the managed care program. In the 2000–2001 survey, child welfare respondents indicated that they were more likely to believe that managed care leads to a shift of costs to the child welfare system (McCullough & Schmitt, 2003, p. 88). Given the small number of respondents who actually had mechanisms in place to track whether cost shifting was taking place, it is unclear if these results are really a trend toward no cost shifting, if they are a data problem, or if this is a function of not getting enough responses.

As with the last survey results, mental health respondents tend to believe that cost shifting is taking place more from the child-serving systems to managed care than vice versa, whereas child welfare respondents perceive that cost shifting is taking place generally from the managed care system to the child welfare system.

## Effects of Managed Care Reforms on Access to Services

As with the last survey, both CWLA and HCRTTP asked a number of questions to assess the effect of the managed care reforms on access to behavioral health care services, including acute and extended care services as well as other services that affect the child welfare population.

### Access to Behavioral Health Care Services Since Managed Care

In 2000–2001, only a small percentage of respondents (12.4%) indicated that they felt that initial access to basic behavioral health care services was better in comparison to before managed care, whereas almost half (43.8%) of the child welfare respondents indicated that they did not know whether the initial access was better or worse compared to before managed care. Of respondents, 25% indicated that access was worse. The rest of the respondents (18.8%) did not answer (McCullough & Schmitt, 2003, p. 90). In the current survey results, child welfare respondents were equally split in terms of whether initial access to basic behavioral health care services is easier (26.7%), had not change (26.7%), or they did not know (26.7%). There was a slight decline in the percentage of respondents who reported that it made it worse (20% vs. 25% in 2000–2001). This seems to indicate a potential level of improvement in initial access to the basic behavioral health care services for the child welfare populations than before managed care.

Unfortunately, this is not the case for access to extended behavioral health care services (care beyond short-term stabilization). In the 2000–2001 survey, 25% of child welfare respondents reported access to extended care services to be worse. No one reported access to be better, and 18% reported no change, whereas 37.5% did not know and 18.8% did not answer (McCullough & Schmitt, 2003, p. 90; see Table 10). The current survey results seem to indicate that access to extended care services for the child welfare populations compared to pre-managed care seems to be getting worse (40%). Only 33.3% reported no change, whereas one state indicated that access had improved (6.7%). Only one (6.7%) did not answer. In this survey, respondents were more responsive to this set of questions.

**Table 10**

**Child Welfare League of America Access to Behavioral Health Service (in percentages)**

Type of Access	2000–2001 (n = 16) <sup>a</sup>				2003–2004 (n = 15)			
	Better	Worse	No Change	Don't Know	Better	Worse	No Change	Don't Know
Initial access to behavioral health services	12.4	25	12.5	43.8	26.7	20	26.7	26.7
Access to extended behavioral health services	0	25	18	37.5	6.7	40	33.3	20

<sup>a</sup> 18.8% of respondents did not answer the question.

The CWLA 2003–2004 survey results are significantly different than the results for the HCRTTP 2003 state survey. Most managed care systems continue to report improvement in initial access to a basic level of behavioral health services compared to pre-managed care (86% in 2003, 70% in 2000; Stroul et al., 2004, pp. 139–140; see Table 11). Improvement in access to extended care services (beyond short-term stabilization) reportedly increased significantly since 2000 (36% in 2000, 62% in 2003; Stroul et al., 2004, p. 140). The survey also asked mental health respondents about waiting lists for behavioral health services. The results show a slight increase in the waiting list being better—48% in 2000 and 50% in 2003. They also showed a decrease in it

getting worse—20% in 2000 to 9% in 2003 (Stroul et al., 2004, pp. 139–140). The CWLA survey did not address the issue of waiting lists.

**Table 11**

**Health Care Reform Tracking Project Access to Behavioral Health Services (in percentages)**

	2000		2003	
	<i>Better</i>	<i>Worse</i>	<i>Better</i>	<i>Worse</i>
Initial access to behavioral health services	70	15	86	6
Access to extended behavioral health services	36	14	62	6
Waiting lists for behavioral health services	48	20	50	9

Note: The remaining managed care systems reported no change in these three areas. Adapted from Stroul et al. (2004, p. 140).

**System Responsible for Behavioral Health Services (Acute and Extended Long-Term Care)**

To better understand access to the two key types of services that are particularly important for the vulnerable population of children involved with the child welfare system and their families—acute and extended long-term care—CWLA and HCRTF respondents answered questions regarding which system was responsible for and had the dollars to pay for these services (see Table 12). Child welfare respondents indicated that the most common systems responsible for having the behavioral health dollars to provide acute (episodic, short-term) behavioral health services to children and adolescents in the child welfare system were the Medicaid behavioral health care contractor (67%), the public mental health system (60%), and the public child welfare system (33%). In addition, child welfare respondents reported that to a lesser degree, the substance abuse system (20%) and the juvenile justice system (13%) are responsible.

