NATIONAL RESOURCE CENTER
FOR FOSTER CARE
& PERMANENCY PLANNING
at the Hunter College
School of Social Work

THE IMPLEMENTATION OF MANAGED CARE IN CHILD WELFARE:

THE LEGAL PERSPECTIVE

PREPARED BY
DENISE WINTERBERGER MCHUGH, JD

NRCFCPP CONSULTANT

SPRING 2000

129 East 79th Street • New York, NY 10021
TEL 212/452-7053 • FAX 212/452-7051
www.hunter.cuny.edu/socwork/nrcfcpp

A service of the
Children's Bureau/ACF/DHHS

"The Implementation of Managed Care in Child Welfare: The Legal Perspective" was prepared for the National Resource Center for Foster Care and Permanency Planning at Hunter College School of Social Work of the City University of New York. The Center is funded by the Children's Bureau, U.S. Department of Health and Human Services. It is reprinted here with permission from the Center. For additional copies, please contact the Center at 212-452-7053.

The purpose of this paper is to provide an overview of the legal issues raised by the implementation of managed care principles in child welfare. It does not constitute legal advice and is selective as to the issues covered. Further, laws and procedures often change and are subject to differing interpretations. Readers of this paper should therefore, be sensitive to such differing interpretations and as to those changes that may have become effective after the research for this paper was completed.

ACKNOWLEDGMENTS

The author would like to thank the following people for their invaluable guidance and assistance in the preparation of this paper.

Michael Ambrose, Children's Bureau, Administration on Children, Youth and Families, U.S. Department of Health and Human Services; **Ellen Batistelli**, Child Welfare League of America; **Patricia B. Dishman**, Tennessee Department of Children's Services, Office of Children's Services Administration; **Karla Fultz McHenry**, Iowa's Mental Health Access Plan, Office of Field Support; **Bonnie Garrity**; **Tracy Kraft-Tharp**; **Lorrie L. Lutz**, LP3 Associates; **Ronald Manderscheid**, Center for Mental Health Services, U.S. Department of Health and Human Services; **Jackie McCubbin**, Ohio Department of Human Services; **Charlotte McCullough**, Child Welfare League of America; **Kathleen McHugh**, Children's Bureau, Administration on Children, Youth and Families, U.S. Department of Health and Human Services; **Angelina Palmiero**, U.S. Department of Health and Human Services; **Dorothy Webman**, Webman Associates; and **Fran Winter**, Office of Legal Affairs, New York City Human Resources Administration.

Public agencies around the country are looking at, and in certain cases implementing, a managed child welfare service delivery system in an effort to contain costs and improve services to the children and families they serve.[1] There are, however, a number of issues, including legal ones, which public agencies must consider before moving ahead with managed care in child welfare. If these issues are not addressed, the promises of managed care - cost containment and improved services – may not be realized.

The legal issues on the federal level that pose the greatest significance to the implementation of managed care principles in child welfare involve: permanency planning and safety; the role of the judiciary (the juvenile court and class action litigation); privatization of the child welfare case management function; categorical funding and allowable costs; and fair competition.[2]

These issues may arise in one of two situations: indirectly, as a result of managed care being implemented in Medicaid mental health services; and directly, where the child welfare system itself is being transitioned into a managed care service delivery system on its own or as part of an interagency managed care initiative that includes child welfare as one of the players. Child welfare law and regulations, however, apply to all child welfare cases regardless of the system or provider serving the case. Thus, both Medicaid managed care mental health programs and child welfare managed care programs must be designed and implemented with these laws and regulations in mind. Although these legal issues generally do not pose an absolute barrier to the implementation of managed care in child welfare, they will surely impact the system's design.

To the extent possible, examples will be offered illustrating how different public agencies have approached some of the issues raised in this paper.[3] These examples are by no means exhaustive. Further, they may not be applicable to all agencies struggling with system reform in child welfare due to the uniqueness of local political, economic, geographic and other factors.

MEDICAID MENTAL HEALTH MANAGED CARE

Child welfare has already experienced the impact of managed care through the implementation of state Medicaid managed care initiatives. Currently, managed care organizations are receiving funding to deliver primary and behavioral health (mental health and substance abuse) services to Medicaid recipients, including children and families served by the child welfare system. These initiatives have been made possible primarily through the use of federal Medicaid waivers.[4] A brief overview of the

[1] In 1997, The Child Welfare League of America conducted a survey regarding managed care and privatization of child welfare systems across the country. Of the 50 states that responded, 31 indicated that they were planning or implementing one or more initiatives involving the "privatization of certain management functions or the use of managed care approaches" in child welfare. Charlotte McCullough et. al., Managed Care and Privatization Child Welfare Tracking Project 1997 State and County Results, Draft Final Report 2 (Child Welfare League of America 1977).

[2] States considering or planning to implement managed care in child welfare or in Medicaid mental health must also review state law for potential issues as to implementation.

[3] The author takes no position on the successfulness of the cited examples. They are merely offered as possible models to address the legal issues raised in this paper. These models and their design may also have changed over time.

[4] In March 1996, 14 states were administering public sector managed behavioral health care programs for mental health or substance abuse. This number has almost doubled in 1998 to 25 states. Moreover, the initial trend toward total privatization seems to be changing over time to a combination of public and private ventures. *Lewin Releases Findings from SAMHSA's Tracking System,* THE CHILDREN'S VANGUARD, Apr. 1998, at 5.

Medicaid program and the waiver process follows.[5]

THE MEDICAID PROGRAM

Medicaid is a federal and state financed program that provides medical assistance to poor and low-income individuals.[6] Medicaid was enacted in 1965 as an amendment to the Social Security Act at Title XIX.[7] Over the past 30 years, it has become a critical factor in the financing and delivery of health services to poor and low-income children and families, including those served through child welfare.

Federal law, by and large, determines Medicaid eligibility as to qualified persons and covered services. Some discretion, however, is left to the states in terms of covering certain optional categories of eligible individuals and services under its state's plan.[8]

Federal law also sets certain requirements that all state Medicaid plans must meet unless waived or otherwise approved by The Health Care Financing Administration (HCFA). Often when a state has sought to implement managed care in Medicaid, the state has requested federal waivers of one or more of these requirements (state-wideness[9], comparability[10], and freedom of choice[11]) from HCFA.[12]

Federal Medicaid waivers have provided states with an opportunity to experiment with the principles of managed care as a means of containing increased program costs, improving program quality and expanding access to services. These waivers have permitted states to change the way in which Medicaid services are delivered and to expand eligibility to individuals not previously covered by Medicaid. The federal government has granted, in particular, two types of waivers under the Federal Social Security Act that are important to the implementation of Medicaid managed care. These are: section 1915(b) waivers, commonly referred to as "freedom of choice" waivers[13], and section 1115

[5] Please note that Medicaid has also become an important federal funding source used directly in child welfare to provide medical and remedial services to children and their families.

[6] The federal/state share concerning the cost of the Medicaid program varies based on a statutory formula that takes into consideration the state's per capita income as compared with the national. The amount of federal funding also varies based on the type of Medicaid service provided. MADELYN DEWOODY, MAKING SENSE OF FEDERAL DOLLARS: A FUNDING GUIDE FOR SOCIAL SERVICE PROVIDERS 5 (Child Welfare League of America, Washington D.C. 1994).

[7] Medicaid law may be found at 42 U.S.C.A. Secs. 1396a-1396v (West 1992 & Supp. 1999).

[8] DEWOODY, *supra* note 6, at 2.

[9] 42 U.S.C.A. Sec. 1396a(a)(1) (West Supp.1999).

[10] 42 U.S.C.A. Sec. 1396a(a)(10)(B) (West Supp. 1999).

[11] 42 U.S.C.A. Sec. 1396a(a)(23)(A) (West Supp. 1999).

[12] Recently, Title XIX was amended at 42 U.S.C.A. Sec. 1396u-2 to permit states to implement a managed care service delivery system without having to seek waivers of Medicaid's statewideness, comparability, and freedom of choice plan requirements under certain circumstances. Section 1396u-2, however, exempts certain children with special needs, including those who are receiving foster care or adoption assistance under Title IV-E of the Social Security Act, or who are placed in foster care or who are otherwise in out-of-home placement from mandatory enrollment with a managed care entity. 42 U.S.C.A. Sec. 1396u-2(a)(2)(A) (West Supp. 1999) (provisions relating to managed care).

[13] 42 U.S.C.A. Sec. 1396n(b) (West Supp. 1999)

research and demonstration waivers[14]. The first type of waiver is specific to the Medicaid program; the second is available to certain programs created under the Federal Social Security Act.

A section 1915(b) waiver allows states to modify state plan requirements (state-wideness, comparability and freedom of choice)[15] under section 1902 of the Federal Social Security Act. In return, states must demonstrate cost-effectiveness and adequate access to quality services.[16]

A section 1115 research and demonstration waiver also permits states to modify state plan requirements. In addition, states may: expand program eligibility to cover additional populations; expand covered services to include additional services; relax the requirement that 25% of HMO participants be non-Medicaid; extend the consumer lock-in period beyond 6 months; and reallocate disproportionate share payments to the Medicaid managed care program.[17] In return, states must demonstrate adequate access to quality services and cost neutrality to the federal government.[18]

Demonstration projects implemented under a section 1115 waiver are experimental in nature and require a tightly structured research design. Although section 1115 waivers have been generally difficult to obtain, states have often found them necessary to implement policy options not permitted by state plan amendments or other program waivers.[19]

THE ROLE AND RESPONSIBILITIES OF THE MENTAL HEALTH AND CHILD WELFARE SYSTEMS

Three issues have arisen in the context of Medicaid managed mental health programs that have particular significance to children and families served by child welfare who require mental health services. These issues are: the respective roles and responsibilities of the mental health and child welfare systems; child welfare's overall goal of permanency and safety for children; and the authority of the juvenile court over child welfare cases. The first issue will be addressed directly below; the remaining issues will follow as their own section.

An overlap exists between the child welfare and mental health systems in that they often both serve the same population and provide the same or similar services. Yet, each system has its own role and responsibilities as set forth in federal and state law. Given this overlap, it is extremely important that public agencies responsible for mental health and child welfare clearly identify the population to be served by the managed care organization (MCO) delivering mental health services and its role and responsibilities towards that population. This understanding must be explicitly stated in the contract with the MCO so that the public agencies' performance expectations can be met. A clear

[14] 42 U.S.C.A. Sec. 1315 (West Supp. 1999)

[15] Ronald W. Manderscheid, Ph.D. and Marilyn J. Henderson M.P.A., Federal and State Legislative and Program directions for Managed Care: Implications for Case Management 4 (U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, Center for Mental Health Services Oct. 1995).

[16] Ronald W. Manderscheid Ph.D., Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

[17] Manderscheid and Henderson, *supra* note 15, at 4.

[18] Mental Health Policy Resource Center, Inc., Medicaid Section 1115 Waivers: Mental Health and Substance Abuse-Related Provisions of Five State Demonstrations 6 (U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, Center for Mental Health Services June 1995).

[19] *Id.*

delineation of the roles and responsibilities between the child welfare and mental health systems is also essential to ensure that children and families receive the mental health services that they require on a timely basis.

