CHAPTER 8:
FRANKLIN COUNTY MANAGED CARE

The managed care study examines the impact of a managed care strategy on outcomes for children in Franklin County. Franklin County Children Services (FCCS) employs case rate contracting[1] on a sample of cases, with the goal of more effective and efficient use of limited service resources.

8.1 OVERVIEW

FCCS is the only PCSA in Ohio that uses the flexible Waiver funds to implement a managed care experiment involving two private agencies with case rate contracts. The contractors provide case management and services or referrals for a sample of cases transferred to ongoing services by FCCS. They receive a case rate for each referral that is randomized to them and that they then accept. Each private agency has caps on referrals, so that they do not exceed their capacity. There are certain categories of cases which they are excused from serving (such as medically fragile children and children in permanent custody). Despite serious limitations in the case transfer process (discussed later in this chapter), FCCS' effort to randomly assign children to private contractors or the public child welfare agency (FCCS) offers an opportunity to quantitatively assess the impact of managed care on children.

The evaluation of the FCCS experiment tests the hypothesis that the use of case rate financing results in no worsening of outcomes for children. This is not an evaluation of a specific clinical intervention; rather, case rate financing is assumed to change purchasing decisions so as to allow workers to provide different services or to provide services in different ways. In order to do this, the study team used administrative data to build long case histories[2] of how the children fared and then classify the histories into a set of five quality-ranked profiles. These profiles place the highest value on case histories where children are served in-home without abuse or neglect. The second highest value is placed on case histories where children are temporarily served out-of-home but are eventually reunified with their families or achieve permanent living arrangements with other nurturing families – all without further abuse or neglect. Lower value is placed on case histories of children served out-of-home who were still out-of-home at the end of the observation period. Lowest value is placed on case histories with repeat abuse or neglect under any circumstances, and other outcomes such as running away or placement in a detention facility.

[1] A *case rate* is a fixed fee paid to a contractor for all services delivered to a client over a treatment period or an episode of care. For example, a contractor may receive a flat case rate of $5,000 for each family referred; some families receive services for 3 months, and some receive services for 9 months, but the case rate is the same. The contractor receives the same payment amount for all the families.

[2] The team used data on children whose cases opened to services between January 1, 1999 through December 30, 2001, and examined their histories through September 2006. This period constitutes their case histories.

FCCS itself has somewhat broader expectations for its managed care experiment: that the use of case rate financing will lead to increased system effectiveness, where effectiveness is defined in terms of both child outcomes and service costs. However, this study does not address cost issues; it focuses only on the impact of the intervention on child outcomes. The study seeks to verify that using private contractors to take responsibility for part of the caseload does not worsen child outcomes.

8.2 FRANKLIN COUNTY CASE RATE FINANCING PROCESS

Through its contracts with the private agencies and its internal procedures, FCCS established a formal process for the assignment and ongoing management of child welfare cases. Among the most crucial aspects of the process were random assignment, referral caps, case management responsibilities, and conditions related to reopened cases. Except where indicated below, FCCS is still operating its managed care experiment as it was during the time covered by this study.

- When a referral came into FCCS[3], it was randomly assigned to a private agency or to the public agency, prior to being received by intake or investigation units. Workers did not know the random assignment until a case was opened, when the worker looked for the flag that indicated its assignment. All cases that were logged in were randomly assigned, and all were eligible to be served by the private agencies except Permanent Court Commitment (PCC), Planned Permanent Living Arrangement (PPLA), medically fragile, and courtesy supervision cases.[4] Contractors were not allowed to refuse other types of cases. Once a child was assigned to a private agency, all subsequent cases involving the child's family members were assigned to that same agency while the case was open and for 18 months after the case was closed.
- As discussed later in this chapter, approximately half of all cases initially assigned to the private agencies were actually served by the public agency. These cases, called "hold-backs" in this report[5], included those in the four excluded groups (PCC, PPLA, medically fragile, and courtesy supervision), as well as those that were opened after a private agency's cap was reached and thus were not transferred to the agency. Due to inadequate documentation in the data files, the research team was unable to determine which of these reasons led to a particular case being served by the public agency after it had been assigned to a private agency.
- FCCS set the sampling ratios based on prior case flows, trying to make sure that the appropriate numbers of opened cases were assigned to each private agency. Although

[3] Cases can come in through court referrals, abuse/neglect incident reports, and service requests by families (voluntary cases).