**Table 12**

**Child Welfare League of America—System Responsible for Behavioral Health Services (n = 15) (in percentages)**

<i>System Responsible for Behavioral Health Care</i>	<i>Acute</i>	<i>Extended</i>
Medicaid behavioral health care contractor	67	53
Public mental health system	60	67
Public child welfare system	33	73
Substance abuse system	20	6
Juvenile justice system	13	33
Education	6	6
Public child welfare contractor under child welfare initiative	6	0
Medicaid managed care physical health plan	6	6
Other	33	26.7

The CWLA 2003–2004 survey also addressed the issue of who is responsible for and has the dollars to provide long-term behavioral health services to children and adolescents in the child welfare system. The most common responses by the child welfare respondents were the public child welfare system (73%), the public mental health system (67%), the Medicaid managed behavioral health care contractor (53%), and the juvenile

justice system (33%). The Medicaid managed physical health plan, the education system, and the substance abuse system were all at 6%. Under the “other” category for both the acute services and extended care services, child welfare respondents noted that when none of the listed systems were responsible, generally it was because the responsibility lay with the fee-for-service Medicaid program.

The HCRTP 2003 state survey found much higher percentages of managed care systems (95% in 2003) covering both acute and extended care services (Stroul et al., 2004, p. 140; see Table 13). *Extended care* was used to refer to similar services as the long-term care used in the CWLA survey, that is, care extending beyond short-term stabilization. On the surface, this might look like a good result given that many children involved with child welfare require these types of extended care behavioral health services. It is of some concern that the child welfare respondents do not have the same perspective as to whether the managed care plans cover acute and extended behavioral health services. They reported that the Medicaid behavioral health care contractor was responsible for acute health care services in only 73% of the cases, and for extended behavioral health care services in only 60% of cases.

**Table 13**  
**Health Care Reform Tracking Project Percentage of Systems Including Acute and Extended Care**

	1997–1998	2000	2003
Acute care only	26	9	5
Acute and extended care	74	88	95
Extended care only	0	3	0

Note: Adapted from Stroul et al. (2004, p. 140).

This raises the question of whether child welfare agencies are made aware of coverage, or perhaps they are so used to paying for it themselves that they do not explore other options and therefore are not aware. The earlier finding of few of either managed care programs or the child welfare system doing or getting little education and training might be part of what is leading to the lack of knowledge or underreporting.

# Effects of Medicaid Managed Care Reforms on Services for Children in the Child Welfare System

As in almost all managed care programs, both managed care and the child welfare systems are responsible for some behavioral health acute and extended care services; therefore, it was important to explore the effects of the managed care programs on access to these services.

Both the HCRTTP 2003 state survey and the CWLA 2003–2004 survey asked questions to check trends regarding the effect of initial access to services for the child welfare population. A continuing trend appeared to exist for the child welfare respondents to view this as more difficult than the mental health respondents. In addition, CWLA respondents indicated the trends were getting worse, whereas the HCRTTP respondents reported them as getting better (see Tables 14A and 14B).

**Table 14A**

## Medicaid Managed Care Reform Effect on Other Services (in percentages)

<i>Effect on Services</i>	<i>2000–2001</i>	<i>2003–2004</i>
Initial access to inpatient care is more difficult	37.5	46.7
Average lengths of stay in psychiatric inpatient facilities are shorter	37.5	40
Average lengths of stay in psychiatric inpatient facilities are longer	0	0
Initial access to residential care is more difficult	37.5	33.3
Average lengths of stay in residential treatment centers are shorter	12.5	26.7
Average lengths of stay in residential treatment centers are longer		6.7
Do not know		20
Other		25

Note: Data for 2000–2001 adapted from McCullough & Schmitt (2003, p. 90).

**Table 14B**

## Effect on Services When Access Is More Difficult or the Length of Stay Is Shorter (in percentages)

<i>Effect</i>	<i>2000–2001</i>	<i>2003–2004</i>
Premature discharge before stabilization occurs more often	31.3	40
Child is placed in community-based setting without clinical capacity to serve him or her	18.8	33.3
Increased use of residential treatment as an alternative to inpatient hospitalization	6.3	33.3
Inappropriate use of child welfare emergency shelters	18.8	26.7
Inappropriate use of juvenile justice facilities	25	26.7
Child discharged without safe placement	18.8	13.3
Do not know		26.7
Other		26.7

Note: Data for 2000–2001 adapted from McCullough & Schmitt (2003, p. 90).

Although only 37.5% of the 2000–2001 CWLA survey respondents indicated that initial access to inpatient care is more difficult, 46.7% indicated it is more difficult in 2003–2004 (McCullough & Schmitt, 2003, p. 90). This trend of increasing problems was reflected in the child welfare respondents reporting that the average lengths of stay in psychiatric inpatient facilities has gotten shorter—40% in 2003–2004 up from 37.5% in 2000–2001 (McCullough & Schmitt, 2003, p. 90). The child welfare respondents also reported increases in the average lengths of stay in residential treatment centers as being shorter—26.7% in 2003–2004 up from 12.5% in 2000–2001 (McCullough & Schmitt, 2003, p. 90). None of the child welfare respondents reported that the average lengths of stay in inpatient psychiatric facilities got longer, and only one state responded that the average lengths of stay in residential treatment centers has gotten longer. Both issues were not reported on in the 2000–2001 survey. The only area that seemed to have an improvement in the trend was initial access to residential care. The child welfare respondents reported a decrease in difficulty in this area to 33.3% in 2003–2004 from 37.5% in 2000–2001 (McCullough & Schmitt, 2003, p. 90; see Table 14A).

