2.2.2 Financing

At the heart of the Title IV-E Waiver is fiscal flexibility. Whereas most states receive Title IV-E monies only in proportion to the amount of out-of-home care they use, Ohio counties receive a fixed amount of funds, which they can then use in whatever way they choose, not just on out-of-home care and not just for Title IV-E eligible children. Experimentation with creative financing thus becomes a valid activity, whether to purchase services for families, provide training opportunities to staff, or offer discretionary funds to workers, to use as needed to meet specific child and family needs. Both ODJFS and the fourteen demonstration counties place a high priority on learning how use of innovative financing practices leads to more positive outcomes for children and families.

Capitation is the primary principle behind any managed care approach, the process whereby a fixed amount of money is paid in advance to cover the costs of services needed by eligible individuals or families. In receiving a flat rate per person, the provider promises to provide all needed services regardless of whether the cost of those services exceeds the payment. Herein lies the risk: can each child's needs be appropriately met without financial loss to the provider? Capitation and risk can take many forms, and are often negotiated with the potential providers/managed care entities. Commonly, as the degree of risk to the provider increases, risk-sharing arrangements become more crucial. Many options exist for establishing capitated, shared-risk service arrangements, limited to a certain group of children and families, or broadly applied to the general child welfare population.

Summary: Capitated contracts are the essence of managed care financing strategies, and it is clear that ProtectOhio counties have been able to use the flexibility of the Title IV-E Waiver to develop these types of contracts. In Year 3, four demonstration counties had established capitated contracts with local providers, while no comparison counties did so. However, it is interesting to note that in the last year, two demonstration counties have ended their capitated contracts, and the extent to which managed care financing techniques were built into these contracts decreased. In addition to capitated contracts, the study team also explored the flexible use of IV-E and other funds to support activities that might not otherwise be available. Findings indicate that both demonstration and comparison counties have been able to find flexible funding sources (Waiver funds, as well as TANF, PRC, etc.) that allow them to purchase similar services, promoting a reduction in placement days. However, demonstration counties appear to be more enthusiastic and planful in their use of flexible funds, because they know the magnitude of their flexible Waiver funds.

Capitated Contracting

Several ProtectOhio PCSAs are engaged in capitated contracts, with varying conditions related to risk sharing, sanctions and rewards, holdbacks, etc. During the course of the evaluation, the site visit team has explored the nature of these contracts, how well they are faring, and what changes are being made in the contractual relationships. This arena of activity promises to be particularly rich in lessons for child welfare practice.

Approximately a quarter of the demonstration counties are experimenting with managed care financing methods. Four of the demonstration counties have capitated or case rate contracts in place, although the specifications differ substantially in who is served and how the contracts are structured. It is interesting that in Year 2, six demonstration counties reported having a capitated contract, while in Year 3 only four demonstration counties reported using this financing strategy. Two demonstration counties have chosen not to continue their capitated contracts for a variety of reasons. One county, Lorain, has returned to a fee-for-service contract with the provider and is no longer using the contractor for residential services. The other county, Stark, experienced difficulties in negotiating the contract for specialized foster care and the contract was never established.

Each of the current contracts is profiled below.

Crawford County: Crawford County CSB decided to explore managed care options as a way to reduce its skyrocketing placement costs. In 1997, CSB contracted with SAFY, a residential treatment and foster care provider, to serve high-need children, especially those needing out-of-county placements. Under this contract, when it is determined that a child needs to be placed, and CSB foster homes cannot take the child, the FCF clinical committee reviews the case. After they have explored all other options, the case is passed to SAFY. SAFY uses supportive services to prevent placements, provides placement options ranging from regular foster care to residential treatment, and offers intensive wrap-around services at reunification. SAFY responsibility ends once the child has been maintained in a permanent setting for six months. In the first year, SAFY received a case rate of $38,325/year; this increased to $45,000 in 1998. The group stop-loss was set at $225,000, with a no eject-no reject policy. SAFY contracted with some of its placement providers using a case rate contract and a no eject-no reject policy, thus sharing the risk somewhat.

CSB reported early success in the SAFY contract, with fewer children placed out-of-county, more children reunified, and children returning home sooner than they were before SAFY. The savings generated were shared with FCF, in particular to fund creation of a family resource center. However, by Year 3 of the evaluation, the CSB expressed serious concerns about the SAFY contract. With the development of other new services in the community, it was unclear if this contract was still serving the agency well. The contract is currently being renegotiated.

Franklin County: In FY1999, Franklin County CSB contracted with two different provider networks – Ohio Youth Advocates Program (OYAP, primarily a foster care agency), which has numerous subcontractors; and a consortium called Permanent Family Solutions (PFS), composed of Buckeye Ranch (a residential provider), Directions for Youth (primarily providing adolescent in-home services), and Children's Hospital Guidance Center. In FY1999, each network received about 14 cases per month; in Year 3 it was up to 30 cases (about 17% of total CSB cases). Intake, investigation, and adoption are handled by CSB; case management and all service delivery is the responsibility of the managed care contractors. FCCS staff serve as QA monitors.

At the time of the Year 3 interview, the contracts remained largely unchanged. The case rate was $23,074 for OYAP ($20,515 for PFS), with incremental payments at referral, three months later, and at closure. The contract included sanctions for reopening a case within 18 months; risk-sharing on individual cases when the case cost exceeds four times the case rate; a 5% risk corridor on total expenditures (increased to 10% in the second year); and a set-aside of $970,000 to protect against overruns.

FCCS prepared a Managed Care Outcome Report for the 2000, comparing the managed care contracts to FCCS performance over the first 18 months of the contracts. The results showed that the three groups performed equally well on a range of outcome measures (see box).. The report also showed FCCS per case costs to be slightly higher than the managed care contractors ($23,325 compared to the average case rate of $21,795).

During the Year 3 interviews, the county reported that these contract arrangements were going well, with few modifications needed. The agency continues to monitor the services being provided and was satisfied with the way things were going. The CSB is planning on extending the contracts and would do so regardless of the continuation of the Waiver.

Outcomes from Franklin County Managed Care Contracts

Performance by the two managed care contractors was found to be comparable to FCCS regions on the following outcome measures:

- ✓ Frequency of face-to-face contacts
- ✓ Open case maltreatment rate
- ✓ Case reopening for service
- ✓ Median days in temporary custody
- ✓ Number of moves before leaving care
- ✓ Reunification rates
- ✓ Children served in home

* Source: FCCS *Managed Care Outcome Report for 2000*

Franklin County has also embarked on a quasi-managed care arrangement for provision of mental health and substance abuse services. FCCS and ADAMH are jointly funding three NetCare staff, located in the FCCS Intake office. These staff provide on-site assessment of mental health and substance abuse needs, and can assure that service referrals get priority. The two agencies are pooling the funds they had each been spending on common clients, and use these funds for the non-Medicaid share of services to all FCCS clients. When the pool is exhausted, the plan is to share the costs 50-50. This pool has not yet been expanded to include services for the managed care contract children.

Hamilton County: Hamilton County DHS has three managed care contracts, each addressing different issues. The first, and longest running, is a contract for the provision of services to multi-agency, or "cluster" children. The contract is supported by all the major child-serving agencies. The original contractor went bankrupt. In fall 1998 Creative Connections took over the $13 million contract. They provide care management and services through a reduced network of providers. The five-year contract is capitated; the FY1999 rate was $3130 per month per child. The contract includes a no reject policy, risk sharing after the first $500,000, stop-loss protections and individual client maximums; in addition, there is a cap on administrative costs and care management costs. At the end of each year, contractor performance is compared to outcome targets; if they fail to meet the target, funds are deducted from the next quarterly payment. At the time of the Year 3 interviews, this contractor was continuing to lose money.

Because the provider has a large endowment, they are able to absorb the cost for now, but there is discussion of merging this contract into the Magellan contract. This contract was the only one of the three with full risk sharing.

The second contract is with a private, for profit behavioral health managed care company, Magellan Public Solutions, who is contracted to manage all therapeutic services for the child welfare population, including outpatient and out-of-home care services. The contract began in January 1998, after 2 years of planning and negotiation. The contractor serves as an administrative services organization. Their charge was to reduce the rate of growth in costs to 3-4% (down from the historical 20-30% increase experienced in residential care), for a small, separate administrative fee. Further, they are to turn over the entire system to the county at the end of five years, if the county desires it. The first year goal was to cut costs by 10%; the incentive was that they would share in the savings, but this goal was not achieved. This contract had performance incentives in it for reducing the cost of therapeutic services, but has yet to be able to achieve these goals.

The QA report on first year of operations showed that Magellan failed to earn any incentive payments for its performance on a set of administrative and service standards[1]. The Managed Service Organization (MSO) achieved only 21.5 of 59 administrative benchmarks, and only 28.5 of 89 service benchmarks.

The third contract, IMPACT, is for the management of substance abuse services to child welfare children and families. The Alcohol and Substance Abuse Board created a quasi-managed care system, which includes a single provider coordinating intake and assessment, and referral to a panel of providers. Assessment takes place within the DHS building with strict timelines for access to services.