Thereafter, the MCO and the child welfare system must continually collaborate with each other on both the systemic and individual case levels in order for children and families to be served well. For instance, Merit Behavioral Care of Iowa -- the MCO responsible for the management and provision of Medicaid mental health services in Iowa -- has developed collaborative working relationships with other service systems[20] and their providers in order to coordinate the delivery of mental health services to children and families, including those served by child welfare.[21] As a result of this collaborative approach, the parties involved have acquired a better understanding of each other's roles and responsibilities.[22] In Iowa, child welfare is generally responsible for child protection and delinquency issues, whereas Merit under the Mental Health Access Plan is responsible for providing mental health services to the child.[23]

In certain child and family cases, the collaborative approach may require that the parties engage in joint case planning. Joint case planning provides intensive case management for those children and families that require it in order for the child's permanency goal to be achieved on a timely basis.[24] Referrals may be made for joint case planning by a variety of persons, including child welfare workers, mental health providers, family members, court officers, and internal care management staff.[25] Overall, the purpose of the joint case planning process is to encourage and support permanency for children and reunification of children with their families.[26]

Recently, in a move to further coordinate service delivery, Iowa issued a draft RFP in 1997 for an administrative link between a proposed behavioral health program comprised of Medicaid managed mental health and substance abuse and the child welfare/juvenile justice systems.[27] The successful bidder would have been at full financial risk for substance abuse and mental health services and would have been required to develop management links to the state's child welfare and juvenile justice systems.[28] Comments received in response to the draft RFP were not supportive of the

[20] Iowa's Department of Human Services houses within it child welfare, mental health, substance abuse, and juvenile justice. Paul Hedquist et. al., *The Impact of Managed Medicaid Services on Child Welfare and Child Mental Health Systems in Iowa*, The Child and Family Focus, BEHAVIORAL HEALTHCARE TOMORROW, Aug. 1996, at 2, 2.

[21] *Id.* at 3.

[22] *Id.*

[23] Massachusetts is another state that is attempting to coordinate its Medicaid behavioral health carve out program with child welfare, including a child welfare program called Commonworks that utilizes managed care principles to achieve permanency for youth on a more timely basis. Cathie Taylor, *Massachusetts: A Study in Child and Family Services Innovation*, THE CHILDREN'S VANGUARD, Apr. 1997, at 3.

[24] Hedquist, *supra* note 20, at 2.

[25] *Id.* at 6.

[26] *Id.* at 3.

[27] Judy Barber, *Restructuring Iowa's Child Welfare/Juvenile Justice System: A New Program Could Be Three Years Away*, THE CHILDREN'S VANGUARD, July 1998 at 1.

[28] *Iowa Plans to Award Single Contract for Addiction, Mental Health, Child Welfare and Managed Care*, BEHAVIORAL HEALTHCARE TOMORROW,

state's approach.[29] Accordingly, a second draft RFP was sent out for comment that altered the approach from administrative links to a folding in of the funds targeted for Medicaid-eligible children and Medicaid child welfare/juvenile justice services under the managed care contract. Once again, the feedback was negative.[30]

In an attempt to resolve the matter, the Iowa state legislature sponsored a public forum on the issue of a publicly managed child welfare and juvenile justice system. As a result of the forum, a work group was formed to develop a plan to address the various concerns that had been raised. In February 1998, this group presented several short and long-term strategies to the legislature for consideration. As a part of its continuing work on long range strategies, the work group intends to review other state's efforts involving public/private partnerships in child welfare and juvenile justice before presenting any recommendations for final decision.[31]

An important outcome of this process, as it related to the privatization of certain public functions, has been the recognition that government has a different level of responsibility in child welfare and juvenile justice than it has in mental health and substance abuse treatment in terms of child protection and community safety. Accordingly, there is a reluctance to contract out these public responsibilities entirely to a private vendor.[32]

PERMANENCY PLANNING AND SAFETY

In 1980, Congress enacted Public Law 96-272 (The Adoption Assistance and Child Welfare Act of 1980). This Act codified in statute for the first time the concept of permanency planning on the federal level by amending the Title IV-B program (child welfare services) and creating the Title IV-E program (adoption and foster care assistance) under the Social Security Act. [33] By doing so, it became the public policy of this country that efforts must be made to keep families together whenever possible through: the prevention of unnecessary foster care placement; the reunification of children in foster care with their families of origin; and the timely adoption of children unable to return home.

In 1997, Titles IV-B and IV-E were once again amended because of dissatisfaction with the child welfare system's inability to meet the original goals of Pub. L. 96-272. These goals being child safety; permanency; and child and family well-being.[34] Specifically, on November 17, 1997,

---

Oct. 1997, at 23.

[29] Barber, *supra* note 27, at 1.

[30] *Id.* at 2.

[31] *Id.* at 3.

[32] *Id.*

[33] Permanency planning has been defined as "the systemic process of carrying out, within a brief, time-limited period, a set of goal-directed activities designed to help children live in families that offer continuity of relationships with nurturing parents or caretakers and the opportunity to establish lifetime relationships." Anthony Maluccio & Edith Fein, *Permanency Planning Revisited*, *in* FOSTER CARE: CURRENT ISSUES AND PRACTICES 197 (Martha Cox & Roger Cox eds., 1983), *reprinted in* Karoline Homer, *Program Abuse in Foster Care: A Search for Solutions*, 1 VA. J. SOC. POL'Y & L. 177, 185 (Spring 1993).

[34] Title IV-E Foster Care and Eligibility Reviews and Child and Family Services State Plan Reviews, 63 Fed. Reg. 50057, 50061 (Sept. 18, 1998) (Proposed Rule).

President Clinton signed into law "The Adoption and Safe Families Act of 1997" (ASFA), the most significant piece of child welfare reform legislation since 1980. ASFA amends Titles IV-B and IV-E in several ways. First, ASFA makes clear that child safety must be the paramount concern guiding all decisions affecting service provision, placement and permanency planning. Second, ASFA shortens the time frames in which permanency planning decisions must be made. Third, AFSA supports the timely adoption of children who are unable to safely return home to their families. Fourth, ASFA requires child welfare systems to focus on quality and outcome based performance.

Unlike other systems of care where managed care has been implemented, public child welfare agencies are required to provide permanence and safety for children in accordance with these requirements.[35] Given this charge, child welfare agencies must assess not only a child's clinical needs, but also his or her need for safety and protection and for social supports, as well as to consider the needs of the child's family. While many children have multiple treatment needs, removal from the home is usually because of compromised safety. Thus, the nature of the intervention in child welfare goes well beyond stabilizing or improving a child's individual level of functioning. Instead, child welfare must assess and address the needs of the entire family with whom the child will grow and develop.[36] For those children who must be placed out-of-home, the goal of foster care is to provide a safe and stable living arrangement on a short term basis, while efforts are made toward reunification or, if that is not possible, towards another permanency planning goal. Accordingly, any attempt to transition child welfare into a managed care service delivery system must reflect child welfare's overriding mandate to provide permanency and safety for children.

Recognition of a child's need for permanence is a driving force behind current efforts to reform a number of child welfare systems. For example, The Massachusetts Department of Social Services has implemented an expanded Commonworks Adolescent Services Program (Commonworks II) that relies on the application of certain managed care principles in order to improve service delivery for youth aged twelve to eighteen who are in the care and/or custody of the Department. The broad goal of this effort is to achieve permanency for youth as quickly as possible by unifying/reunifying them with their families, relatives, guardians or adoptive families, or by preparing them to live independently in their communities.[37] As a result of improved service delivery, Massachusetts expects that permanence will be achieved on a more timely basis for these youth.[38]

---

[35] It is noteworthy that these requirements are generally consistent with the principles of quality managed care in that they require the use of the most appropriate, least restrictive setting that assures the child's safety, for the shortest period of time possible. Other principles of quality managed care that are consistent with child welfare best practice standards are: preventive and crisis access to services, with a focus on prevention; coordination of care; full array of services; standardized intake and assessment; service continuity until outcomes are achieved; and accountability.

[36] Tracey Feild, Managed Care and Child Welfare Are They Compatible? Design Issues In Managed Care for Child Welfare 5 (Institute for Human Services Management, Bethesda MD, Jan. 18, 1996).

[37] Letter from Linda Carlisle, Commissioner, The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Social Services to Prospective Bidders, regarding the Commonworks Adolescent Services Program Request for Proposal (Feb. 26, 1996).

[38] Tennessee and Kansas also expect to improve permanence for children by implementing managed care principles in child welfare.

THE ROLE OF THE JUDICIARY

THE JUVENILE / FAMILY COURT

Any plan to transition child welfare to a managed care service delivery model must take into consideration the role and authority of the juvenile court in child welfare cases pursuant to federal and state law. Under the legal framework set up by Title IV-E of the Social Security Act, state juvenile courts act as the gatekeeper to the nation's foster care system. Congress assigned this function to the courts as a means of securing permanent homes for children by preventing them from either being unnecessarily placed or continued in foster care placement for unnecessarily long periods of time.

To begin with, in order for states to access federal foster care funds, there must be a judicial determination approving the child's placement in care or a voluntary placement agreement, which may also have to be approved by the court depending on the child's length of stay.[39] This judicial determination is needed not only to access the cost of the child's foster care placement but also for the state's related administrative and training expenses. (This section's primary focus will be on the role of the judiciary under Title IV-E of the Social Security Act as to the placement and provision of services to children and families through the child protection process as opposed to a voluntary request for services or placement.)

As part of its order to place a child in foster care, the court must find that the child welfare agency has made 'reasonable efforts' to prevent that child's placement in care.[40] The 'reasonable efforts' requirement, for the most part, is consistent with managed care quality and cost principles. Generally, a child's best interest will be served by remaining or returning home with adequate services to ensure the child's safety and development. 'Reasonable efforts', however, does not require a child to remain or return home, even with the provision of services, if by doing so, the child's safety is put at serious risk of harm.[41]

As to those children who have been placed in foster care, a permanency planning hearing must be held no later than twelve months after the child's placement in care and periodically thereafter.[42] At the hearing, the court, or administrative body appointed or approved by the court, must make a determination as to the permanency of that child including whether, and if applicable, when a child will be: returned home; placed for adoption (with the state filing a petition to terminate parental

[39] Federal matching funds under Title IV-E may not be provided for longer than 180 days unless the court determines, within that time frame, that a child's continued voluntary placement in care is in the child's best interest. 45 C.F.R. Sec. 1356.30(b) (10-1-98 Edition). Voluntary placements are optional and the criteria for these placements vary between states. Most states have restrictions on voluntary placements that are stricter than federal law.

[40] The Adoption and Safe Families Act of 1997 (ASFA) lists certain exceptions when the child welfare agency is no longer required to make "reasonable efforts" to either preserve or reunify a family because a court of competent jurisdiction has determined that: the parent has subjected a child to aggravated circumstances as defined in state law (including but not limited to abandonment, torture, chronic abuse, and sexual abuse); the parent has committed murder, voluntary manslaughter or "aided or abetted, attempted, conspired or solicited" the murder or voluntary manslaughter of another child of that parent; the parent has committed a felony assault that resulted in serious bodily injury to the child or another child of the parent; or the parent's parental rights as to a sibling have been involuntarily terminated. 42 U.S.C.A. Sec. 671(a)(15)(D) (West Supp. 1999).

[41] Under ASFA, when 'reasonable efforts' are made to preserve or reunify a child with his or her family, the child's health and safety must be considered paramount to all other factors considered. *Id.* at 671(a)(15)(A).

