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Preparing for a Managed Care Environment

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Managed care is a term that has become familiar to many of us as a service delivery model utilized in the physical health arena. More recently, the principles of this model have been applied to the delivery of mental health services. Managed care has gained much popularity due to its potential for cost savings; savings that are achieved through the coordination of all services through one point (often referred to as the primary care provider) and the monitoring of services to eliminate the delivery of any services the Managed Care Organization (MCO) determines to be unnecessary. Now, MCOs are looking toward the public sector, including juvenile justice, as the next arena for expansion. In turn, many state and local governing units are looking towards managed care as a way to control, or at least contain, skyrocketing costs in their juvenile justice and child welfare systems.

Managed care is not, however, one specific plan for service delivery. Rather, it can take many forms and its definitions are as numerous as its applications. In general, it may be said that managed care is a system of service delivery in which costs are controlled through a mechanism that ensures that the services a person receives are appropriate and "medically necessary," thereby eliminating unnecessary use of services. This is usually achieved by a professional, or group of

professionals, at the Managed Care Organization serving as the gatekeeper(s) to service and making decisions, based upon a set of protocols, as to which services are necessary for an individual client. This varies significantly from the traditional fee-for-service system in which the determination of services is strictly between the direct service provider and the client.

While the lure of cost savings is inviting to state and local officials, it must be remembered that the managed care programs were originally designed to handle the delivery of physical and, in some instances, mental health services in a private, for-profit setting. Many of the policies, procedures and even underlying principles do not readily assimilate to the goals of the juvenile justice system. In this new arena, services cross the line between physical and mental health into social and judicial services and the additional goals of justice and personal accountability and public protection enter into the decision making process.

Pennsylvania is taking a proactive approach to the study of this issue with Governor Tom Ridge charging the state's Juvenile Advisory Committee with responsibility for examining the policies, procedures and principles of managed care as they relate to the juvenile justice system and for making official recommendations to the Administration. In response, the JAC has formed a Managed Care Subcommittee consisting of interested members of the JAC as well as pertinent juvenile and child welfare specialists from across the Commonwealth.

The Subcommittee enjoys the expertise of representatives from the state's Department of Public Welfare, the Pennsylvania Commission on Crime and Delinquency, the Juvenile Court Judges' Commission, the County Commissioners' Association, the Pennsylvania Council of Children's Services and the National Center for Juvenile Justice. In addition,

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Subcommittee members include juvenile court judges, juvenile probation officers and private sector service providers.

At its first meeting in January 1998, the Managed Care Subcommittee determined that there were two separate, yet equally pertinent, issues that must be explored. The first being the effects of Medicaid managed care on youths in the juvenile justice system and the second being the direct application of a managed care model to the delivery of juvenile justice services (i.e. day treatment programs, residential facilities, juvenile probation, etc.). The following sections will briefly outline these issues, their critical impact on juvenile justice, and the process the Subcommittee will be undertaking to provide the Governor with recommendations that will promote the delivery of quality services to Pennsylvania's delinquent youths and that will protect the safety of Pennsylvania's citizens.

▼ Medicaid Managed Care

On December 31, 1996, the Federal Health Care Financing Administration (HCFA) approved the Pennsylvania Department of Public Welfare's request for a 1915(b) waiver to implement a mandatory managed care program for medical assistance recipients. This waiver frees states from Medicaid mandates which then allows states to adapt health services for the Medicaid-eligible population. The Department describes the overall goals in designing such a program as follows:

- To improve access to preventative services, primary care and early prenatal care for the medical assistance population;
- To ensure that every medical assistance recipient is able to choose a primary care provider who will serve as his or her family physician and be responsible for providing all basic medical services;
- To improve the quality of health care outcomes by enhancing the ability of urban and rural communities to retain existing providers and attract new ones; and
- To stabilize the Commonwealth's medical assistance spending and to place future spending on a more predictable and sustainable course.

(Statewide Mandatory Medicaid Managed Care, Discussion Paper. Pennsylvania Department of Public Welfare: December 1996.)