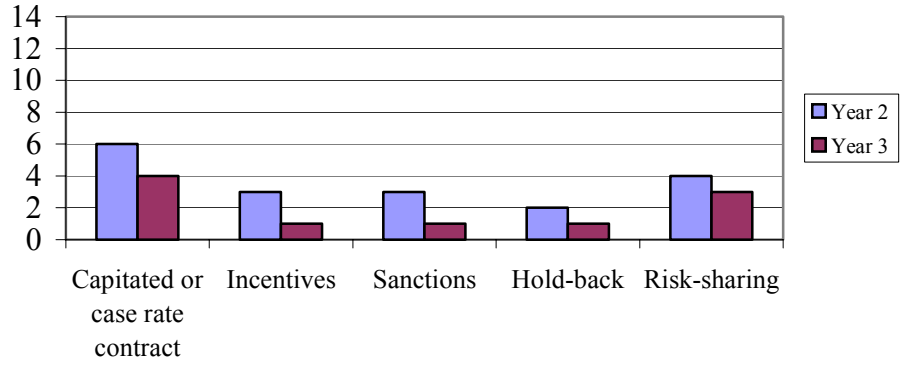
Early results indicate that service costs have been reduced significantly, while timeliness and quality have improved.

Portage County: Portage County DHS has a case rate contract that predates the Waiver. Northeast Ohio Adoption Services (NOAS) is responsible for doing whatever is needed to secure a finalized adoptive placement for a specified number of children. NOAS' role includes training and recruiting adoptive families, child assessment, working closely with Portage County DHS to prepare the child, matching child to family, taking primary responsibility for the placement, and providing post-placement and post-adoption services. Because it is a small contract, Portage DHS is able to resolve problems with individual cases as they arise, and to negotiate special rates if necessary, eliminating the need for any formal risk-sharing arrangement. At the time of the Year 3 interviews, Portage County DHS was still satisfied with the arrangement with NOAS and had acquired additional funds to support the contract.

[1] Hamilton County DHS, *Magellan Public Solutions Performance Review* for the period January 9-December 31, 1999.

Overall, the four demonstration counties with capitated contracts use a limited degree of financing techniques. While three of the four counties have some degree of risk sharing, there were few other managed care financing strategies that were being used during the third year of the Waiver. This is a noticeable difference from Year 2 (Figure 2.9). This change is not surprising, in that managed care contracting takes child welfare agencies into new territory, and the early years can be expected to be exploratory ones. The largest of the demonstration counties, Franklin and Hamilton, are perhaps better equipped technologically to undertake these ventures, and many of the other counties are eagerly watching their experiences. Should Ohio's Waiver be extended, more counties may begin to move into this arena.

Figure 2.9: Demonstration Counties Using Financing Techniques



While the number of demonstration counties using capitated contracts has decreased and the financing techniques being used are somewhat limited, it is still notable that none of the comparison counties use capitated contracts. As far as the future of capitated contracts in Waiver counties, those counties with current contract indicate that they intend to keep these contracts even if the Wavier was no longer available: these contracts have become a part of the way the PCSA does business for these counties.

Other evaluation counties are interested observers of the managed care financing experiments. In the Year 2 site visits, several demonstration counties expressed interest in exploring capitation and risk-based contracting, but for the most part are happy to wait and see what happens in the counties already trying the strategy. Several comparison counties similarly stated that, while they are ready for managed care, they are nonetheless waiting and learning; their primary concern is losing control of the case once it is assigned to a managed care contractor.

The evaluation team will continue to monitor the progress of these counties and others that may turn to capitated financing arrangements in the future. It will be important to document both the challenges they encounter and any results they experience, especially in terms of outcomes for children and families.

Flexibility of IV-E Funds

Last year, the Process Study asked the question: how are the demonstration counties using their flexible IV-E funds? This year, the study team examined whether the comparison counties, too, had made use of any non-categorical funds available to them to embark on specific efforts otherwise not pursued with their usual funding streams. The study team found that both the comparison and demonstration counties funded a number of programming and staffing initiatives through the use of either flexible IV-E dollars or other non-categorical funding sources such as excess TANF funds, ESSA, PRC, Family Stability monies and occasionally undesignated levy monies[2]. In general, while little doubt exists that the Waiver funds have provided the demonstration counties with a tremendous opportunity to try new approaches and fund needed initiatives, they and the comparison counties have both managed to find and take advantage of other flexible funding sources.

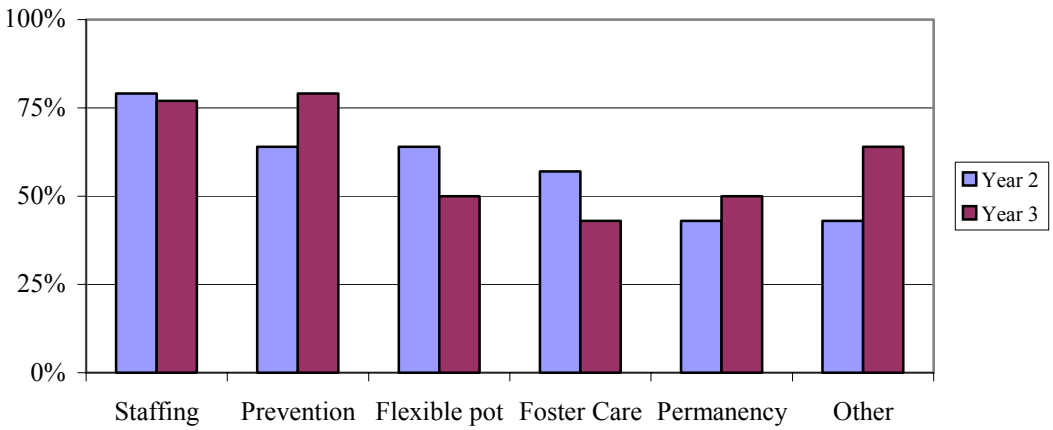
Moreover, except in the area of permanency initiatives, little contrast is evident between the demonstration counties and the comparison counties in the ways they spend their flexible funds. It should be noted, though, that the study questions for Year 3 referred to both reinvestment of IV-E funds and use of other flexible funding sources and did not rigorously distinguish between the two. Many demonstration counties used a combination of sources, including IV-E funds and other pots, to fund the initiatives discussed in this section, and do not, in general, have a method of distinguishing exactly which source of money was used for which expense. Thus, the data may not clearly show the impact of the IV-E funds, given the wide availability of other monies.

What did come through clearly was the enthusiasm of demonstration counties for trying new and more flexible uses of the money available, whether Waiver funds or other sources. Many of the demonstration county respondents perceived a greater freedom than ever before, for example, to engage in preventive programming and hire new staff. The Waiver funds may indeed be spurring a spirit of innovation, a subtle but important effect that also may be significant in future years if the other sources of money dry up. If the study is extended, the study team hopes to explore more fully the use of Waiver funds more extensively and rigorously, using fiscal data and analysis if possible.

[2] Some of the non-Waiver sources of funds are more "flexible" than others. For example, the leftover TANF and PRC monies carry an income eligibility requirement but could be (and were) used in a variety of ways to assist low-income families and children.

Figure 2.10 contrasts the ways demonstration counties used their flexible IV-E funds in Year 2 and Year 3 of the evaluation. In the second year of the evaluation, the demonstration counties reported that they took advantage of their IV-E flexibility most frequently to fund direct service staffing initiatives, primarily creating new positions and hiring to fill vacant positions. While staffing initiatives continue to be important this year, more of the demonstration counties focused their flexible funds on developing new prevention programming. This slight change could be attributed to the widespread and generally successful efforts of the counties to address their staffing shortfalls in the past few years, freeing PCSA administrators to consider and spend on other pressing issues and needs. Another predictable change in emphasis was the diminished number of counties that put flexible funds towards foster care per diem increases this year; some of the counties that increased their rates last year would have no need to do so again so soon.

Figure 2.10 Change in Demonstration Counties' Use of Flexible IV-E Funds



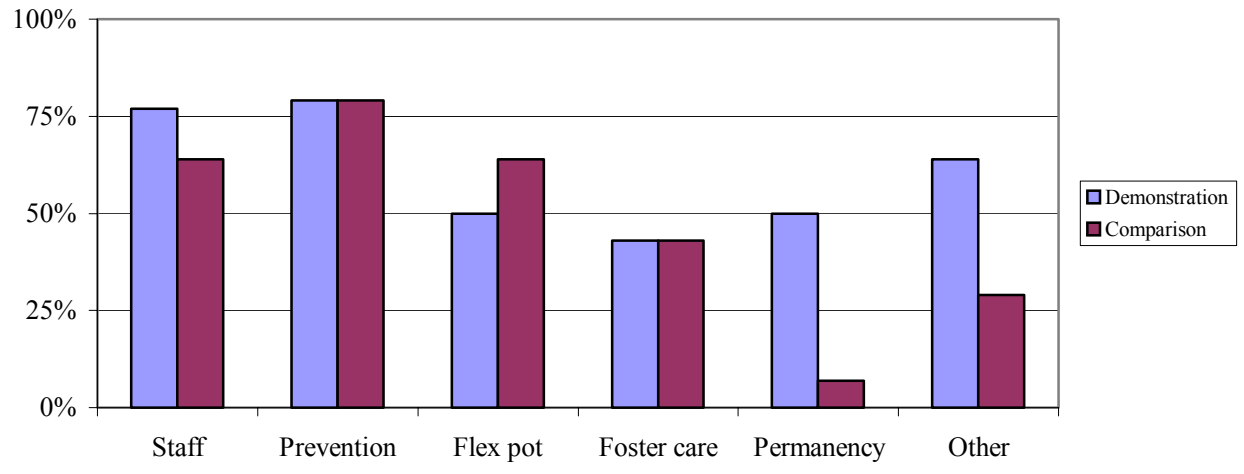
Finally, in Year 3 of the evaluation, several more demonstration counties were able to spend their flexible funds on other efforts such as cost-sharing with other agencies for children not in PCSA custody, hiring organizational development consultants, and even purchasing the PRO-IV software used to assist in the implementation of Caseload Analysis. The counties' involvement with the Waiver and the reliable availability of Waiver money may be fostering a spirit of innovation as well as contributing to a reduction in traditional "turf battles" with other agencies over funding. Because the demonstration counties received limited IV-E dollars, they have a continued financial incentive to reduce placement days. This financial incentive may serve to reduce territorial approaches to placement costs, encourage careful case management to avoid unnecessary placement, and increase already aggressive permanency efforts.