[42] ASFA changed the time frame for these permanency planning hearings from 18 months to 12 months. *Id.* at 675(5)(C). For those children who continue to remain in foster care, permanency planning hearings must be held at least every twelve months. *Id.*

rights); referred for legal guardianship; or another permanent living arrangement, if the previous options are not appropriate for the child.[43]

To further ensure that foster care is only a temporary placement, ASFA also requires child welfare agencies to file, or join, a petition to terminate parental rights (TPR) with the court as to those children who have been in foster care for fifteen months out of the most recent twenty-two months from the date the child entered care or when a court of competent jurisdiction has determined that: a child is an abandoned infant as defined under state law; the parent has committed murder, voluntary manslaughter, or 'aided or abetted, attempted, conspired, or solicited' such murder or voluntary manslaughter of another child of the parent; or has committed a felony assault that resulted in serious bodily injury to the child or another child of the parent.[44] There are three exceptions to this requirement concerning the filing of a TPR petition. These are: if the child welfare agency decides not to file a TPR concerning a child who is in the care of a relative; if the agency documents a compelling reason as to why termination of parental rights is not in the child's best interest; or if the agency has not provided the services that it had deemed necessary on a timely basis for the child's safe return to home.[45]

Although the juvenile court clearly plays an important role in monitoring and enforcing child welfare's efforts to provide permanency and safety for children under Title IV-E of the Social Security Act, it is state law that determines the full extent of the court's authority in child welfare cases. This authority may include approval of: placement; treatment plans; movement of children within foster care; and discharge from foster care. In some states, courts may even have the authority to order specific services and placements. It is therefore, essential that the court's authority be considered when designing the managed care plan, especially in terms of at-risk financial arrangements, where the court's authority supersedes the control of the entity assuming the risk. Given the critical role that the juvenile court has in child welfare cases, efforts also need to be made to collaborate with the court on the development and implementation of the managed care plan. Hopefully, such collaboration may lead to some possible solutions that balance the court's responsibilities with the managed care entity's need to manage the provision of services to children and their families.

Even if the scope of judicial authority is not a problem in a particular state, court delay may be. Prior to the mid-1970's and later the enactment of P.L. 96-272 in 1980 that established Title IV-E of The Social Security Act, courts were required to determine only if maltreatment had occurred and whether the child needed to be removed from the home.[46] This expansion of the court's role in child abuse and neglect cases under federal and state law has resulted in an increase in the complexity and in the number of hearings held.[47] Generally, changes in custody status, such as

[43] *Id.*

[44] *Id.* at 675(5)(E).

[45] *Id.*

[46] MARK HARDIN, JUDICIAL IMPLEMENTATION OF PERMANENCY PLANNING REFORM: ONE COURT THAT WORKS 9 (American Bar Association, Center on Children and the Law, Washington D.C. 1992).

[47] The Federal Omnibus Budget Reconciliation Act of 1993 set aside grant funds to state courts to use over a 4 year period to improve the court's handling of child abuse and neglect cases so that children would achieve permanency in a more timely manner. Under these grants, state court systems were to assess the court's processing of child abuse and neglect cases, develop a plan to improve the process, and then implement the plan.

termination of parental rights and adoption, and in some states, discharge from care and even changes in level of foster care placement, must receive prior court approval. If the court's calendar is backlogged, however, these changes in custody status will not be processed in a timely manner, thereby potentially increasing the managed care entity's financial risk. Accordingly, the possibility for court delay must also be addressed in the managed care plan.

CLASS ACTION LITIGATION

A different aspect of judicial authority that public agencies should take into consideration when developing a managed care plan for child welfare involves class action litigation. As child welfare caseloads and the number of children placed in foster care have increased in recent years, so have the number of class action lawsuits brought against public child welfare agencies. Currently, a little less than half the states in this country are involved in class action litigation regarding the child welfare system, mostly at the federal court level. The majority of these lawsuits have been resolved through consent decrees that specify the reforms that the child welfare agency will make. In these cases, the court generally retains jurisdiction while the child welfare agency implements the terms of the decree to ensure compliance.

The basis of these lawsuits have been for violations of federal statutory law, most notably Title IV-E, constitutional law violations, such as due process and the right to safety while in state custody, and state law claims.[48] Accordingly, class action litigation has focused on all aspects of child welfare, including child protective, prevention, foster care, and adoption services.[49] Prior to the enactment of P.L. 96-272, child welfare lawsuits were generally brought as single issue actions focusing on a particular aspect or part of the system. Following its enactment, system-wide litigation ensued to enforce compliance with P.L. 96-272's mandate that all eligible children be served in accordance with its terms.

During the planning phase, child welfare agencies must consider the terms of any court order or court ordered settlement involving class action litigation in connection with the public agency's plan for implementing managed care in child welfare. In so doing, the public agency may have to either change the system's design to incorporate the decree's terms or seek a modification of them.[50] In any event, the public agency should attempt to work collaboratively with the other parties in the case and any court monitor or like entity providing oversight for the court. The following are three examples that illustrate how different public agencies have approached the implementation of managed care in child welfare within the context of a consent decree.

---

[48] Robert Horowitz, *Child Welfare Class Action Litigation in the 1990s: An Overview*, *in* WHERE DO WE GO FROM HERE? CONSENT DECREES, COURT MONITORS AND CHILD WELFARE REFORM IN THE 1990S, Proceedings from the National Symposium, at 3 (Child Welfare League of America, Sept. 12-14, 1993).

[49] *Id.* at 3-4.

[50] Public agencies interested in developing a managed care service delivery system within the context of a consent decree or court order should ask themselves the following questions to determine whether the plan's design and/or the decree's terms need to be modified: is the decree process or outcome oriented, restrictive or flexible in its terms; what is the public agency's relationship with the other stakeholders or parties involved with the case (e.g., plaintiff's counsel, monitor, the court); what is the public agency's compliance record with the decree's terms; does the managed care plan benefit children and families or is it focused primarily on cost containment; is the managed care plan system-wide or narrow in focus; is the consent decree system-wide or narrow in focus; and is the managed care plan dependent on the performance of organizations not under the court's jurisdiction (e.g., privatization initiatives, integrated managed care plans across public systems)? The answers to many of these questions should help public agencies decide on how to move forward with a managed child welfare plan within the context of a consent decree or court order. This list was developed in cooperation with Robert Horowitz, Esq., American Bar Association, Center on Children and the Law, Washington D.C., and Professor Kathleen Ohman, Graduate School of Social Work, University of Denver, Denver, Colorado.

In B.H. v. McDonald, the Illinois Department of Children and Family Services (the Department) signed a consent decree that was entered by the court in December 1991 with respect to children who were abandoned, abused or neglected by their parents and taken into the Department's custody for care and protection. Full compliance with the decree's terms was expected to be achieved by July 1, 1994. However, the parties and the monitor realized early on that the full compliance by such date was unlikely, essentially because of managerial and structural issues. With that in mind, the parties requested permission from the court to further develop and implement the Department's 'Strategic Management Initiative', including its 'Managed Care Initiative' for special needs children.[51]

On the other hand, in Wilder v. Bernstein, a class action lawsuit involving the New York City foster care system, the Federal District Court for the Southern District of New York issued a temporary restraining order (TRO) on January 12, 1996 preventing the City from moving forward with its managed foster care plan on a system-wide basis. The court issued the TRO from the bench because it was not convinced that the plan adequately protected children under the court's jurisdiction from harm. Ultimately, the parties agreed that the City would not move forward with the managed care plan until April 1, 1996 at which time the City would present its plan to the court. In return, plaintiffs agreed to withdraw their motion for a preliminary injunction.[52]

In the last example, when the Kansas Department of Social and Rehabilitation Services decided to redesign its child welfare system by implementing a privatization initiative applying certain managed care principles, it listed the settlement agreement entered into between the Department and The American Civil Liberties Union as a requirement to the RFP. Specifically, the Department requested documentation from all prospective bidders describing their ability to adhere to the terms of the settlement agreement.[53] Successful bidders would then be monitored by the Department for compliance purposes.[54]

PRIVATIZATION OF THE 'CASE MANAGEMENT' FUNCTION

The shift from a fee-for-service to a managed care service delivery system in child welfare requires public agencies to reassess and redefine their roles and areas of responsibility in the new system. Having done so, public agencies must then clearly delineate those areas where they will retain decision making authority, those areas where they will share such authority, and those areas where the contractor will be solely responsible.[55] A particular issue that public child welfare agencies have struggled with is to what extent can they legally privatize their role as 'case manager' under a managed care service delivery system. Presently, this appears to be an open question subject to interpretation under federal law. However, there are a number of factors that public agencies need to consider in answering this question for themselves.

---

[51] B.H. et. al. v. Jess McDonald , Joint Memorandum in Support of the Parties' Motion for Entry of Agreed Order Regarding Consent Decree (No. 88 C 5588 N.D. Ill.).

[52] Wilder v. Bernstein, (Southern District of New York) (No. 78-Civ-957).

[53] Kansas Department of Social and Rehabilitation Services, RFP #31823, Section 4.4(f), at 16; Kansas Department of Social and Rehabilitation Services, Children and Family Services Commission, Overview of Service Delivery Initiatives.

[54] Document entitled Kansas Department of Social and Rehabilitation Services, Accountability and Monitoring.

[55] Attributed to Charlotte McCullough, Director Managed Care Institute, Child Welfare League of America, Washington D.C.

Although there is no one uniform definition of the term 'case management', it has generally been thought to include decision making authority as to certain key areas of responsibility in a child welfare case that public agencies have generally exercised. These key areas may include the decision to: open and close a child protection case; initiate court action; place a child in custody; establish and change a child's permanency planning goal; change service intensity or level; establish a visitation policy in a particular case; discharge a child from care; and terminate parental rights and proceed to adoption.

Federal law applicable to child welfare is silent as to whether the case management function can be privatized.[56] In other words, there is no directly stated prohibition against doing so. Instead, federal law holds states ultimately responsible for the placement and care of children in foster care and for all other federal mandates under Title IV-E and other provisions of the Social Security Act.[57] Moreover, under federal constitutional law, some public child welfare agencies have also been held legally responsible under certain circumstances for ensuring that children are not harmed while in state custody based on the involuntariness of the state's action.[58] Accordingly, if a public agency were to privatize all or any case management responsibilities, federal law would seemingly still hold the public agency accountable for its contract agent's acts. In addition to engaging in a legal analysis, however, public agencies must look at this issue in terms of their ethical responsibility to care for vulnerable children and families under a public trust concept that considers whether case management is a core function fundamental to the operation of government and consequently, inappropriate for transfer, in whole or in part, to a private entity.[59]

As states have begun to move toward a managed care service delivery system in child welfare, some states have determined that they will retain their decision making authority as to those aspects of a case that relate to a child's permanency and safety needs.[60] The following is a description of how two states, Tennessee and Massachusetts, have attempted to address the privatization of the case management function in the context of a managed care service delivery model.

On July 1, 1996, The Tennessee Department of Children's Services established a managed care plan for children's services that provides behavioral health services to children and their families at risk of

---

[56] Aside from federal law, public agencies must also review state law to determine whether the case management function can be privatized.

[57] 42 U.S.C.A. Sec. 672(a)(2) (West Supp. 1999).

[58] *See generally* Brendan Kearse, *Abused Again, Competing Constitutional Standards for the State's Duty to Protect Foster Children*, 29 COLUM. J.L. & SOC. PROBS. 385 (Spring 1996); Karoline Homer, *Program Abuse in Foster Care: A Search For Solutions*, 1 VA. J. SOC. POL'Y & L. 177, 203-11 (Spring 1993); Laura Oren, *DeShaney's Unfinished Business: The Foster Child's Due Process Right To Safety*, 69 N.C.L. REV. 113 (Nov.1990); Laura Oren, *The State's Failure To Protect Children And Substantive Due Process: DeShaney In Context*, 68 N.C.L. REV. 659 (Apr.1990).