On February 1, 1997, the Department operationalized these goals in a program known as HealthChoices. (See Box 1 for further description of HealthChoices) The Southeast Region of Pennsylvania (Bucks, Chester, Delaware, Montgomery and Philadelphia counties) became the first area in the state to fall under the auspices of HealthChoices. Combined, these counties represent approximately 36 percent of the state's total Medical Assistance population. The program is scheduled to begin operation in the Southwest Region (Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties) by January 1, 1999, in the Capitol/Lehigh region by January 2000 and throughout the remainder of the state by January 2001.

While this program is not a direct juvenile justice program, it is impacting greatly upon the juvenile justice system, as a vast number of its clients are eligible for medical assistance. To grasp the fundamentals of the HealthChoices program, the Managed Care Subcommittee invited representatives from the Department of Public Welfare to present to the Subcommittee at its February meeting. The presentation was followed by a panel discussion of juvenile justice professionals from the Southeast Region who are presently being affected by HealthChoices.

What became most clear from this portion of the inquiry is that Medicaid managed care will impact upon all agencies providing any type of clinical services to children and youth. These agencies must be aware of the new procedures and policies, must provide staff with training in this area, and should be as involved as possible in the design of a Medicaid managed care plan in their area to ensure that it meets the specific needs of the clientele it is serving.

In addition, as is the case with any new program, panel participants conveyed both positive and negative consequences. One specific benefit highlighted was an increase in access, and speed of access, to mental health services in some areas. Challenges currently facing the program include streamlining the enrollment/change in enrollment process to accommodate children moving in and out of residential placements, addressing the related issue of accessing care within statutorily prescribed time frames, and clarifying requirements regarding information sharing and access to information (i.e. this has been an area of concern for foster parents and others assuming temporary custody of children).

Healthchoices

The Pennsylvania Department of Public Welfare had nearly 20 years experience with voluntary managed care programs that were offered in the state's largest counties and approximately 10 years of experience with mandatory managed care through a Philadelphia program known as HealthPass. Based on the lessons learned through these experiences, Department officials designed the HealthChoices program based upon the following definition of managed care:

A system of health delivery under which an insuring organization accepts a monthly payment and is held accountable for the health outcomes of the purchaser's beneficiaries, who are in turn held accountable for establishing relationships with their primary care provider and appropriately accessing health care services." (*Statewide Mandatory Medicaid Managed Care, Discussion Paper. Pennsylvania Department of Public Welfare: December 1996.*)

The HealthChoices program involves three primary components: (1) Physical Health services, (2) Behavioral Health services (i.e. mental health and substance abuse), and (3) the Independent Enrollment Assistance Program. The Physical Health component requires all contracting Health Maintenance Organizations (HMOs) to be licensed in each county within the region, to assume full risk based upon a monthly capitation rate paid for each client, and to utilize only primary care providers (PCPs) who are board certified, board eligible, and who specialize in family medicine, internal medicine, pediatrics or Obstetrics/Gynecology. Once enrolled in an HMO, all a client's physical health services must be ordered through the primary care provider and approved according to the protocols of the HMO.

The Department of Public Welfare decided to separate behavioral health services based upon the input received from segments of the stakeholder community including private sector MCOs, service providers, behavioral health consumers, family members of those in care, state and local government, legal advocates and other interested parties. The Behavioral Health component is designed to require one entity to manage services for each county. That entity can be the county itself if the county can demonstrate the ability to meet the Department's fiscal and program requirements including capitation payments, or the county may contract with a single HMO to provide services to all Medical Assistance recipients.

The Independent Enrollment Agency is a new component designed to assist medical assistance recipients in selecting the physical health HMO most suited to their needs. After witnessing the shrewd marketing strategies of the physical health care HMOs in the Southeast Region, this component was designed to help ensure that participants select the HMO that is best suited to their needs instead of the program currently running the most tempting promotional offer.

Quality assurance in the HealthChoices program will be provided through a strong emphasis on outcomes based evaluations and quality measures. The Department has set clear criteria for both the physical health and behavioral health contractors to ensure consumer satisfaction. The Department has also devised a formal grievance and appeal process. This process will allow consumers and providers to resolve complaints regarding the quality of care and/or the oversight of care in the determination of which services are medically necessary.

▼ Managed Juvenile Justice Services

The other major area the Subcommittee is studying is the direct application of managed care policies and principles to the provision of juvenile justice services. While such managed care principles as outcome-based performance measures, integrated management information systems and the centralized coordination of services may hold promise to enhance the juvenile justice system, other aspects of managed

care pose a serious threat to the existing system and to the integrity of the court.