The responses of the mental health respondents show a different picture. The HCRTTP 2003 state survey results show continuing trends in improvement in access to behavioral health inpatient services. Unlike the 46.7% of child welfare respondents reporting that initial access is more difficult, only a small percentage of mental health respondents reported a perception that initial access is more difficult (11% in 2003). This is a decrease from what was reported in 2000 (20%; Stroul et al., 2004, p. 140). In 2003, almost two-thirds (63%) reported that initial access to inpatient services is easier (this question was new this year for the HCRTTP respondents and was not asked of the child welfare respondents; Stroul et al., 2004, p. 140). The percentage of managed care systems reporting that average lengths of stay for inpatient services are shorter increased from 63% in 2000 to 80% in 2003 (Stroul et al., 2004, p. 140). This percentage was higher than for the child welfare respondents (40% in 2003–2004; see Table 14A). This 40% is actually an increase in the percentage reported in 2000–2001 (37.5%; McCullough & Schmitt, 2003, p. 90). As with the child welfare respondents, no mental health respondents reported that the average lengths of stay are longer (Stroul et al., 2004, p. 140).

“In both 2000 and 2003, the HCRTTP respondents reported a number of problems resulting from decreased access and shortened inpatient lengths of stay” (Stroul et al., 2004, p. 140). Although several of these problems that directly affect children in the child welfare system were reported less frequently in 2003 than in 2000 by the mental health respondents, this was not true for the child welfare respondents. The only problem that child welfare respondents reported apparent improvements in was in children being discharged without a safe placement—13.3% in 2003–2004 down from 18.8% in 2000–2001 (McCullough & Schmitt, 2003, p. 90). Still, this is a significantly higher rate than in the HCRTTP 2003 state survey, which reported a decrease in children being discharged without a safe placement from 8% in 2000 to 3%, or only in one managed care system, in 2003 (Stroul et al., 2004, p. 140).

The 2003–2004 CWLA survey showed a continued trend toward increased use of residential treatment as an alternative to inpatient hospitalization (33.3% vs. 6.3% in 2000–2001), along with an increase in the inappropriate use of child welfare emergency shelters (26.7% in 2003–2004 vs. 18.8% in 2000–2001) and a slight increase in inappropriate use of juvenile justice facilities (26.7% in 2003–2004 vs. 25% in 2000–2001; McCullough & Schmitt, 2003, p. 90). On the other hand, the HCRTTP trend has been toward a decrease in the inappropriate use of child welfare emergency shelters (cited by 21% of systems reporting in 2000 vs. 6% of systems in 2003) and a decrease in children being discharged without needed services (33%). This too decreased in 2003 to 13% of the systems reporting (Stroul et al., 2004, p. 141).

It would appear that despite the fact that the survey received less response from child welfare respondents, a trend continues for mental health respondents to view things as much better than the child welfare respondents. Given that these issues are crucial to the service delivery of children in the child welfare system, one could argue that the field has an increased need for better coordination and collaboration regarding addressing the behavioral health needs of this specialized population. These discrepancies also raise concerns about the implications of some of the approaches taken by the managed care programs to address the needs of this specialized population, which could benefit from further study. For example, what is the incidence of increased medication usage among children discharged from inpatient care before they are stable?

Although the HCRTTP 2003 state survey reports decreases in problems related specifically to services for children in the child welfare system, which is encouraging, this raises questions regarding the discrepancies between the HCRTTP respondents' perceptions and the child welfare respondents'. Basically, child welfare respondents see increases in all the problems, as in Table 14A, with the exception of a slight decrease in children being discharged without a safe placement. The concern raised in the HCRTTP 2003 state survey report regarding findings about shorter lengths of stay in inpatient care continuing to have major implications for the child welfare system due to the serious emotional problems faced by many children involved with child welfare is a shared concern by the child welfare system (Stroul et al., 2004, p. 141).

# Effects of Managed Care Reforms on Child Welfare Providers

As with the 2000–2001 CWLA survey, the new survey asked child welfare respondents whether child welfare providers are included in the provider networks that are part of the Medicaid managed care program. Despite variations in the numbers of respondents between the two survey periods, respondents provided the same rates of inclusion as in the previous survey. According to the child welfare respondents, child welfare providers are included in the provider network only 46.7% (46.7% in 2000–2001) of the time (the same as in 2000–2001), whereas 40% said they are not (20% said no and 20% indicated they did not know in 2000–2001) and 13.3% (13.3% in 2000–2001) did not answer (McCullough & Schmitt, 2003, p. 91).