[59] *See* ANNE B. DRISSEL, MANAGED CARE AND CHILDREN AND FAMILY SERVICES A GUIDE FOR STATE AND LOCAL OFFICIALS, at 41-45 (Cindy Brach ed., Prepared for the Annie E. Casey Foundation by The Policy Resource Center, 1996); Cindy Brach and Donna Mauch, *Public Responsibilities in Managed Care*, MANAGED CARE CHALLENGES FOR CHILDREN AND FAMILY SERVICES 19-27 (Leslie Scallet et. al. eds., Prepared for the Annie E. Casey Foundation by The Policy Resource Center 1996).

[60] Please see the section above on *The Role and Responsibilities of the Mental Health and Child Welfare Systems* for a discussion of the proposed Iowa initiative involving linkages between the managed mental health and substance abuse programs and the child welfare and juvenile justice systems.

or placed in state custody.[61] This program includes both child welfare and juvenile justice cases. Under the "Continuum of Care Model," the Department is the Social Treatment Organization that directly manages the private agencies under contract to provide the continuum of care through which children and their families will move.[62] Contractors are paid the same daily rate regardless of the level of care and/or service intensity that the child and family receives.[63] The continuum is designed to reduce length of stay and increase successful outcomes for children and families by providing contractors with the flexibility necessary to deliver services in the least restrictive, most cost-efficient manner appropriate for that child and family.[64]

Under this contract model, the Department performs the child protective service investigations and intake work and makes referrals to the contract providers for placement and services. The Department also sets the original and any subsequent permanency planning goals for the child. Once referred, the Contractor is responsible for case assessment and management responsibility for the plan of direct care.[65] The Contractor also has the responsibility of determining when each child and family is ready for movement through the continuum and the appropriate subsequent level of care or services required. The Contractor, however, must notify the Department prior to moving any child and family within the continuum.[66]

In child protective service cases, the Department, as well as others, must give prior approval for any plans for unsupervised visitation with the person responsible for the abuse and neglect and for reunification with the family.[67] The Contractor is responsible for ensuring successful permanency for children for nine months following discharge from care. If a child returns prior to the completion of the nine months, the Contractor must accept the child and family back into the continuum for care and services.[68]

In the second example, The Massachusetts Department of Social Services developed the Commonworks program to improve service delivery and permanency for abused and neglected youth age twelve through seventeen who are in the care and custody of the state by utilizing certain managed care principles. Under its Commonworks II program, Massachusetts determined that it must retain case management for all referred youth based on the legal responsibilities inherent with a

---

[61] In early April 1998, the Department issued an RFP to expand the project scope to include services for non-custodial children. Lorrie L. Lutz, *Tennessee Child Welfare System Moving Toward Contracts With Local Networks*, THE CHILDREN'S VANGUARD, Apr 1998, at 1, 1.

[62] *Tennessee's Department of Children Services Develops Social Treatment Organization*, OPEN MINDS, Dec. 1996, at 9.

[63] Tennessee Department of Children's Services, Continuum of Care Program, Attachment A, Scope of Services, at 1.

[64] *Id.* at 1; Tennessee Department of Children's Services, Continuum of Care Services, Attachment O, Provider Services/Resource Management, Produced for the Select Committee on Children and Youth, October 9, 1996.

[65] Tennessee Department of Children's Services, Continuum of Care Program, Attachment A, Scope of Services, at 3-4, 9, 11-15, 19.

[66] Tennessee Department of Children's Services, Continuum of Care Program Model Contract, Attachment A, Scope of Services, at 9, 12.

[67] *Id.* at 12.

[68] *Id.* at 19-20.

state's acceptance of care and custody of children.[69] Massachusetts defines case management as "the means employed in carrying out the Department's responsibility for determining and addressing the needs of children, particularly with regard to where a child lives, visitation with family, medical care, and education." Moreover, "case management encompasses the processes and procedures used to make decisions about children and their families, plan for and take appropriate actions and ensure that the actions taken have achieved the intended outcomes."[70]

The Commonworks II Model involves the use of Lead Agencies and provider networks as well as a Services Management Organization that is suppose to assist the Lead Agencies in the performance of administrative functions. Although the Department retains case management, the Lead Agencies and Network Providers are suppose to share in the planning and decision making process on a case-by-case basis with the Department through the concept of treatment planning.[71] Treatment planning involves the development and achievement of objectives outlined in treatment plans that are based on the Department's service plan. These plans are to be reviewed regularly with the Department and modified to reflect any progress and/or changes in treatment.[72] In its proposed program model, Massachusetts "envisioned that Commonworks Lead Agencies and network providers [would] assume a more proactive role in the planning process through active participation at regularly scheduled meetings of the Treatment Planning Team, at the six month Foster Care Review and in quarterly reviews with DSS social workers."[73]

While providers are to assume responsibility (with prompt notification to the Department) for case actions involving movement of youth within a network, other types of movements outside the network still require prior Department approval.[74] These latter types of case actions include: determining and changing permanency planning goals; discharges from the network and/or Department care; approval of aftercare/discharge plans; termination of services; medical or surgical consents (except in emergencies); changes in treatment activities with families and with other Department or state agency involved children; and visitation with families.[75] Massachusetts, however, makes clear that it is still ultimately responsible and retains authority for any and all case action decisions involving youth referred to the Commonworks II program.[76]

From these two examples and others, the initial trend appears to be that public child welfare agencies are retaining some decision making authority related to the safety and permanence of children when transitioning to a managed care service delivery system.[77] However, even if a public

[69] Massachusetts Department of Social Services, Commonworks Request for Proposals, Program Overview and Design, Sec. 4.2.5.5, Case Management Treatment Planning 39 (Feb. 1996).

[70] *Id.*

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] *Id.*

[75] *Id.* at 40.

[76] *Id.* at 39-40.

[77] According to the 1996 survey prepared by the Child Welfare League of America (CWLA), of the 41 states considering the

child welfare agency were to decide that it was legally and ethically appropriate to contract out all or part of its case management function, that agency would still be held accountable for its contract agent's acts should that agent fail to meet federal law mandates. Accordingly, the public agency must carefully monitor and evaluate its contract agent's performance and be prepared to remedy any failure on the part of the contractor to meet its contractual obligations. This may suggest therefore, that it is only possible for states to construct shared risk rather than fully at-risk agreements with managed care entities in child welfare.

CATEGORICAL FUNDING

Child welfare relies heavily on a number of different federal funding streams under the Social Security Act in order to carry out its charge to provide safety and permanence for children.[78] Each of these funding streams has its own set of requirements, some being more restrictive in use than others. The categorical nature of these funds has created and continues to create challenges for states and localities to provide a well coordinated continuum of services. The principles of managed care alone will not solve this issue. In fact, flexible funding, without categorical restriction, is generally considered a prerequisite to the successful implementation of managed care so that a range of services can be offered and delivered in an effective and efficient manner to meet the individual needs of each child and family. Accordingly, public agencies considering a managed child welfare system must engage in careful planning to determine how they will create flexibility in funding to support a full continuum of services and the pricing structure to support that delivery system.

OVERVIEW OF CHILD WELFARE FUNDING

By way of background, the primary federal funding streams in child welfare include: Title IV-E to support foster care services and related administrative costs and training, independent living, and adoption assistance[79]; Title IV-B to support child welfare services under Subpart 1 and family preservation and support services under Subpart 2; Title XX to support social services, including child welfare services; and Title XIX (Medicaid) to support certain child welfare services.[80] Previously, a number of states also relied on Title IV-A (Emergency Assistance to Families (EAF)) to support child welfare services. Under the "Personal Responsibility and Work Opportunity

---

application of managed care principles in child welfare:

> 8 states are considering plans in which the state would be entirely responsible for managing, delivering and monitoring the services covered by the managed care plan; 15 states are considering plans in which the state would manage the system, but would contract out certain administrative functions; and 7 states would seek an outside organization, agency, or vendor to contract for, deliver, monitor the services under the plan.

CWLA Managed Care Institute, Highlights of 1996 Survey on Managed Care and Child Welfare 3 (Child Welfare League of America, Washington, D.C. 1996).

[78] States also support child welfare services with their own funds. Some of these funds may again be restricted in terms of allowable use. If so, steps may need to be taken to free them from their requirements through either state legislative and/or administrative action.

[79] ASFA now authorizes adoption incentive payments for FY's 1999-2003 within available appropriations to states that exceed their baseline number of children adopted out of foster care and meet certain other requirements. These incentive payments must be used for child and family services. The incentive payments are $4,000 for each foster child and $6,000 for a foster child with special needs. 42 U.S.C.A. Sec. 673b (West Supp. 1999).

[80] Title IV-E may be found at 42 U.S.C.A. Secs. 670-680 (West 1991 & Supp. 1999); Title IV-B may be found at 42 U.S.C.A. Secs. 620-629e (West 1991 & Supp. 1999) (Subpart 1 begins at section 620 and Subpart 2 begins at section 629); Title XX may be found at 42 U.S.C.A. Secs. 1397-1397f (West 1992 and Supp. 1999); and Medicaid may be found at 42 U.S.C.A. Secs. 1396a-1396v (West 1992 and Supp. 1999).

Reconciliation Act of 1996," however, "Aid to Families with Dependent Children," which included the EAF program, was repealed and replaced by "Temporary Assistance to Families" (TANF). Accordingly, this paper will not address the particular issues surrounding EAF as it existed prior to welfare reform. However, in deciding how to use these TANF block grant dollars, states and counties should keep in mind the need to continue to fund direct child welfare services to ensure that families are kept together, whenever possible.[81]

Particularly problematic for the implementation of managed care is the traditional bias in the system's categorical funding structure to support residential services, as opposed to non-residential services.[82] Specifically, Title IV-E of the Social Security Act, which supports certain foster care costs (board and maintenance), is an entitlement. It is not limited by appropriation. This means that reimbursement to the state for foster care maintenance is driven by the number of eligible children[83] who are placed with eligible foster care providers.[84] The percentage of federal reimbursement for these costs is related to the state's Medicaid match rate.[85] Title IV-E also provides for federal reimbursement of adoption assistance (related to the state's Medicaid match rate), training (at seventy-five percent of costs allocated to Title IV-E eligible children in the state's caseload), child placement and administrative costs (at fifty percent of costs allocated to Title IV-E eligible children in the state's caseload), and transitional independent living costs (limited by appropriations).[86]

On the other hand, Title IV-B of the Social Security Act, which is specifically designated to fund direct child welfare services and family preservation and support services is limited by appropriations.[87] Yet, states rely on Title IV-B to fund direct services to children and families in order to meet Title IV-E's 'reasonable efforts' requirement mentioned above. In terms of appropriations, however, Title IV-B has not kept pace with Title IV-E over the years as to increases in funding.[88]

---

[81] *See* David A. Berns and Barbara J. Drake, *Combining Child Welfare and Welfare Reform at the Local Level*, POLICY & PRACTICE, March 1999, at 26.