Use of Flexible Funds in Demonstration and Comparison Counties

The study team identified five specific areas in which flexible funds might be spent, and one "other" category to capture innovative efforts and cost-sharing arrangements with other agencies. Demonstration counties were asked to identify the areas where they were spending flexible funds, that *would not have happened in the absence of Title IV-E flexibility*, even when they did

not specifically track the use of the IV-E dollar to that initiative. Comparison counties similarly identified new efforts they were pursuing using new or increased flexible dollars at their disposal. Figure 2.11 indicates that both groups of counties have used flexible funds quite broadly to improve their ability to meet the needs of children and families.

Figure 2.11 Uses of IV-E Waiver Funds and Other Flexible Funding Sources



Prevention programs and services: Both comparison and demonstration counties pursued prevention programming and new staffing strategies vigorously with their non-categorical funds. For both sets of counties, prevention was the number one use of flexible funds: eleven demonstration counties and eleven comparison counties (79% overall) funded diverse efforts ranging from true primary prevention to intensive intervention as a last-ditch effort to keep children from being removed from their homes. The new initiatives included after-school enrichment and recreation programming for K-5, family coaches and "assistants" to assist with daily tasks and homemaking education, wraparound services and "Fast Track" services, drug and alcohol assessments, services to unruly youths and their families, intensive home-based therapy, and even a partial hospitalization program. Many of the new programs and approaches to prevent placement were focused on adolescents, perceived as difficult to serve through traditional child welfare system and very difficult to place out of home in a least restrictive setting.

Staffing, internal capacity and training: More than two-thirds of the demonstration counties and the comparison counties (77% and 64% respectively) spent flexible funds on staffing-related needs. Half of these 18 counties created new positions and hired new staff. Although all the counties focused their funds on direct service staff, most often mentioned were new investigators and assessment staff to help control intake (and make appropriate decisions) when involvement with a family is just beginning, and new adoptive home finders and foster care recruitment staff. Some of the PCSAs also took the opportunity presented by the availability of funds to increase salaries to retain good workers and attract new hires, and to provide more and better training for

staff. One demonstration county (Stark) used its flexible IV-E funds to help maintain its own legal department, so that it need not rely on the prosecutor's office.

The high proportion of both demonstration counties and comparison counties who directed flexible funds towards increased staffing and internal capacity may illustrate how the overall economy can mute the effects of having flexible Waiver monies. Because the finances of comparison counties were generally comfortable in the past year, new positions and salary increases were possible where they may not have been so in less affluent years. On the other hand, in less affluent times, the Waiver funds may provide a stable source of funding for the demonstration counties when they need to attract and retain staff. Future years of the evaluation may test this hypothesis, as the economy in Ohio and indeed nationally has shown a weakening.

Flexible Funding Pots: Approximately half of the comparison counties (64%) and half of the demonstration counties are using flexible pots of money for their workers to use creatively to prevent removal from the home, support a foster care placement, or support reunification. Many of the expenditures are one-time-only emergency assistance, such as buying a bed for a child, paying a heating bill, or paying the rent. (Miami County calls their pooled fund for emergency assistance "Ten-Minute Money.") Another county provides a flexible pot for foster care "auxiliary" costs, such as paying for a field trip, music lessons, or camp. A non-designated pot of money also has allowed workers in a few of the counties to purchase emergency counseling or mental health intervention where the family cannot afford private care and the mental health agency is not providing/cannot provide it in a timely fashion.

Foster Care Per Diem Increases: -four of the counties (five demonstration and six comparison sites) spent flexible funds on increasing foster care per diems to attract more potential families. These expenditures appear to reflect the continuing significant need across all counties for more foster homes and the desire of many Ohio PCSAs to move away from network homes and open more agency homes (see services section above).

Permanency Initiatives: The demonstration counties have been considerably more active than the comparison sites (50% compared to 7%) in using flexible funding to expand permanency options, primarily increasing adoption subsidies for hard-to-adopt children and creating assisted guardianship programs. These efforts supplement the staffing increases in adoption workers reported by many counties under the *Staffing* subsection discussed above. One likely explanation for this contrast between the county groups is the greater attention that demonstration counties naturally give to reducing placement days, since they face not only the usual ASFA pressures but the added impetus of the Waiver funding cap.

Other: Fourteen counties (nine demonstration and five comparison) use flexible sources of funding to undertake a variety of other efforts not mentioned above. All of the demonstration counties in this category participate in placement cost-sharing arrangements in which the placed children are in the custody of another agency, where it appears the child and family are heading for a referral to the PCSA and can be diverted, or at least resolved more quickly. (Again, this may reflect both an increased willingness to break down the barriers between agencies and a desire to reduce PCSA placement days and increase Waiver savings.) Some counties are also

using the available funds for managed care activities, including capitated contracts, purchasing of software to manage caseloads, and bringing in organizational development consultants.

At first glance, the Waiver does not seem to be a determining factor in whether or how counties are spending flexible funds. However, the wide availability of non-Waiver flexible funds in Year 3 of the evaluation is significant in that it may well tend to mask the actual effect of the IV-E Waiver. In years when the economy is perceived as strong, such as last year, where many PCSA's reported their finances as stable or even "flush," the agencies are more able and more willing to spend on new initiatives, new staffing, increases in foster care rates, and other non-mandatory efforts. Thus, the comparison counties may appear to be as committed to flexible funding as their demonstration counterparts, when in fact they simply have more money than usual and can direct it to some new efforts. In fact, some demonstration counties believe they were actually at a disadvantage in receiving other types of flexible funds from the local DSFS agency, due to their participation in the Waiver, while comparison counties had a greater access to these flexible pots. The question for future years is, if (as is likely) TANF, PRC, Family Stability and levy monies are less available or not available at all, will the comparison counties have the ability to continue to spend money on prevention programming, staffing capacity, and innovations in case management?

More significantly, even though in coming year (or years, if Ohio receives the extension it has requested) demonstration counties will continue to have the ability to spend IV-E dollars flexibly, will they do so if placement numbers go up and the other non-placement funding sources run dry? Richland County, a demonstration county, may provide an interesting insight into the interplay between IV-E Waiver dollars and other flexible sources of money. The county reported that it spent none of its IV-E Waiver earnings on any of the efforts listed below, because all of the money had to go to increasing placement costs (Richland County's placements increased by 15% between FFY1999 and FFY2000). Richland did, however, have staffing increases, provide prevention programming, set aside emergency money for workers to prevent placement, and provide adoption subsidies – using ESSA, AdoptOHIO, Kinship, and "temporary state dollars." As these funding streams could not be spent on placement, and the Waiver dollars could be, the county directed the IV-E dollars to placement. The question is whether, absent the support of the other funding streams, Richland would have diverted some of the IV-E dollars away from placement and into some of its new efforts. Again, although in a different way, the availability of other monies may be hiding the effects of the IV-E Waiver.

The benefits of the IV-E Waiver flexibility over other sources of funding may be best illustrated in the area of permanency options. ESSA, PRC, TANF, and Family Stability monies, used by the comparison counties to fund some of their prevention and staffing efforts, would not be appropriate or available for funding adoption subsidies, both because of the ongoing nature of the subsidy payment and because children who might be eligible for PRC or TANF monies would also be eligible for adoption subsidies under Title IV-E. The problem comes when (1) a child is not IV-E eligible, and/or (2) a subsidy higher than the IV-E rate is needed to facilitate the adoption. Unless a comparison county had levy or other local flexible dollars at its disposal, it would not be able to respond to those issues. Participation in AdoptOhio can enhance a PCSA's recruitment and placement activities but does not provide funds for subsidies. Thus, in the area

of adoption, demonstration counties clearly have an advantage; indeed, one demonstration county (Portage) noted that increasing adoption subsidies for children with "very special needs" was "one of the most significant uses of the Waiver."

The Process study team will continue to closely examine differences in flexible spending between demonstration counties and comparison counties in the remaining years of the Waiver, paying special attention to PCSA access to flexible funding sources outside of child welfare, such as TANF and PRC.

2.2.3 Competition

As child welfare agencies become more attuned to cost effectiveness and to making the best use of their contractors, the idea of competition enters the discussion. At the simplest level, the PCSA can look at its contractors as competitors, because they may perform some of the same functions as PCSA staff. The positive side of competition is that all parties can learn from one another, and practice ultimately improves. This benefit is muted, however, by the common misconception in child welfare that the goal of competition is only to reduce cost, sometimes at the expense of service quality. This belief has deterred many in child welfare from actively working to use competitive forces to improve the service system.

Managed care is often touted as a way to increase the competition, and thus the efficiency, of providers in a service network. The larger the provider network, the more potential exists for choice among services and among providers of a given service, thus affording greater opportunity to meet an individual's needs. However, unless multiple providers of comparable services exist, creating competition, providers may not feel any pressure to keep service quality high, or even to continue to offer a service that is required only infrequently. Especially problematic may be assuring inclusion of culturally-specific services and providers. PCSAs have opportunities to invite new providers into their county, or to otherwise stimulate competition, in the interests of improving service quality and choice.