Mental health respondents, on the other hand, reported consistently greater percentages of child welfare providers included in the provider networks for the managed care systems. In both the HCRTTP 2000 and 2003 state surveys, respondents indicated that slightly more than half the managed care systems (53% in 2000, 54% in 2003) included child welfare providers (i.e., providers who traditionally have provided behavioral health services to children and families in the child welfare system (Stroul et al., 2004, p. 143). Despite larger percentages, this is still a concerning finding that has potentially significant implications for child welfare systems. As indicated in the HCRTTP 2003 state survey report:

If a preferred provider is not in the managed care system network, the child welfare agency may be faced with the decision of either paying for that provider's services, or obtaining care from a provider in the network who may not be familiar with the child being referred or may not be generally knowledgeable about children in the child welfare system and their unique treatment needs. The inclusion or exclusion of child welfare providers also may affect continuity of services if children are forced to change providers as they move in and out of the child welfare system. (Stroul et al., 2004, p. 143)

## Service and Interagency Coordination Resulting from Managed Care

The CWLA survey included a new question addressing whether there is an memorandum of understanding (MOU) between the Medicaid managed care program and child welfare system to determine who is responsible for providing and paying for physical and behavioral health services across child-serving systems. The child welfare respondents indicated that 46.7% of the managed care programs have an MOU but 40% do not, and 13.3% did not respond. This indicates that about half of the programs try to coordinate who provides what services and who should be paying for them. This is important as it indicates that less than half of the programs have an MOU, which potentially leads to confusion as to who should be paying for what. Ultimately, children and families are the ones who are most affected by this potential lack of coordination, and they may end up not obtaining needed services.

The surveys asked child welfare and mental health respondents questions regarding the effects of managed care on interagency coordination at both the systems and service delivery level. In the 2003–2004 CWLA survey, 60% of respondents felt that coordination among child-serving systems had improved with the Medicaid managed care program; only 6.6% felt it had worsened and 13.3% saw no effect. This is markedly improved from the last survey. In 2000–2001, although the question had the same number of respondents, only 26.7% reported improved coordination and 33.3% reported not knowing the effect on coordination (McCullough & Schmitt, 2003, p. 92). Despite the lower response rate by the child welfare respondents compared with mental health respondents, the reported percentage of improvement in coordination among child-serving systems corresponds fairly closely with the results found in the surveys of mental health respondents (68% in 2003, 65% in 2000; Stroul et al., 2004, pp. 141–142; see Tables 15 and 16).

**Table 15**

**The Effects of Managed Care on Interagency Coordination Among Child-Serving Systems—Child Welfare League of America (in percentages)**

<i>Coordination Among Child-Serving Systems</i>	<i>2000–2001 (n = 15)</i>	<i>2002–2003 (n = 15)</i>
Improved	26.7	60
Worse	13.3	6.7
No effect	20	13.3
Don't know	33.3	13.3
Did not answer	6.7	6.7

**Table 16**

**The Effect of Managed Care on Interagency Coordination Among Child-Serving Systems—Health Care Reform Tracking Project (in percentages)**

<i>Coordination Among Child-Serving Systems</i>	<i>2000</i>	<i>2003 (n = 15)</i>
Improved interagency coordination among child-serving systems	65	68

At the service level, 46.7% of child welfare respondents indicated that the Medicaid managed care programs had improved coordination between mental health and child welfare services compared to before managed care. As with coordination at the systems level, coordination between mental health and child welfare services had worsened only 6.6%. The respondents reported slightly higher rates of the Medicaid managed care program having no effect on coordination at the service level versus the system level (20% at the service level vs. 33.3%

at the system level), and 20% did not know the effect. The 2000–2001 CWLA survey did not ask this question, so no comparative data exist to examine any trends.

The HCRTTP 2003 state survey did, however, include the question. As indicated in Table 17, the rate of improved coordination between the two systems was 61% compared to pre-managed care, whereas no system indicated that coordination had worsened. Of the mental health respondents, 39% reported that managed care had no effect on coordination between the child welfare and mental health systems (Stroul et al., 2004, pp. 141–142).

**Table 17**

**The Effect of Managed Care on Interagency Coordination Between Mental Health and Child Welfare at the Service Level (in percentages)**

<i>Coordination Between Mental Health and Child Welfare Services</i>	<i>Child Welfare League of America 2003–2004 Survey (n = 15)</i>	<i>Health Care Reform Tracking Project 2003 Survey</i>
Improved	46.7	61
Worse	6.7	0
No effect	20	39
Don't know	20	Not indicated

The HCRTTP 2003 state survey report indicates that managed care systems had improvements in coordination at the service level:

For approximately two-thirds of the systems (60% in 2000, 67% in 2003), respondents indicated that coordination between physical health and behavioral health services has improved. This is extremely important for the child welfare system, in which a major goal is child well-being and coordinating services to meet both a child's physical health and mental health needs is a priority. Respondents also indicated improvement in coordination between mental health and substance abuse services (in 52% of the systems in 2000 and 63% in 2003). It is noteworthy that in 2003, coordination in each of these areas reportedly is worse in only 0% to 3% of the systems. For the remaining systems, managed care has had no effect on coordination. (Stroul et al., 2004, pp. 141–142)

## Link Between Child Welfare Initiatives and Behavioral Health Care Reforms

As with the previous CWLA survey, the current survey asked child welfare respondents whether coordination existed between their child welfare initiative and the state's Medicaid managed care program. Of the states that responded that they have a child welfare initiative ( $n = 14$ ), 66.7% or 10 reported some coordination between the Medicaid managed care program and the child welfare initiative. This is the same number as reported positively in the last CWLA survey results (McCullough & Schmitt, 2003, p. 92). Approximately equal percentages reported that they are totally separate (less than 15% in 2000–2001, 13.3% in 2003–2004; McCullough & Schmitt, 2003, p. 92). In 2000–2001, less than 10% reported they were fully integrated compared with none in 2003–2004 (McCullough & Schmitt, 2003, p. 92).