One specific concern the Subcommittee will be addressing is the preservation of the authority of the juvenile court judge and the juvenile court to order a specific treatment and to determine the length of treatment. Pennsylvania's Juvenile Act (42 Pa.C.S. Sec. 6301 et seq.) was amended by Act 133 of 1995 to incorporate the principles of Balanced and

Restorative Justice into the purpose of the juvenile justice system. This philosophy emphasizes the need to hold a youth accountable for his/her actions, to develop his/her competencies, and to involve the victim and the community in the justice process. The Subcommittee must carefully consider how managed care policies, such as the use of protocols to determine the medical necessity of services, might promote or hinder the achievement of these important goals.

Additional issues surrounding the implementation of managed care principles in the juvenile justice system that the Subcommittee will be addressing include identifying and emphasizing the ways in which juvenile justice clients differ from the general population, ensuring that fiscal savings are not attained through a loss in quality of services or through a reduction in the provision of necessary services, and further defining the role of small private service providers in a managed care environment.

To examine these issues, the Subcommittee is looking within the Commonwealth and nationally for programs that have conducted related research or implemented pilot programs in this area. Within the Commonwealth, one organization has been identified that has conducted detailed research into the effects of managed care on service delivery to children in the child welfare system. This organization, The Laurel Group has identified 11 components of managed care that may have positive implications for the child welfare and juvenile justice systems such as standard assessment procedures, a continuum of services, utilization reviews, emphasis on outcomes, and sophisticated management information systems.

Based upon this research, in February 1998 the Laurel Group developed a pilot Managed Service Organization (MSO). This pilot program will not be involved in direct service provision, but rather, will act as the direct facilitator of a managed delivery system model to support networks/alliances of local service providers. This specific program model was selected based on its ability to provide local service providers with the administrative support necessary to coordinate and streamline the service delivery process while maintaining the strong relationships that currently exist between providers and county governments. The Managed Care Subcommittee will begin hearing testimony from The Laurel Group in March 1998.

On a national level, important studies of managed care and its impact upon children's services have been conducted by such prestigious organizations as the Annie E. Casey Foundation, the National Resource

Network for Child and Family Mental Health Services, and the Child Welfare League of America (CWLA).

A 1996 survey of the states by CWLA further underscores the prominence of this issue finding that **82 percent** of the states are considering turning to managed care or the privatization of services to enhance quality, improve the cost-efficiency of child welfare services and/or to increase the satisfaction of clients. Moreover, CWLA has identified the following seven questions a state must address in planning a managed care program:

- 1) What population is to be covered, what are its service need characteristics, and what are the legal mandates?
- 2) What benefits (services/supports) are included in the plan?
- 3) What are the goals of the system and which outcomes will be measured to determine success?
- 4) How will the system be priced and funded and how will risk be shared?
- 5) How will "gatekeeping," utilization management and case management be handled under a managed care plan? How will public and private roles and responsibilities change?
- 6) How will quality be ensured?
- 7) What information must be managed and what MIS capacity is needed?

(Charlotte McCullough. "Managed Care and Child Welfare: An Overview of 1996 Trends, Issues, and Challenges." The Managed Care Institute of the Child Welfare League of America: 1996.)

The Managed Care Subcommittee will be inviting testimony from the CWLA and other national presenters in May 1998.

DIRECTIONS

Under the Administration of Governor Tom Ridge, the Pennsylvania Commission on Crime and Delinquency's Juvenile Advisory Committee has been charged with the responsibility of developing an annual strategic plan for the Commonwealth's juvenile justice system.

Members of the Juvenile Advisory Committee and its Managed Care Subcommittee believe the emerging issues surrounding managed care are of vital

importance to the juvenile justice system and, thus, are directly related to the development and implementation of the strategic plan. Moreover, members are dedicated to conducting an objective inquiry into both topic areas outlined above and in providing recommendations that promote the best practice for both efficiency and effectiveness in the juvenile justice system. The final report of the Managed Care Subcommittee is scheduled to be presented to the Governor in December 1998.

If you would like more information on the work of the Subcommittee, or would like the opportunity to present to the Subcommittee please contact:

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