Summary: A number of counties have increased the rates they pay for particular services to stimulate growth. This is most often seen in an increase in rates paid to foster care homes to enhance the pool of foster care placements, but counties are also trying to develop new benefits to encourage more foster families to work with the PCSA. It is interesting that this year, more comparison counties have adopted this strategy than demonstration counties. Another approach to increasing competition between providers is the development of preferred provider networks: one demonstration and one comparison county have developed this type of arrangement, and several others are exploring the possibilities.

Findings

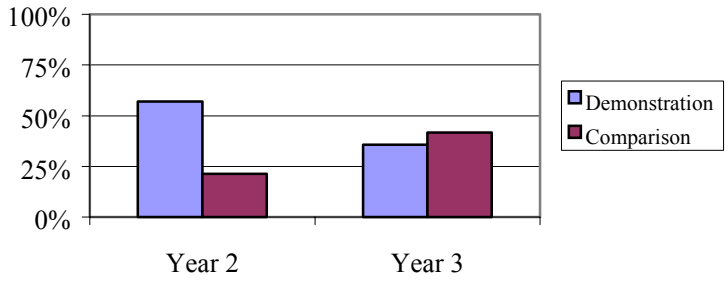
During the site visits, the evaluation team explored PCSA competitive posture from the perspective of how counties are trying to stimulate growth among providers and how they are changing the network configuration and competitiveness. The first dimension of competition is conscious actions to increase the size of the provider marketplace. Thirty-six percent of demonstration counties, as well as thirty-six percent of comparison counties, have made

deliberate changes in payment rates, to encourage new providers to offer services in the county (Figure 2.12).

It is interesting to look more closely at some of the specific steps counties have taken. Most often, the focus is family foster care, with some focus on therapeutic foster care services. PCSAs are not only raising per diem rates but also adding additional "benefits" to the foster care package, such as making payments bi-weekly rather than monthly, assuring that pharmacy services are readily available, including funds for day care, and offering additional reimbursement for education-related activities (e.g. music lessons, athletics).

Figure 2.12 indicates that while demonstration counties were more involved in this rate change strategy in Year 2, during Year 3 of the evaluation, comparison counties seem to have caught up with the demonstration counties. This is not surprising, as many of the demonstration counties immediately adopted this strategy after receiving flexible IV-E funds. Now that their rates are competitive, demonstration counties are focusing their efforts in other areas. On the other hand, comparison counties may have a difficult time finding the funds to support an increase in their per diem rate because of their inability to access flexible IV-E funds. However with the recent availability of flexible funds such as PRC and TANF, to replace levy funds in certain areas, comparison counties may now be better able to change their per diem rates.

Figure 2.12: Rate Changes to Stimulate Growth



PCSAs are also trying to create more competition between providers by developing preferred provider networks. In these arrangements, the PCSA agrees to use the provider's services contingent on a negotiated, usually less expensive, rate. In return, the PCSA guarantees to use the provider before turning to others who offer a comparable service. By setting up these arrangements, PCSAs are able to hold providers accountable if the services provided are not adequate – they put strict service criteria in the contracts. Findings from Year 3 reveal that two counties (one demonstration and one comparison) have already developed preferred provider networks, allowing them to control the cost of purchasing services by negotiating for lower per diems. Three demonstration and one comparison county are considering developing preferred provider networks. In a similar arrangement, one demonstration county has found that by creating a mental health unit within the PCSA, the local mental health provider has realized the need to develop new services or risk losing the business of the PCSA.

Each of these strategies serves to promote the development of new providers and services in the community, as well as limit the growth in provider rates. It will be interesting to monitor the effectiveness of these preferred provider agreements in future years, and whether they are utilized differently by demonstration and comparison counties. Over the course of the evaluation, the site visit teams will continue to monitor activities in this area, and to discuss with local stakeholders their views about expansion of the provider marketplace.

2.2.4 Utilization Review

Utilization review is a formal process, often by an outside party, to ensure that the services being provided are necessary, appropriate, and at the lowest reasonable cost. In child welfare, the most common area undergoing this additional scrutiny is placements, both because they are the most costly on a unit basis, and because they are seen as the most restrictive service option. However, child welfare agencies may also take a closer look at how other services are used, to assure their availability as an alternative to placement. Ultimately, rational decision-making processes, supported by automated data systems, must be put in place to establish and maintain systematic parameters around service usage.

In the site visits, the study team explored the ways PCSA managers limit access to particular services, through formal criteria determining an individual's eligibility, aggregate ceilings on amount of a service that is available, or other decision-making guidelines. The study team also examined the ways in which PCSAs collect and use automated data. In general, demonstration counties make somewhat more use of utilization review mechanisms and MIS than do comparison counties, yet even the demonstration counties are at best only modestly active in these managed care arenas.

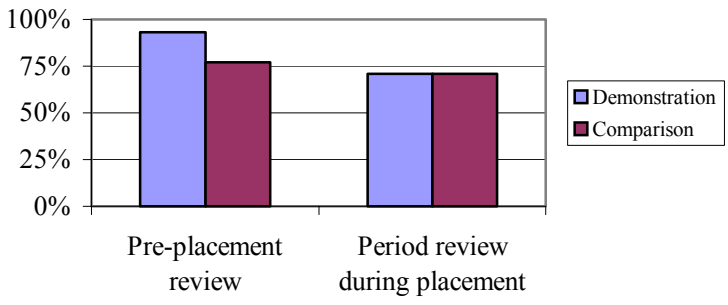
Summary: Demonstration counties continue to develop somewhat more quickly than their comparison counterparts in the area of utilization review, showing more use of placement review processes than comparison counties. In the area of information systems to improve agency decision-making, both demonstration and comparison counties are trying to improve their data collection capabilities, although most counties still primarily rely on FACSIS. It is interesting to note that several comparison counties are acquiring information systems to allow them to conduct more complex analysis of data, slowly catching up to the demonstration counties who have adopted similar types of information systems. Lastly, CLA continues to be implemented to various degrees in half of the demonstration counties and two comparison counties, enabling counties to monitor their use of valuable child welfare resources.

Monitoring/Overseeing Service Usage

Because of the Waiver emphasis on reducing placements, and all counties' awareness of the primary role that placement costs have in the overall operation of each PCSA, counties are giving increased scrutiny to placements: to whether or not placement is needed, for how long, and at what cost. This may involve placing explicit limits on access but more often subjecting placement cases to more stringent review processes than non-placement cases. These monitoring activities can be characterized as utilization review.

The most common avenues to controlling service utilization are pre-placement review processes and periodic reviews after placement has occurred. Over 89% of all study counties engage in at least one of these processes (compared to slightly over 75% in Year 2). Demonstration counties indicate somewhat more tendency than comparison sites to pursue such activity (see Figure 2.13): 93% of the demonstration counties conducting pre-placement reviews, and the 71% of the demonstration counties conduct periodic reviews during placement. Comparison counties are slightly less involved in these activities, with 77% comparison counties doing pre-placement reviews and 71% holding periodic reviews during placements.

Figure 2.13: Strategies to Monitor Out-of-Home Placements



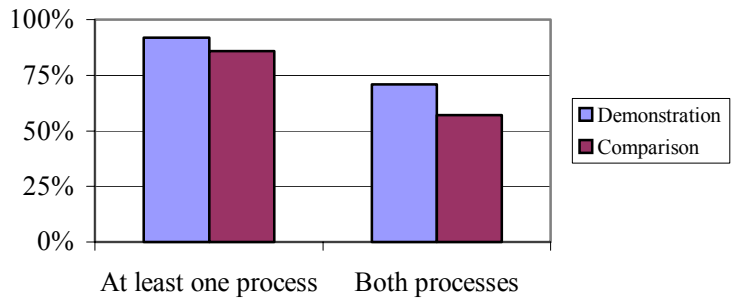
The placement review processes tend to be team efforts, involving staff from various levels within the PCSA, as well as including others in the community, such as FCF players, prosecutors, Family Stability staff, the family, etc: this is reflective of PCSA's recognition of the complexity of the placement decision. These teams most often begin by reviewing the potential placement case and discussing a range of options to avoid the necessity of placement. In many of the smaller counties, management is able to review all placement cases on a weekly basis, removing the need for a formal review function. Several demonstration counties are using somewhat unique review processes; among them are:

- A permanency planning committee reviews each case before filing, and again every month thereafter, to assure movement toward a permanent home.
- New foster homes are being visited on a weekly basis for the first few months, to address any needs or concerns as they arise, rather than waiting for a crisis to develop.
- Staffings every 90 days for children with a goal of reunification, to assure that progress is being made.
- Considering reviewing all placement cases at 30, 60, and 90 days.

In addition, the demonstration counties which have managed care contracts have all instituted formal placement review committees, to retain some control over where children go after referral to the managed care contractor.

Overall, demonstration counties are somewhat more active in placement review (Figure 2.14), with 93% of the demonstration counties using at least one of these two mechanisms and 71% of these counties using both. This contrasts with comparison counties, where 86% of the counties use at least one but only 57% of comparison counties use both approaches to controlling placement use. That this discrepancy is not wider is surprising, since demonstration counties self-selected into the Waiver, often because of a strong desire for more flexible ways to control placements.