### Areas of Coordination

The survey asked the child welfare respondents if some coordination was taking place, what was being coordinated? The results from the 2003–2004 child welfare respondents are significantly different from the older results (see Table 18). The respondents reported coordination is taking place in the following areas: planning 46.7% (40% in 2000–2001), finance 20% (40% in 2000–2001), management 20% (33.3% in 2000–2001), other 20% (not reported in 2000–2001), and service delivery 6.6% (73.3% in 2000–2001; McCullough & Schmitt, 2003, p. 94). Only 6.6% reported not knowing what coordination is taking place. The fact that such a shift away from coordination at the service delivery level exists is of potentially significant concern for the child welfare population. Further study is needed to understand the implications of these results, given the small number reporting ( $n = 14$ ).

**Table 18**

**Child Welfare League of America—Type of Coordination as Taking Place ( $n = 15$ ) (in percentages)**

<i>Area Being Coordinated</i>	<i>2000-2001</i>	<i>2003-2004</i>
Planning	40	46.7
Finance	40	20
Management	33.3	20
Other	0	20
Service delivery	73.3	6.7
Don't know	0	6.7

The survey also asked child welfare respondents, if coordination or integration was taking place, to indicate the mechanisms being used. The child welfare respondents who reported that coordination or integration was taking place stated that the following mechanisms were being used: interagency teams (46.7%), interagency agreements (26.7%), and combined funding and joint management (20%). Twenty percent reported other mechanisms were used, and 6.6% indicated that they did not know what mechanisms were used. The last survey did not ask this question.

It is encouraging to see that coordination is taking place in more than half of the child welfare initiatives and managed care programs and that the areas and the mechanisms being used are those that will enhance the service delivery for children in the child welfare systems and their families.

## **Plans for Further Integration**

As with the 2000–2001 survey, the new survey asked child welfare respondents if their state planned to integrate services and funds to address the needs of children served by multiple systems and whether they planned to include managed care tools and principles, such as prior authorization or level of care criteria. Of the states that answered this question ( $n = 14$ ), 60% indicated they had plans, whereas 26.7% indicated they had no plans, and only 6.6% reported that they did not know or did not answer. Of the child welfare respondents that reported that they had plans to integrate, 46.7% reported that they planned to use managed care tools and principles, 33.3% did not answer, and 20% indicated they did not know. None of the child welfare respondents indicated that they had no plan to use managed care tools and principles.

Although fewer people responded to this question than in the previous survey ( $n = 24$  in 2000–2001), just one fewer state, or nine respondents, in 2003–2004 indicated that their state has a plan to integrate services and funds to address the needs of children served by multiple systems. Of the states that have a multisystem plan to integrate, 26.7% indicated that they are in the early planning stage, up from the more than 20% reported in 2000–2001 (McCullough & Schmitt, 2003, p. 93). Twenty percent reported that planning was fully under way, the same as in 2000–2001 (McCullough & Schmitt, 2003, p. 93). Although one respondent indicated that the state’s plan was in the early stages of implementation, no respondents indicated early implementation of their multisystem plan.

## **Tracking Utilization of Behavioral Health Services by Children in Child Welfare**

In keeping with the HCRTP survey questions, CWLA asked the child welfare respondents to indicate if the Medicaid managed care program tracks behavioral health service utilization of children in the child welfare system, and if so, if they use the data in service planning. According to the child welfare respondents, only 33.3% of the Medicaid managed care programs track the utilization of behavioral health services, whereas 40% indicated they do not, and 20% did not know. These percentages are much lower than those reported by the HCRTP mental health respondents in the 2003 state survey—tracking this system information has decreased since the 2000 state survey (74% in 2000, 63% in 2003; Stroul et al., 2004, p. 143).

Although 60% of child welfare respondents either did not answer (40%) or did not know (20%) whether agencies used the data collected in service planning, they were split on whether the Medicaid managed care programs did (20%) or did not (20%) use the data for service planning. Their mental health counterparts, on the other hand, indicated that 42% of the systems use the data for planning, which is an increase over what was reported in 2000 (32%; Stroul et al., 2004, p. 143). Although the reasons for not using these data in system planning were not determined by either the CWLA survey or the HCRTP state survey, HCRTP did gather information during the impact analyses that “indicated that it may be due to the form in which the data is gathered, the timeframes in which data is generated, and the lack of staff capacity to analyze the data” (Stroul et al., 2004, p. 143).