[82] Of all of the federal funding sources, Title IV-E is generally considered the largest source of federal funds in child welfare. Specifically, Title IV-E funding for foster care and adoption assistance reached almost $4 billion in 1995. The 1996 figure has been estimated at that same level with an increase to $4.7 billion in 1997. Lorrie L. Lutz, *An Overview of the Title IV-E Waivers: States Have New Opportunity to Test Out Creative Use of Title IV-E Funding Stream*, THE CHILDREN'S VANGUARD, Feb. 1998, at 1, 1.

[83] In order for children to be Title IV-E eligible, they must have been eligible for assistance under the state's approved Title IV-A plan as it was in effect on July 16, 1996, but for removal from their home.

[84] *See* 42 U.S.C.A. Secs. 672(a), (b) (West Supp. 1999) (definition of circumstances).

[85] DEWOODY, *supra* note 6, at 56.

[86] Adoption assistance provides for cash payments for eligible children with special needs. Title IV-E training funds cover child welfare training for public and private agency child welfare staff, foster parents and adoptive parents. Reimbursable child placement and administrative costs may include costs associated with "case plan management, pre-placement services, preparation for court, referral for services, case review, case management of and licensing of foster homes and institutions, rate setting and eligibility determination". Transitional independent living covers independent living services for all youth sixteen and older, regardless of Title IV-E eligibility, who are transitioning out of care to independent living. DEWOODY, *supra* note 6, at 56-58.

[87] *Id.* at 49.

[88] Report to the Chairman, Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, U.S. Senate, Foster Care: Services To Prevent Out-Of-Home Placements Are Limited By Funding Barriers 22 (General Accounting Office #GAO/HRD-93-76 June 1993).

In 1993, Title IV-B was amended by establishing two Subparts to broaden the range of services funded. In so doing, the Omnibus Reconciliation Act of 1993 (Pub. L. 103-66) allocated additional monies for family preservation and family support services under Subpart 2 of the Title.[89] As mentioned, there are two parts to Title IV-B. Subpart 1 is limited by appropriations yearly.[90] It funds services to protect children, strengthen families, prevent the unnecessary separation of parents and children, provide children and families who are separated with care and services, and reunify children with their families or achieve an alternate permanent placement for those children who cannot return home.[91] There is a twenty-five percent state match requirement under Subpart 1.[92]

Subpart 2, which funds a broad range of family support and family preservation services, is a capped entitlement.[93] Again, a twenty-five percent state match is required.[94] These funds were capped for a five year period requiring reauthorization in 1998.[95] Under ASFA, Subpart 2 was continued and expanded through FY 2001.[96] In addition to supporting family support and preservation services, Subpart 2 funds must now also be used specifically to provide time-limited reunification services and services to promote and support adoption.[97]

Title XX, the Social Services Block Grant, funds a wide variety of social services, including child welfare services such as family preservation and reunification.[98] It is a capped entitlement, with no state match required, that is funded each year at the amount appropriated by Congress.[99] In 1993, under the Omnibus Reconciliation Act, additional funds were appropriated for the purpose of assisting area residents of designated empowerment zones and enterprise communities for child abuse and neglect prevention and treatment, family reunification, and promotion of economic self-sufficiency.[100] Although Title XX has provided a significant amount of funding to states for social

---

[89] DEWOODY, *supra* note 6, at 51.

[90] *Id.* at 49.

[91] Title IV-E Foster Care and Eligibility Reviews and Child and Family Services State Plan Reviews, *supra* note 34, at 50061.

[92] DEWOODY, *supra* note 6, at 49.

[93] Subpart 2 also funded grants to state courts to improve the handling of child abuse and neglect cases. *Id.* at 51.

[94] *Id.*

[95] *Id.*

[96] Under ASFA, federal funding levels for The Family Preservation and Support Services Program, renamed the Promoting Safe and Stable Families Program, are: $275 million for FY 1999; $295 million for FY 2000; and $305 million for FY 2001. Memorandum from David S. Liederman and Karabelle Pizzigati of the Child Welfare League of America to CWLA Member Agency CEO's and Public Policy Contacts, attaching a summary of The Adoption and Safe Families Act of 1997 (Nov. 25, 1997).

[97] 42 U.S.C.A. Sec. 629(a) (West Supp. 1999).

[98] GAO Report #GAO/HRD-93-76, *supra* note 88, at 16.

[99] DEWOODY, *supra* note 6, at 47-48.

[100] *Id.* at 48-49.

services, its purchasing power has diminished over the years.[101]

As a result of escalating referral rates and inadequate resources, states began to look beyond the traditional child welfare funding streams mentioned above to other federal entitlement programs to support direct services to children and their families in order to prevent placement, to shorten placement, and to prevent replacement in foster care. Specifically, several states began to use the former EAF program and Medicaid to fund these services. As already mentioned, Medicaid is the federal and state financed program that provides medical assistance to poor and low-income individuals. Although federal law, for the most part, determines Medicaid eligibility as to qualified persons and covered services, some discretion has been left to the states in terms of covering certain optional categories of eligible individuals and services under its state's plan. Those states that have pursued the use of Medicaid to fund direct child welfare services have done so based on an expanded concept of health care to include prevention, screening, rehabilitation, and mental health.

CONTINUUM OF SERVICES

Despite the barriers posed by categorical funding, several states and localities have attempted to blend or pool federal, state, and/or local dollars to support a continuum of services for children and families that is more community-based, less crisis oriented and more preventive in nature.[102] Although many of these pooled funding initiatives predate the arrival of managed care in child welfare, they are still a valuable resource to consider on how to develop a flexible funding approach to support a continuum of services under a managed child welfare system.

Pooled funding initiatives have often taken different approaches. However, there are certain characteristics that they share in common. First, the purpose of most of these initiatives is to change the financing of child and family services so as to develop a more comprehensive, community-based service array where children and families receive the services that they require not just the services for which funding is available.[103] Second, pooled funding initiatives look to change a system that is crisis oriented and fragmented into one that is coordinated and preventive in focus.[104] These characteristics are consistent with managed care principles, which require that clients receive the services they need, when they need them, for as long as they need them, in the right amount, no more, no less.[105] By applying these principles, managed care uses early intervention and prevention services as a means of reducing high end services later on as the primary method of intervention.

In pooled funding initiatives, current resources are generally spent by different people, for different purposes and/or different clients.[106] As a result, these initiatives often involve a change in the governance structure of child and family services. In order to make these changes, however, public

[101] *Id.* at 48; GAO Report #GAO/HRD-93-76, *supra* note 88, at 22.

[102] MARY O'BRIEN, FINANCING STRATEGIES TO SUPPORT COMPREHENSIVE COMMUNITY-BASED SERVICES FOR CHILDREN AND FAMILIES 1 (National Child Welfare Center for Organizational Improvement, University of Southern Maine).

[103] *Id.* at 1.

[104] *Id.*

[105] Charlotte McCullough, Managed Care and Child Welfare: A Child Welfare League of America Perspective (attributed to Keith Schaffer, Value Behavioral Health).

[106] O'BRIEN, *supra* note 102, at 2.

agencies must analyze the requirements of each of the funding streams to be pooled to determine how easily their intended purpose and beneficiary can be changed. Some funding streams are flexible in allowable use; others are not. Some require changes in federal and/or state law, while others require administrative action on the federal or state level.

Of all the funding streams utilized in child welfare Title IV-E is probably the most restrictive in terms of allowable use. This is problematic because Title IV-E supports the most restrictive type of intervention, out-of-home placement and yet, is one of the few federal funding streams available in child welfare that is an entitlement. Specifically, states are reimbursed under Title IV-E for the cost of (and the cost of providing) allowable foster care maintenance payments for eligible children placed with eligible foster care providers. These costs are defined at 42 U.S.C.A. section 675(4)(A) as: "food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation."[107] They do not include any direct child welfare services. As a result, Title IV-E has been the most difficult to work with in terms of creating flexible pooled funding to support a broad continuum of services.

Moreover, Title IV-E's restrictiveness in terms of allowable use has also posed problems for public child welfare agencies interested in developing performance based contracts that include an at-risk financial arrangement to support the new managed care service delivery system.[108] Generally, the type of at-risk financial arrangement that is being used in child welfare is a case rate as opposed to a capitated rate.[109] This method of payment is supposed to encourage providers to provide services in the most effective and cost efficient way. In order to do so, however, providers must have the ability to provide children and families with the services they require without regard to categorical restriction. This means that providers must have the ability to create and access a full continuum of services.

Yet, Title IV-E, the largest source of federal child welfare funds in most states, limits reimbursement to only those costs associated with foster care board and maintenance. Given the inflexible nature of these funds, some states have questioned their ability to develop any at-risk financial arrangements that would include IV-E funds as part of the rate. Public child welfare agencies therefore, need to consider the listing of allowable expenditures when determining its pricing structure, whether that be capitation, case rate, per diem or other method, if they intend to rely on Title IV-E reimbursement, without the benefit of a federal waiver, as a part of their overall budget to support the managed care service delivery system.[110]

---

[107] In terms of institutional care, the term also includes those reasonable costs of administration and operation of such institution that are necessary to provide the above listed items. 42 U.S.C.A. Sec. 675(4)(A) (West Supp. 1999).

[108] Another related issue that public agencies also need to address in their managed care plan concerning Title IV-E reimbursement is the continued ability to draw down a sufficient level of federal funding to support the new delivery system. Presumably, as the system becomes more effective and efficient, there may be an overall decrease in the utilization of residential services and with it a loss of federal Title IV-E funds. Some experts in the field have proposed that in order to counteract the potential loss of IV-E dollars under a managed care service delivery system, states need to also consider refinancing additional child welfare services under Medicaid so as to maintain the overall level of federal funding.

[109] A case rate is defined as: "a flat rate based on a fixed amount per client often by diagnosis". Capitation is defined as: "the assumption of risk by a provider for the delivery of a defined set of services to a designated population over a specified time period with the payment calculated on a per-person basis". Charlotte McCullough, Managed Care and Child Welfare: A Child Welfare League of America Perspective (adapted from Beech Acres 1996).

[110] *See* Lorrie L. Lutz and Henry Yennie, *A Model for Flexible Use of Title IV-E Dollars: Consideration for Public Agency Executives in Developing Risk-Based Financing,* OPEN MINDS, Oct. 1997, at 4-5.

Notwithstanding Title IV-E's restrictiveness, Iowa's Decategorization Project is an example of a pooled funding initiative that includes these funds as part of the funding mix. Iowa, like many states, experienced a rapid increase in out-of-home placement costs in the late 1980's. In an effort to curtail this trend, the Iowa legislature enacted legislation authorizing two demonstration projects where counties were given the flexibility to spend their annual child welfare budget without restriction.[111] In essence, demonstration counties were permitted to transfer funds between line items in their budget or use funds to support new services for the purpose of creating a family-centered, community-based array of services that met the needs of children and families.[112] Moreover, demonstration counties were allowed to retain any savings generated at the local level.[113]

In 1992, this legislative initiative was expanded to permit any county "to use their child welfare budgets flexibly".[114] If the county, however, wanted to "to retain savings and enjoy expanded flexibility", it had to apply to become a decategorization project.[115] As of FY 1997, there were twenty-six decategorization projects in fifty-seven counties covering over seventy percent of the state's children.[116]

Initially, most decategorization projects focused on returning children placed in residential care, especially those in out-of-state facilities, to the community. By doing so, localities were able to generate the savings necessary to expand services to those at risk of out-of-home placement.[117] Eventually, these projects are expected to expand the service array even further from secondary prevention to primary prevention services to children and families who are not yet involved with any of the state's service systems.[118]

The way that decategorization works is that every year the state appropriates a child welfare budget that the Iowa Department of Human Services and the Juvenile Courts allocate based on historical factors and need indicators broken down by line item to the regions and then to local areas.[119] This budget includes all of the state child welfare allocation and projected federal child welfare earnings, including Title IV-B Subpart 1, IV-E Foster Care, and Title XX Social Services Block Grant funds, for foster care, group care, purchased adoption services, family preservation, family-centered

---

[111] O'BRIEN, *supra* note 102, at 28.