Figure 2.14: Overall Use of Placement Review



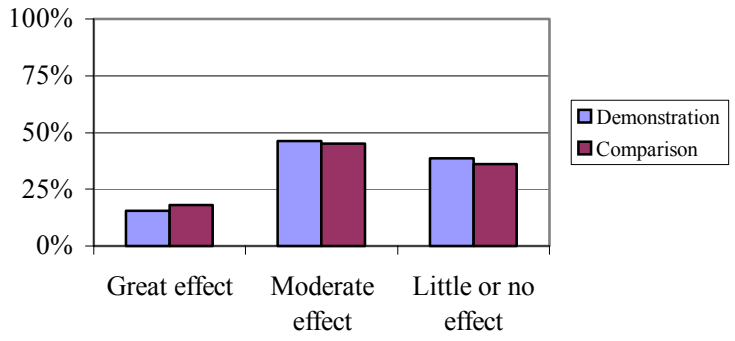
Closer examination of the data support the idea of demonstration counties' stronger commitment, since prior to the Waiver the demonstration counties were already focused on the need to limit access to placement services. Eighty percent of the demonstration counties with a pre-placement review process had had it in place prior to the Waiver, and a similar proportion (78%) had already established their periodic placement review process; the comparison county figures are somewhat lower, 75% and 56% respectively. This suggests that overall, demonstration counties do seem to be more invested in using these processes to control the use of PCSA resources.

Demonstration and comparison PCSAs are equally sanguine about the impact of these review processes on placement utilization (Figure 2.15). Of those using placement review processes, roughly sixty percent of both demonstration counties and comparison counties judge that these mechanisms have moderately or greatly reduced placements. It is interesting to note that this is a smaller percentage than was reported in Year 2 (seventy-five percent of both demonstration and comparison counties), suggesting that administrators (of Year 3 respondents) are perhaps more tempered in their enthusiasm for these review processes.

Management Information Systems

Key to managing service utilization is having automated systems that track aggregate usage patterns and even project long-term costs and capacity needs. The foundation for much of the managed care activity described in this section is a comprehensive management information system, containing sufficient historical data, having a strong tracking capability, and offering linkages between administrative and fiscal data sets. Indeed, one of the core hypotheses for the

Figure 2.15: Impact of Placement Review



Waiver is that demonstration counties will become more systematic in measuring outcomes and will make greater use of automated decision support systems.

Data gathered during site visits and telephone interviews reveals that counties, especially demonstration ones, are moving in the hypothesized direction. Many PCSAs are beginning to pay attention to the data they already have, and beginning to explore various software packages to help them understand what they have and what more they need. The site visits examined the current capability of each PCSA to:

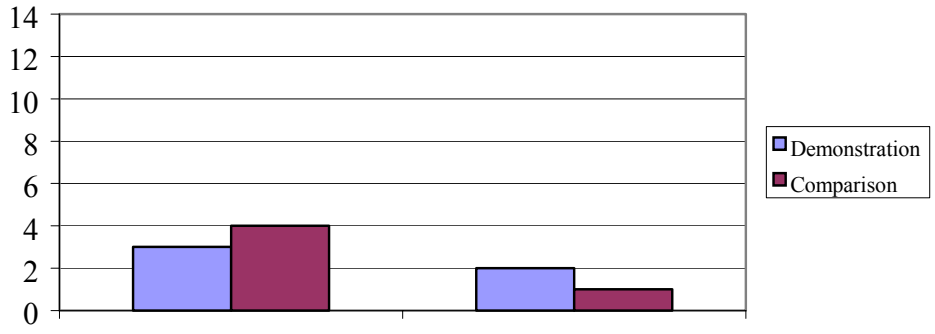
1. Case tracking with FACSIS;
2. Basic case tracking beyond FACSIS (e.g. MicroFACSIS);
3. Link programmatic and fiscal data; and
4. Computer modeling (caseloads, service packages, resource allocation).

In talking to PCSA administrators, the study team explored the extent to which each PCSA focuses on its automated data, from simply using basic FACSIS fields and reports, to committing significant resources to develop independent management information systems. Not surprisingly, PCSAs run the full gamut, with demonstration counties showing somewhat greater activity around data collection, management and analysis.

While most counties still primarily rely on data from FACSIS and MicroFACSIS to track cases, some counties are moving into new areas (Figure 2.16). Several demonstration and comparison counties are beginning to link program and fiscal data, acquiring information systems (e.g. Pareto, Pro IV) that allow them to conduct more sophisticated analysis of agency data. This

information enables them to make more informed decisions regarding how resources are used and the costs associated with these resources. It is interesting to note that within the last year, several comparison counties have become more involved in using these systems, while fewer demonstration counties are now using these additional information systems (one county discontinued use of a computer modeling system due to internal changes.

Figure 2.16: Automated Information Management Activities in Year 3



Caseload Analysis

Caseload analysis (CLA) can be viewed as one particular form of utilization review, although it has elements of other managed care strategies embedded within it. CLA is a standardized methodology that fits within an overall managed care framework of service delivery. As ODJFS has defined CLA, its goal is to categorize needs of families by intensity and duration, in order to equitably distribute cases among workers. It also serves to provide standardized guidance to caseworkers regarding case duration based on type of needs. The ODJFS model of caseload analysis consists of: (1) family assessment, using risk assessment, genograms and ecomaps, and family strengths and concerns, (2) decision-making regarding families, which includes classifying families' needs, categorizing levels of service effort, and determining duration of service, and (3) providing time-limited outcome-based services. These three steps are pursued through use of a workload capacity management system, designed to distribute cases equitably among staff and to assist in managing the workload.

Ashtabula and CLA

Ashtabula, a demonstration county, is an active participant in the Caseload Analysis Initiative. All caseworkers and supervisors are trained in the various tools, such as ecomaps, genograms, and risk assessment, and the county is currently part of a large data collection effort using the results of the risk assessment. County child welfare officials believe, in particular, that the focus on family mapping has led to increased successful kinship placement.

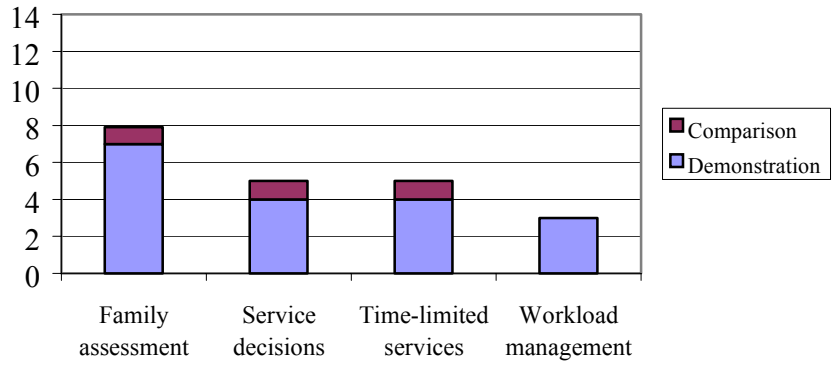
CLA is unusual among ODJFS initiatives in that it has been heralded as a specific managed care strategy, and ODJFS dedicated a staff person to spearhead the effort as well as hired a consultant to help counties implement the model. Beginning in 1995 ODJFS provided limited financial support and consultation services to interested counties to explore use of these methods. With the flexibility offered by IV-E Waiver funds, seven ProtectOhio demonstration counties decided to commit themselves to the effort. Seven demonstration counties are currently involved in the ODJFS CLA initiative; two comparison counties have recently begun using the ODJFS CLA system as well.

Implementation of the CLA model requires a PCSA to make significant changes to all aspects of its service delivery system – assessment, planning, staff deployment, permanency decisions. The CLA counties have encountered various obstacles to smooth implementation of CLA, not the least of which has been delays in installation of the Pro IV system that will enable the counties to compile information about the types of cases they have and use the computerized workload management algorithms. Among the nine counties, two demonstration and one comparison counties are not currently using the Pro IV software, while three demonstration counties are using it and another two demonstration counties is planning on using it. One comparison county is using an alternative software application.

With respect to the extent the counties are using the main elements of the CLA methodology, there is again substantial variation. This year, five of the demonstration counties are currently using CLA for all of the cases in certain units, typically intake; this is an increase from the two counties last year. The other counties are using CLA on only a sample of the cases coming to a particular unit, both because they want to work out any "kinks" in the process before going unit-wide, and because the software to facilitate the process is not yet in place.

CLA is typically implemented in stages, beginning, logically, with cases entering the system and needing assessment. Figure 2.17 illustrates the sequential nature of the key elements. All but one comparison county have implemented the family assessment elements, including use of risk assessment, genograms and, sometimes, ecomaps. Five counties (four demonstration and one comparison) have progressed to the next levels, utilizing service decision-making processes and/or providing time-limited services. Only three demonstration counties report that they have begun to use the workload management part of the model; these three have Pro IV installed in their offices. Compared to last year, CLA counties have moved slightly forward in their implementation of the CLA model, with many counties still exploring the possibilities.

Figure 2.17: Usage of Key Elements of CLA in Year 3



2.2.5 Quality Assurance

Quality assurance is closely linked to utilization review. Assuring the quality of services involves assuring that services are provided appropriately, that is, to those who need them. Counties' extensive efforts to review placements (discussed in Section 2.2.4) are the beginning of quality assurance. However, quality assurance should go far beyond assuring minimal levels of service delivery, to assuring basic compliance with regulations and minimal safety (quality control), plus efforts to steadily improve service quality over time (quality enhancement). Perhaps the fastest growing topic of quality assurance activity is attention to outcomes, assuring not just that services are provided, but that they result in changes for children and families. Quality assurance becomes increasingly important as child welfare agencies turn to contractors, especially managed care contractors, because direct service decisions become more removed from the public agency.

In Year 1, the site visit teams explored county quality assurance activities very broadly, identifying some comprehensive efforts, but, more often, finding a growing awareness of the need to think about quality assurance more systematically. In Year 2 and Year 3, the site visit teams took a more targeted approach, detailing quality control and quality enhancement activities being pursued, exploring how quality assurance is structured, and examining the role of outcomes in counties' quality assurance efforts overall.

Summary: Last year, demonstration counties showed substantially more activity in the area of quality assurance. This year, while the difference between demonstration and comparison counties is not as great, demonstration counties do appear to be using some forms of quality assurance more than comparison groups. Demonstration counties are better able to focus on quality assurance activities. In particular, demonstration counties have developed more units responsible for QA activities and make significantly more use of outcome-focused.

Quality Control

Apart from the placement review mechanisms discussed above under utilization review, the evaluation counties engage in three major types of quality control. Demonstration counties are only slightly more active than are comparison counties in two of three areas, and in quality control overall (Figure 2.18 and Figure 2.19).

The first quality control activity is automated tracking of mandatory case reviews and court filings. While all PCSAs are required to conduct these reviews, not all counties take the added step of using automated mechanisms to assure that the reviews take place in a timely manner. Demonstration counties report more activity than do comparison counties, with 57% of the comparison counties having automated tickler systems and management reports. One demonstration county even has automated tracking of rule violations by contract provider and by foster home; any emerging patterns are discussed by a referral committee, which includes representatives of contractors.

The second area of quality control is PCSA monitoring of network foster homes to assess the safety and appropriateness of the homes. Most PCSA caseworkers visit the network homes to visit the placed child, but they have been reluctant to take on an explicit quality control role with regard to the home itself. Such efforts are not required by law, and, indeed, are often explicitly

Figure 2.19: Number of Quality Control Activity Utilized

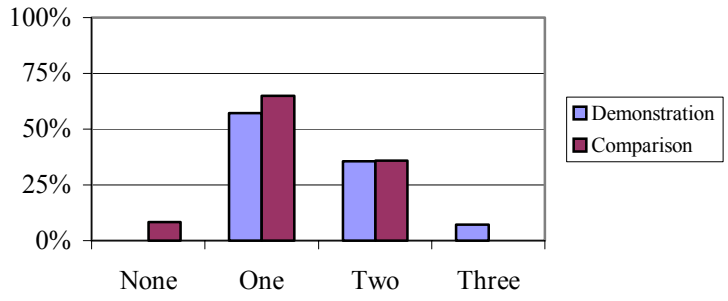
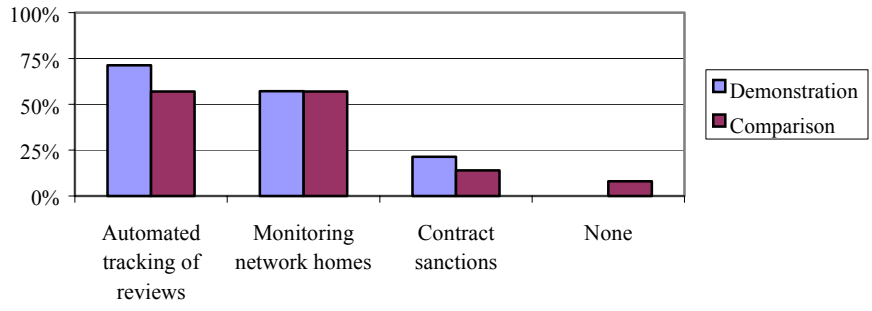


Figure 2.18: Quality Control Activities

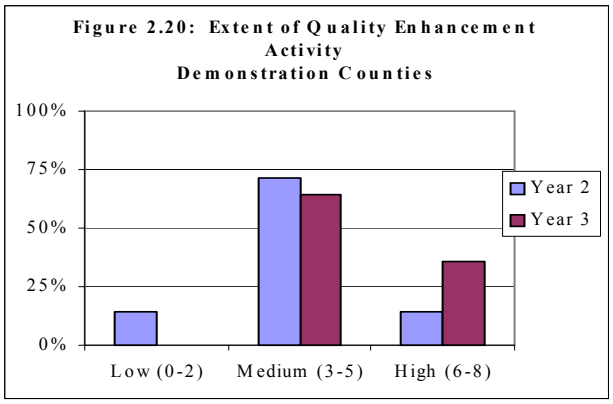


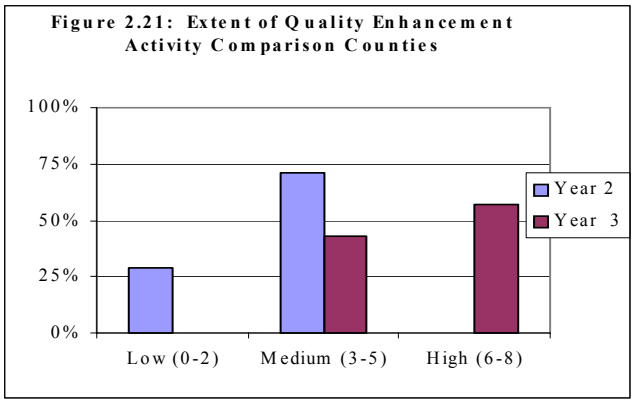
assigned to the agency managing the network. However, as child welfare agencies nationwide have been increasingly faced with serious problems in private foster homes, public action to assure the quality of the homes becomes a more pressing activity. As Figure 2.18 illustrates (above), evaluation counties are taking this seriously. Fifty-seven percent of BOTH demonstration counties engage in such monitoring visits: this is an increase for both demonstration and comparison counties, compared to last year.

The third area of quality control is use of sanctions in service contracts. Only three demonstration counties (21%) and two comparison county (14%) use this strategy: two of these demonstration counties have it as an element of their capitated managed care contract. In at least one of the counties, the PCSA is likely to impose sanctions on the contractor for poor fiscal management.

Quality Enhancement

In the area of quality enhancement, an interesting shift has occurred in the last year. In Year 2, there was a significant contrast between demonstration counties and comparison counties in the sphere of quality enhancement. Demonstration counties appeared to have made the shift from traditional, compliance-oriented quality assurance to recognizing quality cannot be forced but, rather, has to be supported. This year, both demonstration and comparison counties indicate significant increase in number of quality enhancement efforts (see Figures 2.20 and 2.21). It is interesting to note that while demonstration counties in Year 2 were more involved in quality enhancement activities, in Year 3, it seems that the comparison counties in particular are more often using these strategies, compared to demonstration counties. This is perhaps an indication that the evaluation process itself has had an impact on comparison counties, exposing them to some practices that might not have been considered otherwise.[3]





[3] It should be noted that quality enhancement is one of the more subjective topics that the study team explored; because only PCSA managers were interviewed this year, there may be some bias in the response indicating more involvement in these efforts than was evident last year. While managers often feel like these activities are well established, the perception from the worker's standpoint is sometimes different; while activities may be 'available', in reality, line staff may not view these activities as impacting quality service provision.

In particular, the site visit teams explored eight typical areas of quality enhancement activity. As Figure 2.22 and Figure 2.23 (below) demonstrates, both demonstration and comparison counties have clearly increased the number of quality enhancement activities from Year 2 to Year 3. It is interesting to note that again, comparison counties seem more involved in many of these activities than demonstration counties. Overall, PSCA training, cross-agency training, and technical experts are the activities that are most often occurring in both demonstration and comparison counties: these efforts are focused on providing staff with information and support to help them do their jobs better. Topics cover a wide range of issues, including case planning, sex abuse investigations, computer skills, customer services training, etc.

Figure 2.22: Quality Enhancement Activities in Demonstration Counties

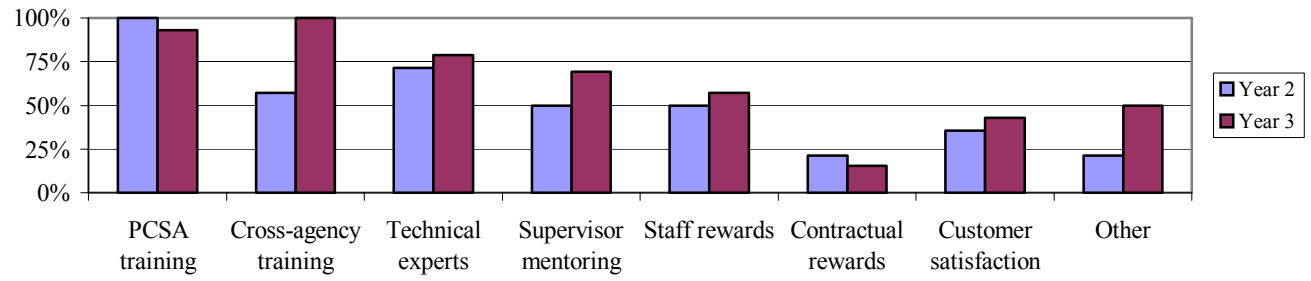
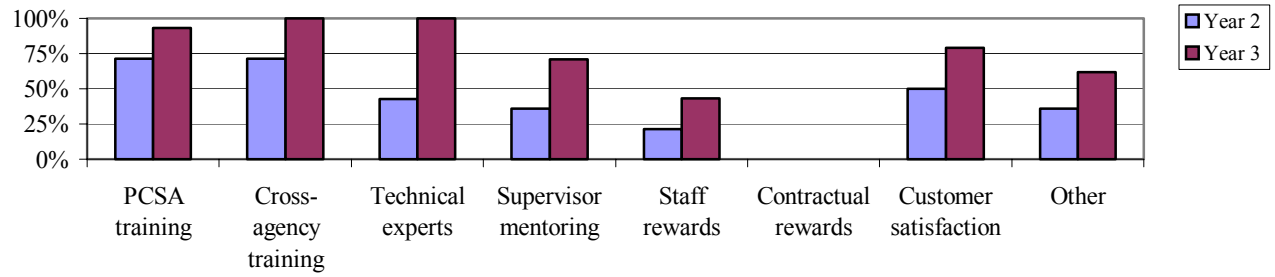


Figure 2.23: Quality Enhancement Activities in Comparison Counties



Demonstration counties report that some of their quality enhancement activity comes as a direct result of the increased availability of non-categorical funds, due to their having flexibility in their Title IV-E funds (see Section 2.2.2 Financing). In particular, three of the demonstration counties who report special training efforts also noted that they had devoted new flexible funds to expand staff training opportunities.

The variety in quality enhancement activities is enormous. Especially creative are some efforts to support workers in doing a better job, and to help them feel "part of the team."

- One demonstration county has a QA help-line for line workers who have clinical or administrative questions.
- In annual performance reviews, workers in one comparison county offer suggestions for projects for their unit. The suggestions are gathered into a single document that is used for

brainstorming on new initiatives for the agency. From this process has come a clothing bank, foster care recognition activities, and a safety committee.

- One demonstration county is making a concerted effort to improve cultural competency, offering field trips to workers to events that help them learn about cultural differences. The same agency is doing targeted recruitment of MSWs for whom Spanish is the primary language. The recruitment process includes two days of paid job shadowing, to see how the recruit fits in the agency and the unit.
- Workers in one demonstration county have formed an Excellence Committee, which sponsors special volunteer projects; staff donated money to do a party to recognize grandparents who are parenting, and gathered donations of school supplies for foster children.

Awareness of the importance of quality assurance translates into activity on both the enhancement as well as the control sides of quality assurance. The six demonstration counties and five comparison counties who are most active in quality control are simultaneously moderately or highly active in quality enhancement (Table 2.2). Given the previous discussion, it is not surprising that this is a significant shift from last year, when only five demonstration counties and two comparison where involved in this level of quality assurance efforts.

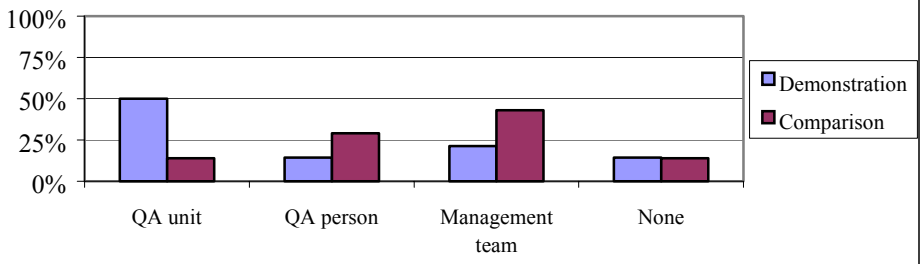
Table 2.2: Activity in Quality Enhancement and Quality Control

	Demonstration Counties			Comparison Counties		
	QE low	QE medium	QE high	QE low	QE medium	QE high
QC low	0	7	1	0	5	3
QC high	0	2	4	0	2	4

Structure of Quality Assurance

As PCSAs become more aware of the importance of quality assurance, they begin to assign organizational responsibility for various quality assurance tasks. Demonstration and comparison counties have taken similar steps (Figure 2.24). Half of the evaluation counties have established a quality assurance unit or a quality assurance "team leader", to give QA greater visibility and clout. One shift from Year 2 to Year 3 is an increase in the demonstration counties who have established a quality assurance unit; increasing from 4 demonstration counties in Year 2 to seven demonstration counties in Year 3. A minority of demonstration and comparison counties have not yet established an organizational "home" for quality assurance; these counties tend to be doing less in the way of explicit quality control or quality enhancement activities. It should be noted however, that for demonstration counties, the number of counties without QA designated staff has decreased in the last year, from four to two. For comparison counties, the number has not changed.

Figure 2.24: PCSA Responsibility for Quality Assurance



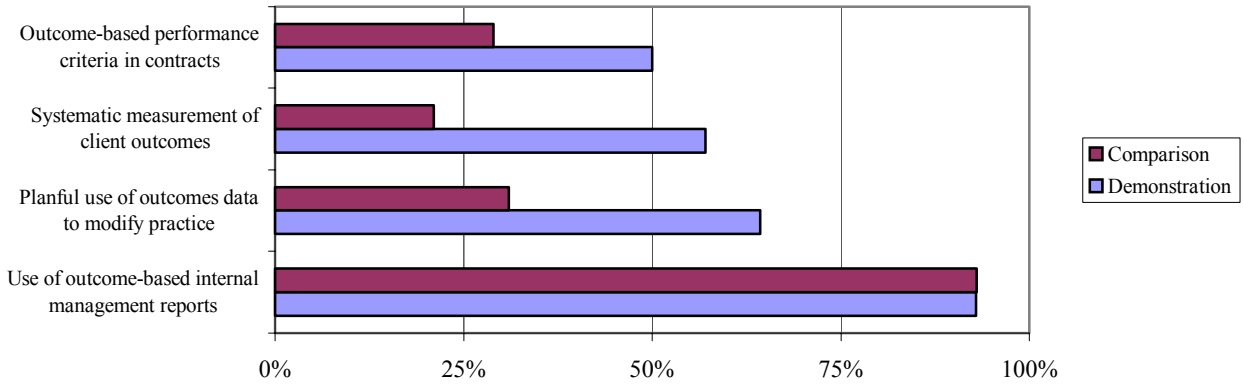
Not surprisingly, the counties with the most quality control and quality enhancement activity tend to be those with an explicit quality assurance presence, either a unit or a dedicated individual. Seven of the eleven most active counties have such (four demonstration and three comparison counties). Typically, the quality assurance unit or person is responsible for an array of quality assurance mechanisms.

- Counties with a QA unit tend to be those who have sought CWLA accreditation (since quality assurance is an important component of accreditation), and have quite an extensive QA infrastructure; in addition, three of these demonstration counties have quality assurance oversight of their managed care contracts located in a contracts unit.
- Counties that have a designated QA person, rather than a full unit, are more likely to focus their energies on compliance issues; they may also develop training in response to identified quality concerns, or may be responsible for analyzing data and exploring programmatic questions and inconsistencies in data reports.
- A few of the most active QA counties are also using outside consultants to help with evaluation or QA tasks, such as to design case tracking systems geared to better distributing workloads.

Outcome Focused Activities

The site visits explored how PCSAs attend to outcomes, explicitly as part of their quality assurance activities but also more broadly, as an important component of good management. Figure 2.25 lists the range of outcome-based activities being pursued in the evaluation counties, highlighting the significantly greater degree of effort in demonstration counties. In both Year 2 and Year 3, the most common activity was the use of some type of internal management report based on outcomes. This reporting may range from using the ODJFS District-generated CPOE reports, to the PCSA preparing its own extensive monthly outcomes reports, in a few of the larger counties.

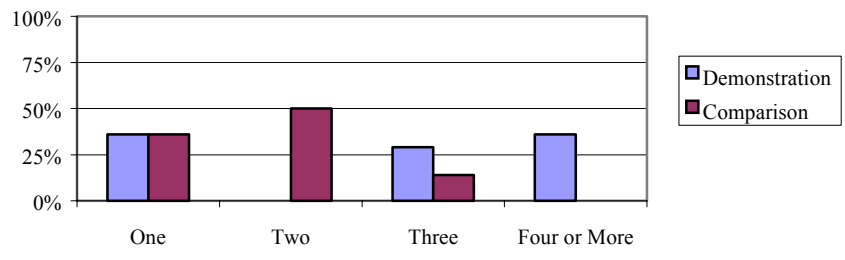
Figure 2.25: Types of Outcome-Focused Activities



For the last two years, in all of the other outcome areas, demonstration counties are significantly more involved in using outcomes than comparison counties. While most of the demonstration and the comparison counties study outcome-based reports, few comparison counties go much further with outcomes (Figure 2.25). Few comparison counties systematically measure client outcomes of their own (apart from the standard CPOE measures), make any planful use of outcomes to modify practice, or use outcome-based performance criteria in their service contracts. Demonstration counties take considerably more initiative than comparison counties in all three of these areas, suggesting that the greater attention to service utilization (discussed in Section 2.2.1 above) may carry over into heightened interest in the results of those services for children and families.

In the aggregate, demonstration PCSAs make noticeably more use of outcomes than do comparison sites (see Figure 2.26). While there are a handful of demonstration counties who are involved in two outcome activities, the vast majority of these counties are involved in at least four or more of these activities, while all comparison counties are involved in three or fewer outcome activities. This is a clear indication that, unlike comparison counties, demonstration counties are clearly focused on using outcome measures to improve PCSA decision making processes.

Figure 2.26: Overall Use of Outcomes



2.2.6 Overall Movement to Managed Care

Managed care offers a broad array of technical mechanisms to improve and simplify service systems. These techniques are not new to child welfare; indeed, many are already being used in service systems around the country and in Ohio. What is new, however, is that managed care seeks to integrate the different components, packaging them into a coherent and rational plan to simultaneously contain costs, enhance service quality and expand the population served – in short, creating a "managed" system.[4] A prime interest of the Ohio and federal stakeholders is to understand the extent to which PCSAs are turning to managed care, developing managed systems for child welfare. Indeed, one of the outcomes identified by the demonstration counties is increased movement toward managed care.

Summary: The Year 2 findings indicated that overall, demonstration counties, acting on their commitment to systems reform, coupled with a greater ability to take the risks that reform entails, experimented with managed care strategies to a significantly greater extent than have comparison counties. However, in Year 3, while demonstration counties continue to increase their involvement in managed care activities overall, comparison counties are making significant changes in the way they offer services, pushing them up in the managed care framework so that they now more closely resemble the demonstration counties. This change suggests that (1) comparison counties may be following the lead of demonstration counties in experimenting with more rational management techniques, and (2) demonstration counties may not have yet exercised all the flexibility that the Waiver offers them.

[4] Kimmich, M. and Feild, T. Partnering with Families to Reform Services: Managed Care in the Child Welfare System. Englewood, CO: American Humane Association, October 1999.

Managed Care Index

Using the eight categories of managed care activity discussed above, the evaluation team has selected 29 discrete items from the Year 2 and Year 3 interviews to create a managed care index. The selection of the items, and the way in which they are combined to yield an index value, is subjective and open to modification. The index presented here is intended as a reasonable starting point for distilling the systemic reforms that PCSAs are making to their operations. Exhibit 2.2 below lists the selected components of the Managed Care Index. All the data compiled in the Managed Care Index was collected during the Year 3 interviews, except where noted.

Exhibit 2.2: Components of the Managed Care Index

Managed Care Category	Specific Item	Weighting**
Service Array	♦ Sufficiency of services ♦ Extent of new services created since Waiver began ♦ Changes made in the way existing services are used ♦ Shift in PCSA service focus* ♦ Whether shift in service focus is reflected in staff, contracting*	15%
Financing	♦ Use of capitated contract ♦ Nature of capitated contract conditions ♦ Title IV-E investment strategies used	17.5%
Targeting	♦ Number of special initiatives* ♦ Whether services are developed for a specific sub-group* ♦ Existence of specialized PCSA units*	10%
Case Management	♦ Type of unit structure* ♦ Speed of transfers of case management responsibility*	10%
Competition	♦ How PCSA providers are affiliated* ♦ How FCF providers are affiliated* ♦ Whether changes made to stimulate competition	10%
Utilization Review	♦ Use of placement review processes ♦ Use of rational decision-rules (including CLA) *	17.5%
MIS	♦ Extent of use of automated management information and access to management information systems	10%
Quality Assurance	♦ Use of quality control mechanisms ♦ Use of quality enhancement mechanisms ♦ Locus of internal quality assurance responsibility ♦ Extent of focus on outcomes	10%

* This data item was collected during the Year 2 site visits.

** The various components of the managed care index have been weighted to create the most appropriate composite measure of managed care activity, placing increased emphasis to the more true 'managed care strategies'.

Utilization of Managed Care Strategies: Ranking of Counties

Every demonstration county and every comparison county is using managed care strategies to some extent. The most obvious examples are the counties that have executed a capitated contract with an outside entity, delegating authority for serving a certain population of children. But this type of activity is atypical of the evaluation counties as a whole; much more common is some type of oversight of the use of placement services, or a varied collection of quality assurance activities, or the addition of numerous services that are needed by children and families. Table 2.3 below reveals the substantial variation in effort among the demonstration and comparison counties, across the eight spheres of managed care activity.

Table 2.3: Managed Care Index Scoring

Managed Care Category	Possible Score (Year3)	Year 2 Average Score	Year 3 Average Score
Service array	9		
Demonstration		4.14	5.11
Comparison		3.64	5.18
Financing	12		
Demonstration		3.82	3.54
Comparison		0	1.26
Targeting	8		
Demonstration		3.57	3.36
Comparison		1.25	1.68
Case Management	5		
Demonstration		1.86	1.86
Comparison		1.50	1.50
Competition	9		
Demonstration		2.43	2.64
Comparison		0.71	1.79
Utilization Review	8		
Demonstration		5.43	5.64
Comparison		4.43	4.86
MIS	4		
Demonstration		2.07	2.07
Comparison		1.43	1.57
Quality Assurance	15		
Demonstration		7.11	8.21
Comparison		5.50	6.86
TOTAL	70		
Demonstration		32.18	34.05
Comparison		20.30	26.72

Three dominant patterns emerge from this table. The first is that both demonstration and comparison counties continue to be more involved in utilizing managed care techniques. In all aspects (except financing methods for demonstration counties), the index score is the same or higher in Year 3 than it was in Year 2, indicating that counties continue to increase their use of these strategies. The area of most growth for both demonstration and comparison counties is service array and quality assurance practices. This pattern suggests that these are strategies all counties can adopt, whether or not they have access to flexible Title IV-E funds.

The second theme that becomes apparent is that demonstration counties are consistently more involved than comparison counties in all of the spheres of managed care activity, but the difference between demonstration and comparison counties has decreased from Year 2 to Year 3. This is an indication that comparison counties are beginning to explore how they can implement managed care principles without being a part of the Waiver. For example, it is interesting to note that, unlike last year, this year a few comparison counties are now experimenting with capitated financing or risk sharing. At the same time, their level of effort to consciously stimulate competition among service providers, target particular populations, and adopt quality assurance methods remains fairly limited, while demonstration counties continue to score markedly higher on these measures.

Lastly, Table 2.3 is also striking in what it says about the overall use of managed care strategies. The average scores for demonstration and comparison counties differed significantly, 32.18 compared to 20.30 for Year 2 and 34.05 compared to 26.72 for Year 3. However; all of these scores fall fairly far below the maximum score of 68 and 70, respectively. Even the highest score, by a demonstration county, was only 47.69 in Year 3 and 47.05 in Year 3. These data suggest that (1) many demonstration counties are not very active, and (2) even those who are active are not pushing the limits of managed care strategies.

Among all the categories in Table 2.3, several categories are clearly "preferred" areas of counties' experimentation. In utilization review, the average score for demonstration counties is 5.64, over 70% of what is possible, and comparison counties are not far behind, with a mean score of 4.86, more than half what is possible: this trend is consistent with the findings from Year 2. Similarly, both demonstration and comparison counties are making significant efforts to improve their use of utilization review processes and increase the service array for PCSA clients. Other categories appear to be "less preferred" areas of activity. This group includes the following managed care strategies – competition, MIS, and case management. It is too early to detect the reasons behind this pattern, although it has been a consistent trend in Year 2 and Year 3 of the evaluation: perhaps change in these areas involves higher levels of risk, or change is not as clearly perceived to be beneficial.

Table 2.3 also indicates how demonstration and comparison counties differ in their use of various managed care strategies. Competition, targeting and financing are strategies where there is the most difference between the demonstration and comparison sites; these are areas where demonstration counties seem be more able to change the way they provide services because of their involvement in the Waiver. Case management, however, presents a somewhat different profile. The performance of the comparison counties closely resembles that of the demonstration

counties. It may be that traditional policies around case management are seen as so central to child welfare practice, that changes may need to be more incremental and carefully analyzed before being widely adopted.

Based on the Managed Care Index score of each of the 28 counties, the various components of the index have been weighted to create the most appropriate composite measure of managed care activity. The resulting scores create three natural groupings of demonstration and comparison counties (Table 2.4).

Table 2.4: Counties Grouped by Level of Managed Care Activity

Counties with High Managed Care Activity		**Counties with Moderate Managed Care Activity**		**Counties with Low Managed Care Activity**	
Demonstration:	Comparison	Demonstration:	Comparison:	Demonstration:	Comparison:
Greene Franklin Hamilton Lorain Medina Muskingum Portage Richland	Butler Montgomery	Clark Stark	Allen Columbiana Hancock Mahoning Miami Scioto Summit	Ashtabula Belmont Crawford Fairfield	Clermont Hocking Trumbull Warren Wood

These three groupings of the evaluation counties provide a clearer picture of what is evident in Table 2.4 above: demonstration counties are using managed care strategies substantially more than are comparison counties. Appendix III lists each county's ranking on each of the eight managed care strategies.

That comparison counties increasing their use of managed care more than are demonstration counties is illustrated in Table 2.5. Ten counties, seven of them comparisons, scored significantly higher on the managed care index this year compared to last year. These counties moved up at least six points from Year 2 to Year 3 in their overall managed care score. This would indicate some major advances in the use of managed care strategies. Table 2.5 indicates that in these cases, the changes most often occurred in utilization review (seven counties), quality assurance (six counties), service array (six counties) and competition (three counties). These finding support the discussion above, that while the demonstration counties continue to have higher scores on many of the managed care strategies, comparison counties are also making significant headway in many of these areas.

Table 2.5: Counties with Significant Change in Managed Care Index					
		Managed Care Index Score for Year 2	Managed Care Index Score for Year 3	Change in Managed Care Score	Managed Care Strategies With Greatest Change
Demonstration	Muskingum	28.45	37.41	8.96	Utilization Review Quality Assurance
	Portage	35.56	41.88	6.32	Utilization Review
	Stark	23.25	31.25	8.00	Service Array Quality Assurance
Comparison	Allen	20.64	27.02	6.38	Service Array Competition
	Butler	25.45	33.05	7.6	Service Array
	Clermont	8.95	23.12	14.17	Service Array Utilization Review Quality Assurance
	Columbiana	14.59	27.55	12.96	Service Array Competition Utilization Review
	Mahoning	17.66	26.87	9.21	Utilization Review Quality Assurance
	Miami	13.62	27.25	13.63	Service Array Competition Utilization Review Quality Assurance
	Wood	9.02	24.83	15.81	Utilization Review Quality Assurance

The underlying dynamic reflected in these data is likely quite complex. On first glance, it appears that the availability of flexible Title IV-E dollars enables demonstration counties to try more things. At that same time, and related to their self-selection into ProtectOhio, the demonstration counties may have a greater commitment to making significant changes. On the other hand, in the last year, there has been a significant increase in the comparison counties' involvement in the use of managed care strategies. This trend will be an interesting one to examine more thoroughly in the ensuing years of the evaluation.

As the evaluation proceeds, the study team will continue to monitor changes in the level of managed care activity in the counties, and will systematically examine what impact the level of managed care activity has on participant and fiscal outcomes.