# P A R T 2: SUMMARY AND CONCLUSION

## Summary

This summary has been divided into three sections: areas of agreement in the findings between the two surveys that are similar to the last report, highlights of information from new questions added to the survey, and areas requiring further investigation. Although overall consistency exists with the previous CWLA survey findings and with the 2003 HCRTP survey, some areas continue to cause concern as to their potential implications for children and families involved in the child welfare system. Many of the concerns identified here have been born out in the less than optimal performance of the state child welfare systems in their CFSRs. These areas of concern are worth studying further to obtain better understanding of their implications for the outcomes of children and families served by the child welfare system.

### **Areas of Agreement in the Findings from the CWLA and HCRTP Surveys That Are Similar to the Last Report**

- Both surveys report a continued trend for managed care programs to exclude children in the child welfare system from being eligible for coverage depending on the type of placement. Although both surveys report an increase in this trend to three-quarters of the managed care programs, CWLA respondents report more of an increase from the last survey than do the HCRTP respondents.
- Half or more of the managed care plans do not pay for services for family members of the identified child unless the family is covered by the plan.
- Both surveys report a continued perception that managed care generally does not affect the practice of parental relinquishment of custody to obtain mental health services.
- Both surveys report child welfare funds are typically used in few of the managed care initiatives, although HCRTP reports a higher percentage (29%) than CWLA (7%). In both surveys, almost three-quarters (72%) of respondents indicate that the child welfare system can typically access behavioral health care funds that are outside the managed care plans, including Medicaid funds.
- Respondents to both reports continue to indicate they believe cost shifting is taking place. As with the previous survey reports, the respondents' ability to actually track whether cost shifting is taking place and the direction that the cost shifting is taking varies. The CWLA respondents report an increased ability to track whether cost shifting is taking place, whereas the HCRTP respondents report a decreased ability. The HCRTP respondents are almost divided in their perception that cost shifting is taking place from the managed care programs to the child-serving systems and from the child-serving systems to the managed care programs. If the CWLA respondents indicated they believed it was taking place, then it was from the managed care program to the child welfare system.
- Although both survey respondents continue to report that child welfare providers are included in the managed care networks, they continue to report they are only included in roughly half the reforms.
- Both groups of survey respondents agree that child welfare staff are engaged to some degree in planning the managed care reforms in most states. More consistency exists in the perception reported by current HCRTP and CWLA respondents than in perceptions of the last survey period. Both sets of

respondents report that in approximately half of the managed care programs, child welfare has significant involvement in planning managed care reform.

- Both survey's respondents agree that some cross-training between MCOs and child-serving agencies is occurring. The respondents continue to differ in perception of how much cross-training is taking place.
- Although the HC RTP respondents report a smaller increase in the amount of coordination between the child-serving systems and the Medicaid managed care program that is taking place, the approximately two-thirds that they report is taking place is more in keeping with what the CWLA respondents reported. This is more than double the rate reported by the child welfare respondents in the last survey.
- The respondents for both surveys reported a similar rate of improved coordination between the mental health and child welfare systems (61% for mental health respondents and 60% for child welfare respondents) compared with before managed care, and no system indicated that coordination had worsened.
- Both surveys found evidence that when coordination between behavioral health reforms and child welfare is occurring, it is happening on multiple levels from system planning to service delivery.

We see continued challenges reported by the child welfare respondents for states having effective data systems for planning, service delivery, and follow up. This is evidenced by the continued trends reported by child welfare administrators in the following areas:

- Few are able to assess track and report on key aspects of the needs of the children and adolescents they serve in the child welfare system, specifically the percentage of children and adolescents served by the child welfare system who have a serious and complex behavioral health need (36%). This is also reflected in the participants' even greater lack of ability to indicate the most common diagnosis as well as their inability to identify substance abuse diagnoses. Additional difficulties continue in their ability to report on whether there has been an increase or decrease over the past five years in the number of children with a mental health or substance abuse diagnosis.
- Few are able to assess the degree to which parental behavioral problems are a primary reason for the initial referral or placement of children in out-of-home care. Even fewer were able to differentiate needs or assess the prevalence of parental behavioral health problems and the percentage of cases in which the primary reason for the referral or placement directly related to parental behavioral health problems.
- Respondents continue to have difficulty tracking and reporting the percentage of parents who relinquish custody to obtain mental health services for their child.
- Respondents have difficulty tracking whether cost shifting is taking place, although more child welfare respondents report being able to do so. Less than half the states and counties are able to do so.

## **New Survey Questions**

The survey asked child welfare respondents a number of additional questions this year that are worth noting, as they have potentially important implications for child welfare systems:

- When asked if they are able to assess, track, and report on substance abuse diagnoses for children and adolescents in the child welfare system, only one state indicated it could.
- The survey asked the child welfare respondents which agency was primarily responsible for and had the behavioral health dollars to provide behavioral health services to the parents of the children in the

child welfare system. They reported that the public mental health system is the agency most likely to have the behavioral health dollars to provide services to the parents.