[4] If a worker opens a case and sees that is in one of these categories, that case will be retained by the public agency even if its random assignment was to a private agency.

[5] The terminology commonly applied in randomized tests is "no-shows" rather than "hold-backs." However, the team decided to call this group "hold-backs" instead, since "no-shows" might imply that the children did not receive any services when they actually did receive services. The few children assigned to the public agency but served by a private agency are called "crossovers" – i.e., they "crossed over" to the treatment condition; this terminology is commonly used for such a group in randomized experiments.

FCCS tried to adjust the sampling ratio so that the allotted number of cases stretched throughout the month, the number of assigned cases often reached the agency's overall maximum (called the "cap") and no more cases were transferred to that agency for the rest of the month. Once a cap was reached, any new cases in that month were not eligible for transfer to a private agency and became the responsibility of the public agency (and thus a hold-back case), regardless of what the random assignment was. If the private agency did not reach its required number for the month, they would make up the difference the following month.

- Separate (and lower) caps are now in place for cases called "blind order" or "fast track" cases. These are cases in which Juvenile Court orders custody of a child to FCCS and notifies the county after the fact. The large majority of these cases involve unruly delinquents, many of whom are in a detention center or temporarily staying with relatives, and they tend to be high-end cases requiring residential placement. Since FCCS learns about the case anywhere from 2 days to 3 weeks after the custody order, there is less time for complying with the 30-day requirement for completing a case plan. One effect was that other types of cases (especially voluntary services) tended to be delayed until the end of the month while workers attempted to comply with the case plan requirements for the blind order cases. This resulted in a disproportionate share of the blind order cases being assigned to the private agencies. In 2001, FCCS implemented separate caps for these blind order cases so that the private agencies' share of the referrals would be proportionate to their share of the overall caseloads, but the blind order caps were not yet in place during most of the period covered by this study.
- Monthly referrals currently are capped at 40 cases (including a maximum of 11 blind order cases) for one contractor and 27 cases (including a maximum of 8 blind order cases) for the other. For cases covered by this study (those assigned between January 1, 1999 and December 30, 2001), the referral rates were somewhat lower: in FY 1999, each contractor received no more than 14 cases per month; in FY 2001 this increased to approximately 30 cases per agency per month (HSRI, September 2001).
- After accepting a referral, the contractor was responsible for providing all needed services, including prevention and foster care, and made all decisions regarding level of care (although the public agency could make recommendations). There was no maximum length of time that contractors could keep cases open, although they were paid a contractually-set amount regardless of the level of care needed or length of time a case was open (their risk was limited by the risk corridor and set-aside discussed below). Also, the contractor's responsibility for the case ended if the child was given the status of PCC or PPLA, or if the child turned 18, ran away, or was referred to a DYS institution. During the time period covering the data used in this study, the contracts included a risk corridor[6] on total expenditures (5 percent the first year, 10 percent the second year) and a

[6] A *risk corridor* requires that the contractor be liable for only a percentage of excessive costs as defined by the public agency; beyond this percentage, the public agency picks up the costs. In addition, the contractor is allowed to keep only a percentage of any savings, and must return the rest to the public agency.

set-aside[7] of nearly $1 million per year to protect against cost overruns (HSRI, September 2002). Currently there is no risk corridor and no year-end reconciliation for the private agencies.

- The private agencies retained some obligation to serve their assigned cases if they reopened to FCCS. If a managed care case reopened during the first 18 months after the case was closed, the private agency was responsible for all service provision.[8] If the case reopened more than 18 months after closing, it was treated as a new case and went back into the random assignment pool. The 18-month provision also covered any cases opened on the child's family members; these cases were required to be served by the contractor with no additional funding provided.[9]

8.3 EVALUATION DESIGN AND KEY QUESTIONS

The study team used FACSIS and FCCS-generated data to analyze outcomes for cases that had been randomly assigned to private agencies or the public agency from January 1, 1999 through December 30, 2001. Case histories through September 2006 were examined. Cases were classified into five targeted groups ranked in a hierarchy from best to worst, where both family preservation and child safety were valued, but more emphasis was given to the latter:

1. Safe in-home services: Case was opened but child was never placed during the period observed, with no substantiated incident disposition subsequent to the initial event that brought the child to the attention of social services, no subsequent placement, and no reopening.
2. A single limited placement followed by prolonged safety: Case was opened, child was placed a single time and exited placement during the period observed, with no subsequent substantiated incidents, no subsequent entry into placement, and no reopening. In addition to children who had been discharged for reunification, adoption, or guardianship, this group also includes emancipated youth and children with other exits that had no subsequent incident disposition, no subsequent placement, and no re-opening episodes.
3. Prolonged stable placement: Child was still in care and had stable placement (i.e., no change in resource case type after 30 days); any change to an adoptive home counts as still being in stable placement.
4. Prolonged unstable placement: Child was still in care and had unstable placement (i.e., experienced a change in resource case type after 30 days), excluding changes to adoptive homes.

[7] A *set-aside* or year-*end reconciliation* allows the contractor to draw down additional funds if the total service expenditures exceed the overall payment by a stipulated percentage.
[8] The initial contract was less stringent about cases that reopened: for reopenings that occurred 6-18 months after closure, FCCS paid a portion of the case rate, gradually increasing for every 3-month increment (paying 1/6 of the case rate for reopening at 6-9 months, 1/3 at 9-12 months, and 1/2 at 12-18 months).
[9] However, if the case actually had been a hold-back (i.e., served by the public agency), additional services would be the responsibility of the public agency, not the private agency.

5. All other cases: All other types of opened cases or exits that experienced subsequent abuse and neglect reports, subsequent placement, any reopened cases with no placements, exit cases involving runaways, child deaths, referrals to DYS institutions, etc.

The long period of case history examination allowed the team to take a very comprehensive look at the long-term quality of outcomes. During this period, some families had cases opened, closed, and reopened within Franklin County. Even when the gap between closure and re-opening was more than 18 months and thus the case was eligible for re-randomization, the team analyzed the case as initially randomly assigned. The hypothesis of interest is that children assigned to the private agencies fared no worse than those assigned to the traditional public workforce with respect to the hierarchy.

8.4 METHODS

The major challenge in this analysis was that the randomization probabilities did not accurately reflect private agency capacity; as a result, a large proportion of cases were assigned to the private agencies after the agencies' monthly caps were reached. In addition, documentation was inadequate for the study team to determine why cases were hold-backs, whether it was because a case was contractually excluded (PCC, PPLA, medically fragile, or courtesy supervision) or was assigned after the agency met its monthly cap. FCCS did not require the private agencies to be elastic in adjusting their capacity to meet whatever needs might be present, as the public agency must do; that is, when the private agencies reached their monthly caps, all subsequent cases during the month stayed with the public agency for services even if their assignment was to a private agency. Given this arrangement, over time FCCS should have adjusted its random assignment process so that only as many cases were randomized to private agencies as could be served by them. However, that did not occur during the observation period of this study. Due to the inaccurate randomization probabilities, FCCS ended up assigning twice as many cases to the private agencies as the private agencies actually served. This excess assignment, and the lack of documentation about why a case assigned to a private agency was actually served by the public agency, raised very difficult issues for the analysis.

The team decided to use ITT (intent-to-treat) analysis, as it is standard in the analysis of all randomized experiments. However, ITT is not a very powerful technique when the hold-back rate is so high, and it can miss effects. The team considered ignoring the random assignment and just comparing the 2098 cases served by the private contractors to the 9496 served by the public agency ("as-treated" analysis), but realized that this would be subject to unacceptable risks of unknown biases because of the lack of documentation about the hold-back cases. The little documentation that did exist suggested that an as-treated analysis would be biased in favor of the private agencies: not only did the caps keep referrals within private agency capacity (while the public agency had no such cap), but the study team also was unable to verify that every random assignment violation was based strictly on the identified criteria. In short, there may have been yet other types of cases that remained with the public agency. Thus, given the unmeasured differences between the public and private caseloads, the study team concluded that the only fair procedure would be to test the implications of *being initially assigned* to a private agency. No

attempt was made to test the effects of services actually provided by public versus private agencies.

Table 8.1 shows that 49 percent of the cases randomly assigned to the private agencies (1947 cases out of 3981) were actually served by the public agency.[10] These cases represent a substantial deviation between random assignment and transfer of actual case responsibility.

Table 8.1: Numbers of Cases Assigned to and Served by Public and Private Agencies*

Cases	Assigned to Public	Assigned to Private	Total assigned
Served by Public	7549	1947	9496
Served by Private	64	2034	2098
Total served	7613	3981	11594

*Based on target children only, excluding siblings

8.5 FINDINGS

The study team analyzed differences in the quality of child outcomes and in the rates of hold-backs (cases originally assigned to private agencies but subsequently served by the public agency) and crossovers (cases originally assigned to the public agency but subsequently served by the private agencies). This section presents those findings.

8.5.1 Child Outcomes

The analysis found no evidence of any significant difference in the quality of child outcomes between cases assigned to private contractors and those assigned to the public workforce. Table 8.2 shows the outcome quality distribution for the two groups. Although it might appear that there were slightly fewer of the most negative case histories among cases assigned to the private contractors, the analysis found that none of the differences were anywhere close to statistically significant. (See Appendix D for the details of the significance testing.) These findings indicate that there is no evidence that children were worse off when served by private agencies.

[10] A tiny fraction of cases randomly assigned to the public agency were served by the private agencies for reasons that the team could not determine.

Table 8.2: Quality of Case Outcome by Random Assignment Status			
Outcome Quality	Percent with Outcome Among Those:		Difference
	Assigned to Private	Assigned to Public	
1. Safe in-home services	39.5%	39.6%	-0.1
2. A single limited placement followed by prolonged safety	23.9%	23.0%	+0.9
3. Prolonged stable placement	2.2%	1.9%	+0.3
4. Prolonged unstable placement	0.7%	0.6%	+0.1
5. All others: repeat abuse/neglect, death, runaway, DYS	33.7%	34.9%	-1.2
Total	100.0%	100.0%	
N*	4597	9155	

*Includes both target children and their siblings

Note that the case history analysis summarized in Table 8.2 includes siblings of the target children (the "target child" is the one who was originally randomly assigned). Table 8.1 excludes siblings. That is the reason that the total served as shown in Table 8.1 (11594 cases) is lower than the total served as shown in Table 8.2 (4597 plus 9155, or 13752 cases).

8.5.2 Hold-Backs and Crossovers

The study team conducted separate analyses to determine whether hold-back decisions or cross-over decisions were linked to known risk factors. The study team was concerned that the hold-backs were not random and, with such a high proportion of them, that the actual caseloads of public versus private agencies would not be comparable. In other words, although the team hoped that the private agencies' capacity caps would not lead to significant differences in the caseloads of the private and public agencies, the hold-backs had to be investigated. The concern about crossovers was much less since there were so few of them, but the team analyzed those also.

The team chose to examine four risk characteristics as possible sources of bias resulting from the hold-back process: (1) any disability (which would include the medically fragile group, already known to have been a criterion for exception to random assignment); (2) ever in congregate care; (3) whether a placement episode ever occurred prior to a child's random assignment date; and (4) whether the child was a recent victim of child maltreatment.[11] If children having one or more of these characteristics were more likely to be held back from private agency services (versus being allowed to go to the private agency), that would suggest an important difference between the private agency service group and the public agency group. Both the hold-back and crossover patterns were examined among children who did and did not

[11] *Recent* means no more than 45 days prior to the random assignment date. These cases are expected to be different from court referrals (often unruly delinquents) and voluntary services (in which parents request services), which do not usually involve CPS investigations or documented child maltreatment.

have the risk characteristics. Tables D.1-D.5b in Appendix D offer more detail. This section summarizes the findings.

Table 8.3 displays the hold-back rates regarding each of these four characteristics. Overall, with one exception, the hold-back rates are fairly similar regardless of whether the children had the risk factors. For example, children who had disabilities had similar hold-back rates as those who had no disabilities (49.8 percent versus 48.0 percent). Likewise, the children who had spent some time in congregate care had similar hold-back rates as those who had never been in congregate care (50.5 percent versus 48.5 percent). Moreover, the children who had placement episodes that occurred prior to their random assignment dates had similar hold-back rates as those who did not have such placement episodes (49.4 percent versus 48.8 percent). These results argue that the hold-back population was not systematically biased on these characteristics. On the other hand, there was a tendency for the children who had been recent victims of child maltreatment to have somewhat higher hold-back rates than children who had not been recent victims[12] (50.8 percent compared to 47.2 percent), and this difference was statistically significant.

Table 8.3: Hold-Back Rate* by Risk Characteristic

Characteristic	Hold-Back Rate When Child:	
	Has Characteristic	Does not have characteristic
Has any disability	49.8%	48.1%
Was ever in congregate care	50.5%	48.5%
Ever had placement episode prior to random assignment date	49.4%	48.8%
Is recent victim of abuse or neglect**	**50.8%**	**47.2%**

**Hold-back rates* are the percentages of cases randomized to a private agency that were actually served by the public agency. Total number of hold-backs = 1947. Siblings are excluded.
***Bolded row shows a statistically significant difference at $p \leq .05$.

These findings indicate that in general, the hold-back rates were similar for children who had and did not have the risk characteristics. However, children who were recent victims of child maltreatment and were assigned to a private agency were more likely actually to be served by the public agency, compared to children who were not victims. This small but statistically significant difference might represent a tendency for FCCS not to transfer cases involving children with this risk characteristic to a private agency, even if the children's assignments were to a private agency. The study team cannot draw firm conclusions based on the available data; however, the existence of the caps certainly could introduce the potential for this type of bias in case transfers.

The team did not find that any of the four examined risk factors were associated with crossovers. Table 8.4 shows the crossover rates for each of the four characteristics. Very few

[12] This includes both children who had never been victims and children who had been victims more than 45 days prior to their random assignment.

children were crossovers, the directions of the differences were mixed, and none of the differences were statistically significant.

Table 8.4: Crossover Rate* by Risk Characteristic		
Characteristic	**Hold-Back Rate When Child:**	
	Has Characteristic	**Does Not Have Characteristic**
Has any disability	0.7%	1.0%
Was ever in congregate care	1.1%	0.8%
Ever had placement episode prior to random assignment date	1.0%	0.8%
Is recent victim of abuse or neglect	0.7%	0.9%

**Crossover rates* are the percentages of cases randomized to the public agency that were actually served by a private agency. Total number of crossovers = 64. Siblings are excluded.

8.6 SUMMARY AND CONCLUSIONS

Under its managed care strategy, Franklin County distributes, among the public agency and two private contractors, the case management responsibility for new child welfare cases. The study team used a hierarchy of long-term case histories to take a comprehensive look at the quality of child outcomes. The analysis found no evidence of any significant differences in the quality of child outcomes between cases assigned to private agencies and those assigned to the public agency. However, among the cases assigned to private agencies, nearly half were never actually served by the private agency; for a variety of reasons, these cases were served by the public agency. As a result, it is very difficult for any analysis of the impact of group assignment to detect a differential effect.

In an analysis of the hold-backs (cases assigned to a private agency that were actually served by the public agency), the team found that, among the children assigned to a private agency, those who were recent victims of child maltreatment were more likely to actually be served by the public agency (i.e., never transferred to the private agency) than were children who were not recent victims. This variation does not compromise the validity of the estimates on child outcomes since ITT procedures were used; however, it is an indication of a systematic difference between the public agency caseload and private agency caseloads.

In conclusion, the team noted that study conditions favored the private contractors. Specifically, they did not have to serve elastic demand and they did not have to serve medically fragile children, whereas the public agency had to accommodate whatever need there was including all medically fragile children. In other words, no matter how thinly stretched the public agency was, it always had to accommodate new cases – which was not the situation for the private agencies. Furthermore, once a child went to PPLA or PCC, the private agencies were required to turn the child back over to the public workers. This can have substantial cost

implications, since children in PPLA frequently require expensive congregate care and those in PCC can be in long placements waiting for their adoptions to be finalized.

The evaluation findings indicate that children randomly assigned to a private agency were no worse off than children randomly assigned to the public agency. Thus any efficiencies achieved did not come at the cost of worse child outcomes. However, these findings are tempered somewhat by the high hold-back rate, which made it harder to detect differences in outcomes. If FCCS wishes to continue its comparative study of children served by the private agencies versus those served by the public agency, the study team recommends (1) better-controlled assignment of cases, adjusting the sampling ratio more accurately to minimize the need to invoke the capacity cap for the private agencies, and (2) more thorough documentation of the reason a case becomes a hold-back or a crossover in order to measure and understand any systematic bias. This would enhance the validity of comparisons made between the two types of caseloads. The study team acknowledges that the cases examined in this study were from an earlier time period, and these changes might have been made for more recent cases.

The managed care study concludes with this report, so there will be no new analysis in the coming years of the evaluation.