[112] In August 1995, a comprehensive evaluation of Iowa's Decategorization Project was published. The evaluation reported positive outcomes on both the family and systems levels. O'BRIEN, *supra* note 102, at 30 (*citing* Madeleine Kimmich et. al., Iowa Decategorization and Statewide Child Welfare Reform: An Outcome Evaluation of Iowa's Child Welfare Decategorization Initiative (1995)).

[113] O'BRIEN, *supra* note 102, at 28.

[114] *Id.*

[115] *Id.*

[116] *Id.*

[117] *Id.*

[118] *Id.*

[119] *Id.* at 29.

services, wraparound funds and court-ordered services.[120] In the past these funds have been decategorized and indistinguishable from one another at the local level with calculations about IV-E eligibility and claiming being done at the state level. Due to the increased number of children covered, the state has now decided to make local projects aware of the federal funds being drawn down under each line item to assist them in their funding transfers. The state further plans "to change the budget process so that each county budget is based on the amount that they actually draw down from federal sources, in addition to its allocation of state dollars."[121]

Key to the success of Iowa's Decategorization Project has been the state's ability to continue to draw down federal funds.[122] Simultaneous with this initiative, Iowa made comprehensive efforts to maximize federal funding as a means of further supporting the development of preventive services without having to increase the amount of state funding. Specifically, Iowa sought to maximize Medicaid through the rehabilitation option, Title IV-E, and the former EAF program. By doing so, Iowa not only increased federal funding for services, but also freed up its general fund dollars to support services and populations not covered by federal funding.[123]

Accordingly, states who are interested in pooling together federal and state dollars to support a managed care service delivery system, and especially those interested in doing so without the benefit of a Title IV-E waiver, should review Iowa's Decategorization Project and other pooled funding initiatives across the country for guidance.

CHILD WELFARE DEMONSTRATION PROJECT

Effective June 1, 1995, the Secretary of Health and Human Services was given the authority to waive certain requirements of Titles IV-B and IV-E for up to ten state proposals to operate a child welfare waiver demonstration project.[124] Recently, that waiver authority was expanded under ASFA to approve the applications of no more than ten states in each of FY's 1998 through 2002. As of December 1, 1999, the Secretary has approved twenty-four waiver proposals from twenty-one states and the District of Columbia to operate a child welfare demonstration project.[125] Prior to June 1995, the Secretary had no authority to waive Title IV-E's requirements.

The purpose of these projects is to pilot child welfare demonstrations regarding alternative means of service delivery, including managed care. Each project's proposal must include an evaluation

[120] *Id.*

[121] *Id.*

[122] *Id.* at 29-30.

[123] CENTER FOR THE STUDY OF SOCIAL POLICY, INVESTING IN CHILDREN AND FAMILIES: IOWA'S EFFORTS TO GENERATE FUNDS TO REFORM CHILD WELFARE SERVICES 2-4 (Washington D.C., Oct. 1994).

[124] 42 U.S.C.A. Sec. 1320a-9 (West Supp. 1999)

[125] In addition to the District of Columbia, the twenty-one states that have received approval to operate a child welfare demonstration project are: California, Colorado, Connecticut, Delaware, Kansas, Illinois, Indiana, Maine, Maryland, Michigan, Mississippi, Montana, New Jersey, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oregon, Washington, and West Virginia. Two states, Illinois and Maryland, have been approved to operate two child welfare demonstration projects in their states.

component that will assess the project's effectiveness, and must be cost neutral to the federal government during the life of the project.[126]

Of those states and the District of Columbia that have received approval, five are expressly using the waiver process to support the application of managed care principles in child welfare with Ohio being the first to receive approval to do so. One particular provision that states, including Ohio, have asked to have waived is the section of the Social Security Act that defines what costs are allowable under Title IV-E.[127] In Ohio's case, the state was given approval to expand the use of Title IV-E funds to support direct services to children and families.

FAIR COMPETITION

The managed care industry has set new precedent within the context of state sponsored Medicaid managed care initiatives for testing both the limits of antitrust protections, as well as the limits of other legal protections as they apply to the RFP (Request for Proposal) and contracting processes. While developing a managed care plan for child welfare therefore, public agencies should be cognizant of federal and state antitrust laws that apply to private managed care entities and providers, and federal and state procurement laws that apply to the competitive bid process.

ANTITRUST

Antitrust is a complex area of law that is extremely fact based in terms of prohibited conduct and available justifications to that conduct. Early legal review and proper planning, however, can help minimize the risk of an antitrust violation. The following is a brief overview of federal antitrust law. It does not constitute legal advice and is selective as to the issues covered. Although the analysis is limited to federal law, state antitrust laws must also be considered when developing and implementing any managed care plan.

The four federal antitrust statutes that are the most relevant to the activities of managed care entities and providers in terms of mergers, joint ventures, diversification, and group purchasing are: sections 1 and 2 of the Sherman Act[128]; section 7 of the Clayton Act[129]; and section 5 of the Federal Trade Commission Act[130].[131] These laws are enforced by the Department of Justice, Antitrust Division ("DOJ"), the Federal Trade Commission ("FTC"), state attorneys general, and/or private parties.[132] Enforcement may be criminal or civil in nature.[133]

---

[126] Child Welfare Demonstrations, 60 Fed. Reg. 31478 (June 15, 1995).

[127] 42 U.S.C.A. Sec. 675(4)(A) (West Supp. 1999)

[128] 15 U.S.C.A. Secs. 1 and 2 (West 1997).

[129] 15 U.S.C. Sec. 18 (West 1997).

[130] 15 U.S.C.A. Sec. 45 (West 1997)

[131] HEALTH LAW PRACTICE GUIDE, Sec. 26:2, at 2, NHLA Health Law *available on* CD-ROM, (Clark Boardman Callaghan, a division of Thomson Information Services Inc. 1996).

[132] *Id.* at 4.

[133] Criminal prosecutions are brought by the Department of Justice for violations of the Sherman Act. All other governmental or private enforcement of these laws are brought as civil actions. *Id.*

Of the four, Section 1 of the Sherman Act is generally considered the most important.[134] Essentially, section 1 prohibits agreements between separate entities found to unreasonably restrain competition. Section 2 of the Sherman Act, on the other hand, generally applies to the exclusionary conduct of single entities with substantial market power. Specifically, section 2 prohibits both monopolization as well as attempted monopolization and conspiracies to monopolize.[135] Aside from the Sherman Act, the two other relevant federal antitrust statutes are section 7 of the Clayton Act and section 5 of the Federal Trade Commission Act. Section 7 prohibits mergers and other consolidations, such as joint ventures, that may be expected to significantly reduce competition.[136] Section 5 of the Federal Trade Commission Act is a "catchall" section enforced only by the FTC. This section applies to business arrangements that either explicitly violate the terms or implicitly violate the spirit of sections 1 and 2 of the Sherman Act and section 7 of the Clayton Act.[137]

A particular issue that warrants discussion with regard to the implementation of managed care in child welfare from the antitrust standpoint is provider integration. For a variety of reasons, service providers in child welfare are interested in and in some cases forming provider networks and/or engaging in other forms of provider integration.[138] These networks can be either "horizontal," where similar types of providers collaborate together, or "vertical," where different types of providers collaborate, to form a network. They may also involve comprehensive or limited integration of provider functions. Key to the success of any network, however, is a clear understanding and agreement among the providers as to the network's goals. These goals will dictate the structure and operations that will bind the network.[139] A typical goal shared by both horizontal and vertical networks is the coordination of activities among providers to enhance economic efficiencies and to improve the quality of service delivery.[140]

Comprehensive integration of provider functions involves the consolidation of the participants' financial and clinical affairs to such an extent that they are brought under common ownership and control. Under certain circumstances, a network model that involves comprehensive integration may be considered a merger.[141]

The primary concern of merger analysis is to determine whether or not the network will have a

---

[134] *Id.* at 2.

[135] *Id.* at 2-3.

[136] *Id.* at 2. An issue that has arisen in the health care field is whether section 7 of the Clayton Act is applicable to acquisitions by non-profit entities, such as hospitals. *Id.* Sec. 26:4, at 8-9.

[137] *Id.* at 4.

[138] Some of the underlying reasons for provider integration include: enhanced operating and financial efficiencies; state sponsored managed care initiatives; improved service delivery; spreading of financial risk; and marketplace visibility.

[139] Anne M. Murphy, Esq., Formation of Networks, Corporate Affiliations and Joint Ventures Among Mental Health and Substance Abuse Treatment Organizations 8 (Prepared for The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Aug. 1, 1995).

[140] *Id.* at 9.

[141] *Id.* at 20.

significant share of the services in the relevant markets so as to be able to exert market power.[142] In this regard, DOJ and FTC ("The Agencies") have issued extensive horizontal merger guidelines that set forth the analytical framework to determine whether a horizontal merger is substantially likely to lessen competition.[143] The central theme of this framework is that these "mergers should not be permitted to create or enhance market power or to facilitate its exercise."[144] The 1992 guidelines as revised should therefore be reviewed in advance as to all proposed horizontal network transactions involving comprehensive integration. As to non-horizontal mergers, guidance may be found at Section 4 of the 1984 Merger Guidelines[145] as read in the context of the revised 1992 Horizontal Merger Guidelines.[146]

Not all providers, however, are interested in consolidating their clinical and financial affairs to such an extent that they are brought under common ownership and control. Instead, these providers are interested in joining together for only a limited purpose. Limited integration may be an initial step towards more comprehensive integration, or it may be the full extent to which providers want to integrate their activities with others.[147] Some reasons for limited integration are: the acquisition of major equipment (e.g., purchase/lease of a management information system); the creation of a new service; or the formation of a managed services organization (MSO) or managed care organization (MCO).[148] Competing providers that join together for a limited purpose, however, must still carefully consider the antitrust implications raised by their joint venture.

In this regard, The Agencies have also issued extensive guidelines regarding Antitrust Enforcement Policy in Health Care.[149] Although these statements are specifically directed at the health care field, arguably they can provide guidance for managed care entities and providers in terms of provider integration in child welfare since they are based on antitrust law and principles applicable to all areas of industry.[150]

In September 1993, The Agencies issued their six policy statements regarding antitrust enforcement in the health care field. These policy statements addressed a number of activities focusing on mergers and various joint activities in health care. In 1994, these statements were revised and

---

[142] *Id.*

[143] U.S. Dep't of Justice & Federal Trade Comm'n, Merger Guidelines-1992, 57 Fed. Reg. 41552 (Sept. 10, 1992) reprinted in 4 Trade Reg Rep. (CCH) Para. 13,104 (with April 8, 1997 Revisions to Sec. 4 Efficiencies). Also found at U.S. Department of Justice and Federal Trade Commission, 1992 Horizontal Merger Guidelines, <http://www.ftc.gov/bc/docs/horizmer.htm>

[144] *Id.* at Para 13,104, at 20,570.

[145] 1984 Merger Guidelines, reprinted in 4 Trade Reg. Rep. (CCH) Para. 13103 at p. 20,564 (Sec. 4 horizontal effect from non-horizontal merger).

[146] 1992 Merger Guidelines, *supra* note 144, at 20,569.

[147] Murphy, *supra* note 140, at 24.

[148] *Id.*

[149] U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) Para. 13,153 (August 18, 1996). (Also found at U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, <http://www.ftc.gov/reports/hlth3s.htm>.

[150] *Id.* at Para. 13,153, at 20,799.

expanded to include, among other things, the collective collection and provision of fee-related information to purchasers of health care services by providers, and analytical principles relating to a broad range of health care provider networks.[151]

In 1996, the 1994 statements were modified to reflect the continued changes that had occurred in the health care market. Specifically, The Agencies expanded the statements on Physician Network Joint Ventures and the more general statement on Multiprovider Networks. Of particular interest is Policy Statement 9 dealing with Multiprovider Networks.[152]

In Statement 9, The Agencies recognize that health care providers have been forming new types of business arrangements, including provider networks. Although these networks can offer significant benefits to consumers, they can also raise antitrust issues, especially if the network includes providers who are otherwise competitors of each other. Unlike some of the other policy statements, Statement 9 does not provide a safety zone for multiprovider networks because of the evolving nature of these networks and the great variety of different types of organizational structures and health care providers involved. What Statement 9 does offer, however, is a review of antitrust principles as they apply to multiprovider networks, a discussion of some issues relevant to the formation and operation of such networks, and examples on how antitrust principles would be applied to hypothetical multiprovider networks.[153]

Generally, multi-provider networks are examined under the rule of reason, rather than the per se standard, as long as they are likely to produce significant procompetitive benefits that will be passed on to consumers, and that the setting of prices (or other agreements generally considered per se unlawful) are reasonably necessary in order to achieve these benefits.[154] For example, it may be reasonably necessary for some multi-provider networks where substantial financial risk is shared among its members to set prices in order to achieve any significant efficiencies. In these cases, any pricing agreements therefore, would be analyzed under the rule of reason, not the per se standard.[155]

Statement 9 also recognizes the possibility that multiprovider networks that do not share substantial financial risk among its members may still be sufficiently integrated in other ways, such as through clinical integration, so as to be likely to produce significant efficiencies that justify joint pricing. The statement, however, cautions that clinical integration may not be relevant to all multiprovider networks due to the diversity of types of providers involved.[156]

---

[151] *Id.*

[152] Policy statement 9 defines multiprovider networks as "ventures among providers that jointly market their health care services to health plans and other purchasers". *Id.* at 20,826.

[153] *Id.*

[154] *Id.*

[155] Statement 9 provides a list of examples of different types of arrangements involving the sharing of substantial financial risk among network participants. This list, however, is not exclusive and does not prevent the review of other types of risk arrangements under the rule of reason. If providers are in doubt as to whether a particular risk sharing agreement constitutes "substantial financial risk sharing," networks are encouraged to seek an advisory opinion through the Agencies' expedited business review and advisory opinion procedures before moving forward with their plan. *Id.* at 20,826-27.

[156] *Id.* at 20,827.

In applying the rule of reason, The Agencies will evaluate the arrangement's "horizontal" and "vertical" impact.[157] To assess the impact, The Agencies will first define the relevant markets and then examine the network's probable competitive impact on those markets.[158] In so doing, The Agencies will consider all market conditions, not just market share and concentration, and balance the anticompetitive impact against the procompetitive impact of a multiprovider network to determine the lawfulness of the arrangement.[159]

Sometimes, a determination under the rule of reason can be reached without an extensive analysis. For example, The Agencies may be able to conclude on an expedited basis that a network is unlikely to be anticompetitive if that network is substantially integrated and includes only a small percentage of providers, on a non-exclusive basis, in the relevant markets. On the other hand, The Agencies will also challenge without extensive analysis a restraint that commonly reduces output or increase prices that is unnecessary to produce the intended efficiencies.[160]

An important factor to be considered when analyzing a network's arrangement is whether that network is exclusive in terms of prohibiting providers from offering their services through other networks. Networks that do so have the potential to reduce competition. Accordingly, The Agencies will review any arrangement that either explicitly prohibits or implicitly results in exclusivity by considering several factors. These factors include: the relative market share of the network's members who are subject to the exclusive arrangement; the arrangement's terms, including its duration and any financial incentives or disincentives associated with withdrawal from the network; the number of providers required by the network and competing networks in order for them to compete effectively; and the justification supporting the need for exclusivity.[161]

On the other hand, a common aspect of most networks is the exclusion of certain providers from participating in a network. The rule of reason generally applies in these cases as well to determine the lawfulness of the arrangement. In applying this standard, however, the focus is not on whether a particular provider has been harmed but rather, whether consumers have been harmed because of reduced competition. Generally, where other networks offering similar services exist or could be formed, exclusion from a particular network will not raise any significant competitive concerns.[162] Competitive concerns, however, will be raised if the exclusion policy causes competition to be harmed by rendering the providers unable to compete effectively. In such situations, the analysis will then focus on whether any procompetitive justifications exist that support the need for exclusion.[163]

---

[157] Agreements made amongst competitors are considered "horizontal," whereas agreements made amongst non-competing parties are considered "vertical" under federal antitrust laws. *Id.* at 20,828.

[158] As to vertical networks, The Agencies will also examine the network's ability to limit competition in markets other than the one in which it operates. *Id.* at 80,829-30.

[159] *Id.* at 80,827-31.

[160] *Id.* at 20,828.

[161] *Id.* at 20,829.

[162] *Id.* at 20,830.

[163] *Id.*

In sum, antitrust is a complex area of the law that relies heavily upon the particular facts of any given situation. Early legal review and proper planning are essential to minimize the risk of engaging or promoting unlawful conduct under federal and state antitrust laws as they apply to private managed care entities and providers.

FEDERAL PROCUREMENT LAW

As already mentioned, the managed care industry has set new precedent for testing the limits of federal and state legal protections as they apply to the competitive bid process. Although this has been more of an issue in the context of Medicaid managed care than in child welfare managed care initiatives, it is still important for public child welfare officials to be cognizant of providing a "level playing field" for all bidders in the competitive bid process. In this regard, two particular cases provide some valuable lessons learned. These are: *Medco Behavioral Care Corporation of Iowa (Medco) v. Iowa Department of Human Services,* and *Value Behavioral Health (VBH) v. Ohio Department of Mental Health.* Both cases involve violations of federal law, in particular federal procurement law, which occurred during the competitive bid process.

Medco Behavioral Care Corporation of Iowa v. State of Iowa Department of Human Services

By way of background, in January 1993, The Iowa Department of Human Services (DHS) contracted with a private vendor, Unisys, in part, to conduct a policy analysis concerning the expansion of Medicaid managed care to include a managed mental health program. Unisys, in turn, subcontracted out this task to Lewin-VH1 (Lewin), a subsidiary of Value Health, Inc.[164] Thereafter, DHS decided in November 1993 to contract out Medicaid funded mental health care to a private entity under a managed care model through a competitive bidding process. Value Behavioral Health, Inc. (VBH), another subsidiary of Value Health, was interested in bidding on the contract.

At this time, Unisys also expressed an interest in bidding on the contract with either Lewin or VBH. Although Lewin did not participate in the actual preparation of the RFP, the issue of conflict of interest arose, in part, because Lewin participated in the policy analysis relating to the implementation of the managed care contract that VBH and Unisys were interested in bidding on. In an attempt to resolve this issue, Lewin voluntarily stopped communicating with Value Health, the parent company to both Lewin and VBH, with regard to all Iowa matters, and then later implemented a similar embargo on communications with Unisys.[165]

Based on Lewin's recommendation, Health Management Associates (HMA) actually prepared the RFP for Iowa's managed mental health care contract. Unbeknownst to DHS, however, was the fact that Lewin had a business relationship with HMA in other states relating to the health care field.[166] As a consequence, Lewin's business relationship with HMA raised an issue because the RFP's structure favored less experienced bidders, such as VBH, over more experienced bidders, such as Medco, by prioritizing the RFP's technical criteria over the cost criteria portion. [167]

---

[164] Medco Behavioral Care Corporation of Iowa v. Iowa Department of Human Services, 553 N.W.2d 556, 559 (Iowa Sup. Ct. 1996).

[165] *Id.*

[166] *Id.*

[167] The court noted in its opinion that the RFP's structure was also developed to accommodate DHS's wish to maintain quality care in a managed care system. At the same time, however, the court noted that it could not ignore the fact that this structure favored

In March 1994, the RFP was issued. Eight bidders responded. VBH and Medco scored the highest on the technical criteria portion of the RFP. The way the RFP was constructed, the cost criteria was not considered unless the bidder met the 340 point threshold on the technical criteria first.[168] At the time, it was thought that only VBH had met that 340 point threshold. Accordingly, the RFP's evaluators recommended that VBH be awarded the contract. Later, it was determined, however, that Medco's bid had been miscalculated and that Medco had also met the 340 point threshold.[169]

On June 14, 1994, DHS named VBH as the vendor. Medco filed an administrative appeal with DHS, which was subsequently denied. Thereafter, Medco filed a petition for judicial review alleging conflict of interest and irregularities in the RFP process.[170] Ultimately, the district court determined that Lewin's various business relationships required the disqualification of VBH as a bidder because of an organizational conflict of interest rendering DHS's award "unreasonable, arbitrary and capricious."[171] The court further found that the evaluators had miscalculated the technical portion of Medco's bid and had improperly considered information outside of the bid proposals. Accordingly, the court reversed DHS's decision and remanded the case to the agency for further proceedings.[172]

Thereafter, VBH appealed the court's decision. Medco filed a cross-appeal. DHS, on the other hand, accepted the court's ruling, rescinded the contract to VBH, and stated its intention to award the contract to Medco. VBH then appealed to DHS challenging its decision. DHS denied VBH's appeal. VBH then filed a petition for judicial review and requested a stay of DHS's contract award to Medco pending appeal. The request for a stay was denied. Based on the court's decision, DHS filed a motion to dismiss the petition for judicial review. The district court affirmed DHS's award of the contract to Medco. VBH appealed and DHS cross-appealed. The Iowa supreme court then consolidated VBH's appeals for hearing.[173]

VBH challenged its disqualification on several grounds. First, VBH argued that the district court had applied the wrong legal standard to determine the existence of a conflict of interest.[174] Second, VBH argued that the district court had erred in disqualifying VBH from the bidding process since the facts did not support a finding that a conflict of interest existed.[175]

As to the first argument, the supreme court noted that it had never set the legal standard to

---

bidders with less experience in the area of Medicaid managed health care systems. *Id.* at 559-60.

[168] *Id.* at 560.

[169] *Id.*

[170] *Id.*

[171] *Id.* at 560-61.

[172] *Id.* at 561.

[173] *Id.*

[174] *Id.* at 563.

[175] *Id.* at 566.

determine the existence of a conflict of interest.[176] In setting the legal standard in this case, the court looked to federal law for guidance, in particular Appendix G, Sec. 10 of 45 C.F.R. part 74 and the Federal Acquisition Regulation (FAR).

In accordance with section 10 of Appendix G, which now can be found with similar language at 45 C.F.R. Sec. 74.43, "all procurement transactions . . . shall be conducted in a manner that provides maximum, open and free competition."[177] Moreover, "procurement procedures shall not restrict or eliminate competition."[178] An 'organizational conflict of interest' that arises during the procurement process is an example of an unlawful restriction on competition under this section[179] Section 10, however, does not define the term. Instead, the term 'organizational conflict of interest' is defined by FAR.

FAR defines an 'organizational conflict of interest' to mean "that because of other activities or relationships with other persons, a person is unable or potentially unable to render objective assistance or advice to the government, or the person's objectivity in performing the contract work is or might be otherwise impaired, or a person has an unfair competitive advantage."[180] "An organizational conflict of interest may result when factors create an actual or potential conflict of interest."[181] "Contracting officials are directed to identify potential organizational conflicts of interest early in the procurement process and to avoid, neutralize, or mitigate those conflicts before awarding the contract."[182] Where a conflict can neither be avoided nor mitigated, disqualification of the bidder is appropriate under FAR.[183]

After extensive review, the Iowa supreme court determined that the district court had applied the correct legal standard in disqualifying VBH from the procurement process based upon the appearance of an organizational conflict of interest that could neither be avoided nor mitigated, and that disqualification was appropriate as a matter of law.[184] In so deciding, the court noted that prior court cases had interpreted FAR to require the disqualification of a bidder based on "an appearance of impropriety where the bidder may have gained an unfair competitive advantage through an actual or potential conflict of interest in the procurement process."[185]

---

[176] *Id.*

[177] *Id.* at 564 (citing 45 C.F.R. Part 74, Appendix G, Sec. 10) (emphasis added).

[178] *Id.*

[179] *Id.*

[180] *Id.* (citing 48 C.F.R. Sec. 9.51).

[181] *Id.* at 564 (citing 48 C.F.R. Sec. 9.502(c)).

[182] *Id.* at 564-65 (citing 48 C.F.R. Sec. 9.504(a)(1), (2)) (emphasis added).

[183] *Id.* at 565 (citing 48 C.F.R. Sec. 9.504(e)).

[184] *Id.* at 568.

[185] *Id.* at 565 (citations omitted). However, "mere conjecture, innuendo or speculation of an actual or potential conflict of interest, without factual support, provides no basis for disqualification." "The facts that are required are those which establish the existence of an organizational conflict of interest, not the specific impact of that conflict." *Id.* (citations omitted).

Value Behavioral Health v. Ohio Department of Mental Health

Less than one year after the Iowa supreme court's ruling in *Medco v. Iowa,* Value Behavioral Health (VBH) brought suit as a plaintiff to enjoin Ohio state officials from completing a contract with another managed care company because of irregularities in the bid process that unfairly prejudiced VBH. Specifically, on April 8, 1997, VBH brought an action in federal district court to enjoin Ohio state officials from awarding its Medicaid behavioral health managed care contract to the Ohio Behavioral Health Partnership (OBHP)[186] , and to award the contract to VBH instead.[187] Through its first and second amended complaints, VBH alleged Ohio state officials unlawfully disclosed VBH's price breakdown to OBHP and allowed OBHP to then amend its bid proposal without allowing other bidders the same opportunity. Additionally, VBH alleged that state defendants unlawfully awarded the contract to a bidder with a nonresponsive bid proposal.[188]

On May 2, 1997, the court issued a temporary restraining order prohibiting Ohio from submitting its contract with OBHP for final approval.[189] Thereafter, on May 30, 1997, Judge Sargus granted VBH's request to permanently enjoin Ohio from completing the contract with OBHP. Judge Sargus, however, denied VBH's request that it be awarded the contract instead. Rather, the judge ordered that state defendants could not rely upon the completed RFP process, in whole or in part, to enter into any future contract with OBHP regarding this subject matter. Further, the court appointed a Special Monitor to oversee any rebidding of the contract to ensure compliance with the law. [190] The following is a summary of the events that led up to VBH's complaint and the court's decision.

On November 4, 1996, Ohio's Department of Mental Health (ODMH) and Department of Alcohol and Drug Addiction Services (ODADAS) issued an RFP for a single private entity to establish and implement a managed care system for behavioral health services and to consolidate and coordinate behavioral health services provided by three state agencies (ODMH, ODADAS and Human Services) and a number of county and community based public and non-profit agencies.[191] Three companies responded to the RFP, including VBH and OBHP. After the bids were received, ODMH and ODADAS evaluated the proposals based on a set of eighty-one preestablished questions. After this initial review, they sent requests for clarification to each of the bidders. OBHP's answers to the request for clarification provides a significant basis for VBH's complaint, in particular OBHP's response to questions concerning 'reinsurance'.[192]

By way of background, the RFP set the total amount that the state would pay to any vendor based on a fixed monthly fee per person. Thus, rather than competing on the total contract cost, bidders were instructed to propose a rate structure that would allocate the cost of medical services by

[186] OBHP is a partnership between Options Health Care, Inc. and Access Ohio, which is a statewide network of behavioral healthcare providers. Options is the managing partner of OBHP.

[187] Value Behavioral Health, Inc. v. Ohio Department of Mental Health, 966 F. Supp. 557, 559 (S.D. Ohio 1997).

[188] *Id.* at 560.

[189] *Id.* at 559.

[190] *Id.* at 576.

[191] *Id.* at 560.

[192] *Id.*

category and the cost of administrative services that were to be provided by the vendor. Unlike unexpended health care costs, which would have to be refunded to the state, the amount of any unexpended administrative costs could be retained by the vendor at the end of the year. The RFP also placed a $1.5 million cap on any potential profits that a bidder might retain.[193]

In its original proposal, OBHP listed the cost of reinsurance as an administrative cost. The sum of reinsurance based on state estimates would have been approximately $5,364,000. In response to the request for clarification, OBHP indicated that it did not intend to purchase reinsurance; instead, it intended to self-insure. Significant to this discussion is the fact that premiums paid to a third party for reinsurance are not refundable even if unexpended. Unlike reinsurance, however, under a self-insurance arrangement it was possible for OBHP to retain the full $5,364,000 (or a portion thereof) if unexpended at the end of the year since this amount was categorized as an administrative cost.[194] As such, the court apparently reasoned that the retention of the $5,364,000 would have essentially circumvented the RFP's $1.5 million cap on potential profits.[195]

During the oral interviews that followed, OBHP assured state officials that the charge for self-insurance would not be retained by OBHP if unexpended. No written documentation, however, was received confirming this understanding until after the cut off date for submission of final proposals, despite the RFP's explicit language that the final proposal was to include all terms and conditions.[196]

On February 3, 1997, the state agencies met and selected OBHP as the 'tentative selected bidder'. During the meeting, a phone call was placed to OBHP to advise the company that it had been chosen as the vendor under the RFP. Thereafter, a second phone call was placed to OBHP to inform the company that its administrative costs were too high and that the total administrative costs could not exceed $.95 pm/pm, the exact figure bid by VBH.[197] Shortly thereafter, OBHP sent a revised rate schedule reducing its administrative costs to $.95 pm/pm and eliminating any charge for reinsurance. No other bidder was given this same opportunity to materially alter its final proposal after submission.[198] After receiving these revisions, the other bidders were notified that they had not been selected as the vendor.[199] State defendants argued that these negotiations with OBHP were appropriate since they occurred after OBHP was selected.[200]

---

[193] *Id.* at 561.

[194] *Id.*

[195] *Id.* at 561-62.

[196] *Id.* at 562-63.

[197] *Id.*

[198] *Id.* at 563.

[199] *Id.*

[200] *Id.* at 575.

On April 8, 1997, VBH brought a section 1983 action in federal district court alleging violations of 42 U.S.C. Sec. 1396a(a)(4) and 45 C.F.R. Sec. 74.43.[201] After a lengthy analysis, the court determined that under certain conditions unsuccessful bidders who have been deprived of a Medicaid contract are intended beneficiaries under this statute and regulation and therefore, may bring a private action to enforce these provisions.[202]

Although due deference is generally afforded to states in the awarding of contracts, courts will intervene in certain exceptional situations as the court did in this case. Here, the court found that the defendants, by their actions, violated 42 U.S.C. Sec. 1396a(a)(4) and 45 C.F.R. Sec. 74.43 in the following ways. First, state officials should not have accepted OBHP's bid because it was unresponsive to the RFP in that it did not limit its potential profit as required by the RFP to $1.5 million. Second, only OBHP was permitted to materially alter its final proposal after submission. Third, state officials improperly disclosed to OBHP the administrative cost figure bid by VBH and then allowed OBHP to change its bid to that amount.[203]

Lessons Learned?

So, what are some of the lessons learned from these two cases? First and foremost, it is exceedingly clear that states need to implement competitive bid processes in strict compliance with federal and state procurement law and policy and to provide all bidders with a "level playing field" during the bid process.[204]

Second, public agencies need to involve their lawyers early on in the procurement process to avoid or at least mitigate any potential litigation down the road. According to Richard E. Ramsay, Iowa's Assistant Attorney General, the agency's lawyers need to analyze the "legal implications of policy decisions concerning the design of the contract program, as well as to analyze who will be putting together the Request For Proposal, who will be evaluating the bids and how the bids will be evaluated."[205] These lawyers should also examine state and federal procurement law, and state grievance and appeal procedures. Finally, the lawyers need to review the evaluation protocol to ensure that it is "fair, accurate, and impartial"and implemented appropriately.[206]

---

[201] *Id.* at 559, 564.

[202] Sec. 45 C.F.R. 74.43 (which governs Medicaid and other Federal Social Security Act entitlement programs) states that: "(1) All procurement transactions shall be conducted in a manner to provide to the maximum extent practical, open and free competition; (2) Awards shall be made to the bidder or offeror whose bid or offer is responsive to the solicitation . . . ; and (3) Solicitations shall clearly set forth all requirements that the bidder or offeror shall fulfill in order for the bid or offer to be evaluated by the recipient." *Value Behavioral Health,* 966 F. Supp. at 570 (citing 45 C.F.R. Sec. 74.43).

[203] *Id.* at 573.

[204] Public agencies should also be concerned with the content of the contract, not just the procurement process. Specifically, public agencies should carefully determine all of the elements that need to be included in the contract and ensure that the contract's language clearly defines the contracting parties' respective rights and responsibilities. *See generally* Lorrie L.Lutz, *The Kansas Child Welfare Privatization Initiative: A Look One Year Later*, THE CHILDREN'S VANGUARD, Feb. 1998, at 6, 9 (better contract and data definitions); Monica E. Oss and Lorrie L. Lutz, *Issues Faced By Public Entities In Applying Managed Care Principles to Children's Services*, THE CHILDREN'S VANGUARD, Jan.1998, at 8-10, 9. (design and management of performance based contracts); Best Principles for Managed Care Medicaid RFP's: How Decision-Makers Can Select and Monitor High Quality Programs (American Academy of Child and Adolescent Psychiatry).

[205] *From Iowa, The Voice of Experience*, MENTAL HEALTH WEEKLY, March 17, 1997, at 3.

[206] *Id.*

Conclusion

Public agencies must carefully consider and address each of these legal issues raised above in their managed care plan. Although these issues generally do not pose an absolute barrier to the implementation of managed care in child welfare, they will surely impact the system's design.

Finally, it must be noted that the implementation of managed care in child welfare is an evolutionary process. We will continue to learn about what works, what does not, and what additional issues need to be considered as more states explore managed care as an alternative service delivery system in child welfare. It is definitely a work in progress still awaiting evaluation. As such, however, sufficient safeguards and legal protections must be built into the managed care system so that the children and families it is designed to serve will not be harmed.