- The child welfare respondents reported that about half the managed care programs have an MOU between the Medicaid managed care program and child welfare system to determine who is responsible for providing and paying for physical and behavioral health services across the child-serving systems.
- The surveys asked child welfare and mental health respondents whether Medicaid managed care programs are responsible for screening children in the child welfare system when entering custody to identify mental health problems and treatment needs. Although close to half of the HCRTTP respondents indicated that they are responsible for screening these children, only about a third of child welfare respondents reported that the Medicaid managed care program is responsible for the mental health screening. The HCRTTP respondents reported much higher rates of mental health screening actually taking place than the CWLA respondents (77% versus 40%).

### **Areas Needing Further Examination**

- The child welfare respondents indicated an increase to 80% of the managed care programs including the child welfare population (61.8% in 2000–2001). HCRTTP, on the other hand, reported that slightly less (74%) of the managed care programs cover children served by the child welfare system who are eligible for Medicaid. This decrease is by almost 20% from the previous survey results. The decreasing coverage of this vulnerable population of children is of concern. Both surveys sought to gain further insight into the specific subgroup of the children involved with child welfare who are covered, and participants reported further discrepancies. Although the HCRTTP respondents indicated that 66% of the children in the child welfare system who are in the custody of child welfare were covered, the child welfare respondents reported only 42% of this group are covered. Given the poor performance on CFSRs by the child welfare system regarding meeting children’s physical and mental health needs, it is important to better understand both the discrepancy in reporting and the implications for the child welfare system in trying to obtain services for the children with whom they are involved.
- The continued trend for children to lose eligibility for coverage based on their placement type raises concerns that children in the child welfare system will continue to experience disruptions in coverage and service delivery because of this. Both surveys found the most common reasons for loss of eligibility were detention, incarceration, and placement in state-operated facilities. This practice makes it very difficult to maintain consistency of service delivery and providers (especially as both surveys found that only half of the managed care plans included child welfare providers in their networks) as well as to ensure that children’s needs are being met. Given the large number of children who are part of the child welfare system who are also involved with juvenile justice, and those who are in the juvenile justice system who have a mental health or substance abuse problem, this is definitely an area of concern. This illustrates the continued need for better policies and practices that minimize these disruptions and enhance service delivery for this special population.
- The CWLA and HCRTTP respondents differed in their perception of whether managed care programs have a discrete planning process for the child welfare population. Fifty-three percent of the child welfare respondents reported no discrete planning process for child welfare, whereas 33.3% report that one exists. The HCRTTP respondents reported that 47% of managed care programs have a discrete planning process for the child welfare population. This is considerably higher than the 33.3% reported by the child welfare respondents. What is of interest is that the mental health respondents reported an overall decrease in the percentage of managed care programs with a discrete planning process in

place. It is important to further examine this discrepancy between the two sets of respondents as well as the decrease in the managed care programs that are involved in a discrete planning process to understand what is driving it. It is important to know if this is a reflection of the decrease of the inclusion of the child welfare population in the overall managed care programs or a result of other factors. It would also be important to examine the effect of the decrease on the children and families served.

- Both the CWLA and HCRTP surveys asked questions about the inclusion of special provisions for children in the child welfare system. Although in both surveys the states continue to report the inclusion of special provisions, the percentage of managed care programs that are including them have been reduced as seen in the HCRTP results. On the other hand, however, there would appear to have been increased inclusion of special provisions by the child welfare respondents, as seen in the CWLA survey results. The results from the 2003–2004 CWLA survey are more in keeping with the findings from the HCRTP 2003 state survey. The family support services special provision was the only area in which both sets of respondents reported the same rate (33%) of managed care systems providing this special provision. This was a decrease from the previous HCRTP survey and an increase from the CWLA survey. This rate of slightly more than half of the managed care programs including the special provisions seems low if one is going to ensure that agencies provide the services and supports families need to look after their special-needs children. The overall findings still raise concerns as to how managed care programs will be able to meet the specialized needs of this vulnerable population of children and families. Although it is encouraging to see that the child welfare respondents see an increase in the inclusion of the provisions, it is still a concern that the HCRTP survey respondents report significant decreases in the inclusion of these services. The potential is for this to make it more difficult for children and families to be successful and for the child welfare system to be able to meet the CFSR performance requirement regarding meeting the mental health needs of the children involved with the child welfare system. In addition, it is unclear why a discrepancy exists in the CWLA findings, which indicate an increase. It would appear that perhaps child welfare respondents have improved their reporting capabilities, as the new findings are in keeping with what the HCRTP respondents reported.
- The child welfare respondents indicated that they perceive that managed care programs affect the provision of physical and behavioral health services and that generally, managed care has made providing services more difficult. If they indicated providing services was more difficult in general, then it was true for both physical and behavioral health services. Given that state child welfare agencies are struggling to comply with the CFSR child well-being indicator for meeting the medical and mental health needs of children, this finding is cause for concern. Also, a large difference exists in the perceptions of the CWLA respondents and the HCRTP respondents regarding access to behavioral health services. The mental health directors reported increasing improvements in access to behavioral health services, whereas the child welfare respondents indicated increasing difficulties in access to behavioral health services. Although the child welfare respondents reported a slight improvement in access to inpatient care, they reported a significant increase in access to extended care services being worse. This is a concern given that child welfare respondents are also reporting that under managed care, patients receive shorter inpatient stays and agencies are increasingly using extended care services as a step down from inpatient care. Under this scenario of shorter inpatient stays, more children would need extended behavioral health care services, and yet it is perceived that access to these services is decreasing as a result of managed care. As children who are part of the child welfare system continue to be covered under the Medicaid managed care programs, the issue of the effect of managed care programs on the provision of and access to physical and behavioral health services is an area that would benefit from further examination and monitoring.

- Almost two-thirds of the CWLA respondents indicated that the child welfare system has the responsibility and dollars for long-term behavioral health services, whereas almost all of the HCRTTP respondents indicated that it is primarily managed care programs. It is unclear why both systems perceive that they have the dollars and responsibility for long-term behavioral health services. It is of some concern that the child welfare respondents do not have the same perspective as their mental health counterparts regarding whether the managed care programs cover acute and extended care behavioral health services. This raises the question of whether child welfare agencies are aware of the coverage. This finding, combined with the earlier finding that few managed care programs provide education and training, might be part of what is leading to the lack of knowledge or underreporting.
- Child welfare respondents' perceptions regarding initial access to basic behavioral health care services and extended care services differ significantly from mental health respondents'. The current survey found a slight decrease over the last survey results regarding initial access to basic behavioral health services being worse than pre-managed care. The HCRTTP respondents, however, reported access as far better than what child welfare respondents indicated (86% improvement compared with 20%). The HCRTTP respondents reported significant improvement in initial access to extended care services from 36% to 62%, whereas 40% of child welfare respondents reported access to these services was worse, with only one state reporting improvement. The child welfare respondents also reported increasing difficulties in accessing inpatient services for about half of the managed care programs. They found a slight decrease in difficulty in initial access to residential care. This was the only area in which child welfare respondents indicated they had decreased difficulties. In cases in which the child welfare respondents reported that initial access was more difficult, the effect for the children they deal with has gotten worse in all categories, with the exception of improvements in children being discharged without a safe plan. A trend continues for mental health respondents to view things as much better than their child welfare counterparts. Given that these issues are crucial to meeting the needs of children in child welfare, the field has an increased need for better coordination and collaboration to minimize the effect of the managed care program on service access for this population. These discrepancies also raise concerns about the implications of some of the approaches taken by the managed care companies toward addressing the needs of this population that could benefit from further study.

## Conclusions

Many of the findings in this report have potential negative implications for the child welfare agencies in being able to meet the CFSR and PIP requirements and indicate areas that could benefit from further study. More research might show state child welfare systems potential ways to effectively work with the managed care programs to meet the needs of the children and families they serve and provide areas for collaboration between the mental health and child welfare systems to facilitate the states' success in meeting the performance requirements in the upcoming CFSR process.

Overall, it is clear that child welfare agencies need to increase their ability to track and assess the behavioral health care needs of the children and families they serve. Managed care systems, on the other hand, need to be able to track the use of services related to children in the child welfare system and their families, as well as outcomes for these people. Although some collaboration is taking place, much stronger collaboration is required to make managed care programs responsive to the special needs of the child welfare population members who are eligible for services.

As with the last report, the researchers found more similarities than differences in results from the CWLA and HCRTP surveys. For the most part, some improvements existed in reporting by the child welfare respondents, with the results often being more in keeping with the HCRTP respondents' reporting. If differences existed between the HCRTP and CWLA respondents, it seemed that child welfare respondents had a less positive view of managed care programs than their mental health counterparts. There continued to be decreased performance by the managed care programs as reported by HCRTP in such key areas as inclusion of the child welfare population, planning for meeting clients' needs, and inclusion of specialized services to meet their needs, with the resulting perceived decrease by the child welfare respondents in overall ability to meet the needs of the child welfare population and their families.

With the continuing changes taking place in the federal and state Medicaid programs, along with the transformation taking place in the mental health and child welfare systems, it will be important to monitor the effects of these changes on service delivery to the child welfare population, and we hope that researchers throughout the field will further examine and study the issues raised throughout this report.

# References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Burns, B. J., Phillips, S. D., Wagner, R., Barth, R. P., Kolko, D. J., Campbell, Y., et al. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of American Academy of Child and Adolescent Psychiatry*, 43, 8.
- Child welfare and juvenile justice—Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services* (Report GAO-03-397). (2003, April). Washington, DC: U.S. General Accounting Office.
- Mauery, D. R., Collins, J., McCarthy, J., McCullough, C., & Pires, S. (2003). *Contracting for coordination of behavioral health services in privatized child welfare and Medicaid managed care*. Washington, DC: Center for Health Services Research and Policy, George Washington University.
- McCarthy, J., & Valentine, C. (2000). *1999 child welfare impact analysis, Health Care Reform Tracking Project: Tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- McCullough, C., & Schmitt, F. (2003). *CWLA SIMI 2000–2001 management, financing, and contracting survey final report*. Washington, DC: CWLA Press.
- Stroul, B. A., Pires, S. A., & Armstrong, M. I. (2001). *Health Care Reform Tracking Project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—2000 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida.
- Stroul, B. A., Pires, S. A., & Armstrong, M. I. (2004). *Health Care Reform Tracking Project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—2003 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida.