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Assessing the Risk of Women and Children Enrolled in Managed Care:

Design Options for South Carolina Officials

Prepared for:

The South Carolina Department of
Health and Environmental Control

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I. Introduction

By mid-1994, roughly 24 percent of all Medicaid recipients were enrolled in some type of managed health care system. This figure represents a dramatic increase from 1983 when just three percent of Medicaid recipients were served in managed care arrangements. In the past two years alone, Medicaid enrollment in managed care has increased by 60 percent (Health Care Financing Administration, 1995).

Almost every state has contributed to this growth. Today, all but eight states have implemented some form of Medicaid managed care and fully 22 states have submitted Section 1115 waivers to conduct statewide Medicaid research and demonstration programs, all of which involve mandating Medicaid recipients' enrollment in managed care. As of July 1995, five of these 1115 waivers were implemented, seven were approved by the Health Care Financing Administration (HCFA) but not yet implemented, and ten were still under federal review (HCFA, 1995).

An increasing number of states have embraced managed care in the hope that several positive goals will be achieved: that access to care will improve as all Medicaid children and their families are linked to a primary care "medical home," that quality of care will improve as service delivery becomes more integrated, and that health care cost inflation will slow as managed care providers are faced with incentives to operate more efficiently. However, state maternal and child health officials are concerned that managed care organizations, which have shown some ability to achieve these ends when serving a predominantly healthy, middle-class clientele, will be less able to effectively serve low-income and high-risk children and families previously served in state and local public health systems. Not only do managed care entities have relatively little experience serving these populations, they also tend to primarily provide services that are medical in nature and have not typically provided many of the access-enabling and psychosocial support services that have been provided by the public sector and have been proven effective in helping disadvantaged families to thrive (Association for the Care of Children's Health, 1987; Buescher et al., 1991; Buescher and Ward; 1992; Korenbrot, 1984; Korenbrot et al., 1993;

Heins et al., 1987; McLaughlin et al., 1992; Olds et al., 1986; Shonkoff and Hauser-Cram, 1987; U.S. Public Health Service, 1989). Furthermore, many of these officials are concerned that managed care providers may not even be able to effectively *identify* children and families that need such additional support; risk assessment protocols used by managed care plans may not focus on identifying the environmental and psychosocial factors that often place low-income families at risk for poor functioning and put their children at risk for poor growth and development.

The State of South Carolina submitted its application for a Section 1115 waiver in March 1994 and received preliminary approval from HCFA of its *Palmetto Health Initiative* (PHI) in November of that year. While the waiver was being prepared in the fall of 1993, the Maternal and Child Health (MCH) program in the South Carolina Department of Health and Environmental Control (DHEC) submitted to Health Systems Research, Inc. (HSR) a request for technical assistance in facilitating the integration of MCH services with Medicaid managed care. Following a site visit to the state in April 1994, during which HSR staff met extensively with both MCH and Medicaid officials, it was decided by both agencies that HSR's resources should be directed toward the development of a draft contract between Medicaid and MCH under which a package of Family Support Services—including outreach, risk assessment, case management, health education, nutritional services, social work services, and caregiver training—could continue to be rendered by DHEC providers and reimbursed by Medicaid within a managed care environment. This product was completed and submitted to South Carolina officials in January 1995.

Following this, South Carolina officials requested that the remainder of HSR's TA resources be used to develop a report on how states are designing and implementing risk assessment systems under Medicaid managed care. With implementation of PHI looming, MCH officials were concerned that managed care systems in the state might not be equipped to effectively identify children and families in need of Family Support Services. Thus, they were interested in learning more about alternative approaches to designing risk assessment systems for at-risk

individuals and families and, in particular, whether other states' experiences with these systems could provide South Carolina with insights into how best to set up its model.

During February and March 1995, HSR conducted telephone interviews with Medicaid and MCH officials responsible for implementing managed care systems in every state that had either submitted a Section 1115 waiver application or has implemented an 1115 waiver program. These officials were questioned regarding how their programs conducted (or planned to conduct) risk assessments to identify populations who might require special services. Specifically, states were asked about policies surrounding how managed care plans identify three distinct populations: high-risk pregnant women, children with special health care needs, and children with mental health problems. In all, detailed information was gathered from 13 states.[1] These states are displayed in Table 1, along with information regarding the status of their waiver programs.

This report presents the findings of these interviews and is organized as follows:

- Section II provides a conceptual framework for considering how to design risk assessment systems under managed care and presents four alternative approaches;
- Section III presents the findings of HSR's interviews and classifies each state's risk assessment approach according to Section II's framework; and
- Section IV presents concluding thoughts regarding the advantages and disadvantages of alternative designs and which model might be most appropriate for South Carolina.

[1] Information was not obtained from a number of waiver states for a variety of reasons. Specifically, the States of Kansas, Louisiana, New York, Oklahoma, and Vermont had not submitted their 1115 waiver applications at the time this study was conducted, and the State of Kentucky, although it had received federal approval, had decided not to implement its waiver when HSR made its inquiries. As this report was specifically developed for South Carolina, it, too, was left out of the analysis.

II. Design Options for Risk Assessment Systems

Any health care system should have in place mechanisms for systematically identifying patients who have, or are at risk of having, health and developmental problems. Such risk assessment systems allow providers not only to detect individuals in need of additional services but also to respond by arranging appropriate follow-up care.

Table 1
Status of State Medicaid 1115 Waivers Programs Studied by HSR

State	*Status of Waiver*
Arizona	Implemented in 1982
Delaware	Approved/Not Implemented
Florida	Approved/Not Implemented
Hawaii	Implemented in 1994
Illinois	Application Pending
Massachusetts	Approved/Not Implemented
Minnesota	Approved/Not Implemented
Missouri	Application Pending
New Hampshire	Application Pending
Ohio	Approved/Not Implemented
Oregon	Implemented in 1994
Rhode Island	Implemented in 1994
Tennessee	Implemented in 1993

Source: Health Systems Research, Inc., 1995

Managed care systems should, in theory, place extra emphasis on establishing rigorous risk assessment protocols; under capitated arrangements it is in their financial interest to detect problems among enrollees as early as possible to avoid the costly outcomes that can result when health problems go undetected. Unfortunately, the same financing structures that are intended to encourage efficiency in managed care can create incentives to underserve high-

risk and high-cost populations. For this reason, state Medicaid and MCH officials in states pursuing managed care waivers may need to pay particular attention to developing policies to help safeguard the health of low-income individuals and families.

With regard to risk assessments, states can choose among a range of policies that will place either fewer or greater controls upon the manner in which managed care plans identify high-risk populations. Based on HSR's experience working with states and its analysis of Medicaid 1115 waiver programs, it appears that there exist at least four alternative policies that states can adopt to influence how risk assessment systems take shape within a managed care environment. These options are described below, listed in order from least to most regulatory.

Option #1 **Allow Plans Total Flexibility.** The least intrusive, most *laissez-faire* policy option is to allow managed care providers total flexibility to design and implement their own risk assessment protocols. This "hands off" approach may succeed in attracting plans to participate in the waiver, but may do so at the expense of state control over whether or how risk assessments are performed. With this policy, state officials have little assurance that high-risk pregnant women or children with special health care needs (including mental illness) will be identified or referred to appropriate care.

Option #2 **Require Performance of Certain Risk Assessments.** In their contracts with managed care entities, states could require that plans conduct certain types of risk assessments. For example, a state could require that plans screen all pregnant women for factors that place them at high risk for a poor outcome, or that plans screen all pre-school children for developmental delay. This policy stance helps to ensure that important assessments are performed and increases the likelihood that at-risk populations will be identified. However, as it falls short of prescribing exactly what kind of risk assessment is performed, variations between plans' protocols are likely. Further, plans may request higher capitation payments to cover the cost of developing and implementing the risk screen(s).

Option #3 **Impose Uniform Risk Assessment Forms and Protocols.** Going a step beyond that described in Option #2, states could not only require that certain types of assessments be performed, but could also require that uniform risk assessment forms and/or protocols be used by managed care providers. This way, the state can assure that consistent assessments occur in all plans participating in the waiver. Further, this approach ensures that assessment protocols are structured so as to detect problems of critical concern to state

officials such as, for example, psychosocial and environmental risk factors for pregnant women. Plans may resist such a policy, however, and argue that it infringes too heavily on their flexibility and medical practices.

Option #4 Require that Certain Assessments be Performed by Outside Agency. The most regulatory policy, and one that presumes that managed care providers are not equipped to perform sufficiently sensitive risk assessments of low-income/high-risk families, is to require that certain types of risk assessment procedures be performed by an outside agency (such as a state or local health department). This policy goes the furthest in ensuring that consistent, high-quality assessments of the caliber the state is accustomed to are performed. However, the approach may also be the most costly (since, presumably, the outside assessment process will be financed separately from the plans' capitations) and potentially duplicative (since an initial screen would, most likely, need to be performed by the plans to determine who needs to be referred out for further assessment). Such a policy also raises potential controversy regarding managed care providers' obligation to follow plans of care developed by the outside agency subsequent to its risk assessment; plan physicians and administrators may feel that such a requirement takes too much control over utilization and expenditures out of their hands.

The answer to the question of which policy is the "right" one may vary significantly from state to state. Factors that will influence the choice include the maturity of the managed care system in the state, the amount of experience the state has had contracting with managed care providers, and the degree to which a state's existing public health infrastructure is experienced with and maintains a capacity to perform high-quality risk assessments. In addition, different policies may be appropriate for different high-risk populations in a given state.

III. Findings

The thirteen states studied generally adopted different risk assessment policies for the three different populations described in Section I: pregnant women, children with special health care needs, and children with mental health needs. Table 2 displays the states using each risk assessment approach for each population.

Table 2
State Risk Assessment Policies under Medicaid Managed Care Waivers

Risk Assessment Policy	**Population**		
	Pregnant Women	CSHCN	Mentally Ill/ SED
Option 1: Allow Plans Total Flexibility	**3**: HI, NH, TN	**7**: DE, HI, IL, NH, OH, OR, TN	**7**: DE, FL, MO, NH, OH, OR, RI
Option 2: Require Performance of Certain Risk Assessments	**4**: IL, MA, MO, OR	**1**: MN	**2**: MA, MN
Option 3: Impose Uniform Risk Assessment Forms and Protocols	**5**: AZ, DE, FL, MN, OH	**1**: FL	**1:** IL
Option 4: Require that Certain Assessments be Performed by Outside Agency	**1**: RI	**4**: AZ, MA, MO, RI	**3**: AZ, HI, TN
Total	**13**	**13**	**13**

Source: Health Systems Research, Inc., 1995

The discussion that follows describes how states have enacted each of these four approaches in more detail, discussing each target population and providing examples of states that are implementing each policy as part of their Medicaid managed care strategy.

A. Option 1: Allow Plans Total Flexibility

Study findings indicate that states have been least willing to permit managed care plans complete flexibility to develop their own risk assessment policies and procedures with regard to pregnant women; only three of the 13 states impose no requirements on plans regarding whether or how they conduct risk assessments for this population. States appear to be much more willing to allow plans total flexibility in the case of children with special health care needs and children with mental health problems, with seven of 13 states placing no policy constraints on how plans assess the needs of each of these two populations.

B. Option 2: Require Performance of Certain Risk Assessments

Relatively few states have chosen to require plans to conduct risk assessments of selected populations without specifying the protocol that is to be used. Three states, Massachusetts, Missouri, and Oregon, require plans to assess the medical and psychosocial risk level of pregnant women but give plans flexibility in developing their own risk assessment tools. Similarly, Illinois requires physicians to follow the standards and provisions of the American College of Obstetricians and Gynecologists in assessing pregnant women's level of risk, but prescribes no particular risk assessment form. Minnesota is the only state that requires plans to assess children's risk of developmental delay (beyond the developmental screen required under EPSDT), and both Massachusetts and Minnesota require children to be assessed for mental illness, but the states do not require that specific risk assessment protocols be used. Oregon's strategy for assessment of pregnant women provides an example of this approach.

Oregon

The Oregon Office of Medical Assistance Programs (OMAP) offers a "maternity management program" for pregnant women. At the option of each capitated plan, in return for an enhanced capitation rate, plans may offer this program to pregnant enrollees. In addition to case management and nutritional counseling, the program calls for the administration of three types of assessments of pregnant women: an initial assessment, a nutritional assessment and a home assessment. These three risk assessment processes are described below.

- **Initial screening.** Although the state does not require plans to use a particular prenatal assessment form, it does require that providers collect information on a woman's current health status and identify any physical, environmental and psychosocial factors that place her at risk. OMAP suggests that client interviews, existing available records and needs assessments, and a woman's current or past providers be used as sources of information.

- **Nutritional assessments.** In addition to the initial assessment, a nutritional assessment that evaluates a woman's need for nutritional counseling must be conducted. Conditions that OMAP suggests might indicate the need for this counseling include chronic conditions, inadequate weight gain in pregnancy, eating disorders, pregnancy-induced hypertension or diabetes, and any other conditions identified by the primary care provider and for which adequate services are not available from a local Women, Infant and Children's (WIC) agency.

- **Home assessments.** Finally, up to four home visits can be conducted during a woman's pregnancy. These assessments evaluate a woman's physical environment, health status, adequacy of food and food preparation capabilities, and social support.

Case managers, who are physicians, physicians' assistants, nurse practitioners, social workers or registered nurses employed by health plans, conduct these assessments. Other providers may also act as case managers under the supervision of one of the above professionals. Based on the results of an assessment, a case manager provides appropriate services, such as coordination with community resources, client advocacy and any follow-up referrals. In addition, the report of the assessment is sent to the primary care physician responsible for the pregnant woman's care. If the assessment indicates that a woman is at risk for poor pregnancy outcomes, the primary care physician can recommend that she receive "high-risk case management" instead of the program's standard case management. OMAP does not specify what services should be included in this high-risk program. One-time nutritional counseling is also available to any woman who has been determined to have nutritional deficiencies. All the services delivered as a part of the Maternity Management Program are covered through the base capitation rates paid by OMAP to managed care organizations.

C. Option 3: Impose Uniform Risk Assessment Forms and Protocols

In this approach, states not only require that managed care plans assess their enrollees' level of risk for certain conditions, but also require that the plans employ specific tools or protocols in conducting these assessments. This policy is most commonly used with regard to pregnant women, with five states requiring the use of specific risk assessment forms for this population. This option is far more rarely used for the other two populations discussed here; only Florida imposes upon plans forms and protocols to be used in assessing children for developmental delay or other special health care needs, and only Illinois uses this approach in assessing children's mental health. Examples of states' risk assessment requirements for pregnant women and children with special health care needs are presented below.

1. Pregnant Women

Many of the states that require plans to assess pregnant women's risk for poor pregnancy outcomes also specify the tools that plans must use to conduct these assessments. Five states—Arizona, Delaware, Florida, Minnesota, and Ohio—fall into this category; the State of Minnesota's process is highlighted below.

Minnesota

Managed care plans with contracts to serve Medicaid enrollees must use one of two standard forms for prenatal assessments. The contract between the Minnesota Medicaid agency and capitated plans originally stated that providers must use the Minnesota Medical Assistance Prenatal Risk Assessment Form for all pregnant enrollees; however, plans collaborated with the Minnesota Department of Human Services to create an alternative form called the Minnesota Unified High Risk Assessment Form. Plans must now use one of these two forms.

The state form must be completed twice, once during the first obstetrical visit and once at 28 weeks, and is divided into two parts. The first part contains general demographic and behavioral risk factors such as maternal age, education, height, social situation, employment, and drug and alcohol use during pregnancy. The second part contains

biological risk factors related to a woman's current pregnancy, such as cervical length, uterine irritability before 34 weeks, weight gain of greater than seven pounds at 22 weeks, weight loss of more than five pounds and presence of protein in urine. Each risk factor is assigned a value from 0 to 10. For example, a pregnant woman who is less than 15 years old would receive a score of 4 on the "maternal age" risk factor, while a woman between the ages of 20 and 40 would not receive any points for maternal age. A woman who receives a total score of ten or greater is considered to be at risk for preterm delivery.

The Minnesota Unified High Risk Assessment Form is also divided into two components, which are grouped and scored differently than those on the state form. The first component is entitled "Major Risk Factors" and includes factors such as history of preterm labor, DES exposure, multiple second trimester abortions, alcohol abuse, multiple gestation, and illicit drug use. The next component on the form includes "minor risk factors" such as a single second-trimester abortion, daily cigarette smoking, bleeding after the 12th week of pregnancy, or febrile illness during the current pregnancy. If a woman demonstrates at least one of the major risk factors or at least two of the minor risk factors, she is considered to be at risk for preterm labor.

Regardless of the form used, providers are required to inform women of the risk assessment results, educate all high-risk patients about preterm labor, and work with them to change their risky behaviors. The base capitation rate paid by Medicaid to plans covers both the risk assessments and any plan of care developed as a result of the evaluations.

2. Children with Special Health Care Needs

Florida is the only state studied that specifies a risk assessment form to be used by plans to identify children with special health care needs, as follows.

Florida

All providers, including managed care plans under contract with the Florida Medicaid program, are responsible for performing a postnatal assessment based on the Florida

Certificate of Live Birth in order to determine eligibility for Healthy Start Care Coordination.

Ten items on the birth certificate are used to determine program eligibility: mother's age, race, education, and marital status; month of pregnancy in which prenatal care began; use of tobacco or alcohol during pregnancy; infant's birthweight; maternal tobacco or alcohol use during pregnancy; and any congenital or other anomalies experienced by a newborn such as cleft lip/palate or a birth injury. Each infant receives a total score based on the ten relevant birth certificate fields. The fields are weighted differently; for example, a score of one is assigned to an infant whose mother is not married, and a score of four is assigned to an infant with low birth weight. A total score of four or more qualifies an infant for the Healthy Start program. In addition, providers can, based on their professional judgment, refer enrollees with scores of less than four to the program.

Providers are required to contact the County Public Health Unit (CPHU) within one week of completing the assessment. The CPHU then assigns a case manager to the infant who offers services meant to complement those delivered by the Medicaid provider. While the screenings themselves are covered through the Medicaid capitated payments, the case management services offered through Healthy Start are financed separately through Title V funding.

D. Option 4: Require that Certain Assessments be Performed by Outside Agency

Under this option, a state would require that managed care plans refer certain clients to an outside agency for risk assessment. This approach is used most frequently among the study states in assessing children for special health care needs or mental illness; Rhode Island is the only state that requires that risk assessments for pregnant women be conducted by a state agency.

1. Children with Special Health Care Needs

Most of the states that require children to be screened for developmental delay or other special health care needs also require that these screenings be conducted by a state or local public health agency, often the state's Title V or Part H agency. Four states—Arizona, Massachusetts, Missouri, and Rhode Island—use this approach. Rhode Island's risk assessment methodology is described as follows.

Rhode Island

The Rhode Island Department of Health essentially provides the same screenings that it developed prior to the state's waiver application, but now offers Medicaid a small role in the development of the plan of care. All Rhode Island newborns receive a Level 1 screening, conducted by a public health nurse in the hospital after delivery, that considers the following risk factors to identify children in need of early intervention services: low gestational age or birth weight; intensive care hospitalization for more than 48 hours; developmental disabilities; parental education of less than 11th grade; mother's age of less than 19 or greater than 37; single caregiver; less than six prenatal care visits before 36 weeks or no prenatal care visits before five months; and parental mental, physical or developmental disabilities. Responses to the questions are weighted, with the highest scores assigned to infants with developmental disabilities, birth weight of less than 1500 grams, and intensive care hospitalization for more than 48 hours. The presence of any one of these factors, or two of any other factors, indicate that a child requires a home visit within two weeks of the Level 1 screening.

During the home visit, a home assessment is conducted to examine five areas of family functioning: home environment, family risk factors, parent-child attachment, family resources, and family concern and priorities. More detailed assessments may also be completed by public health nurses if deemed necessary, including the CDC Lead Questionnaire, the Safe Home Report, the HOME Inventory, Community Life Skills Scale, a smoking assessment, a substance abuse assessment, a violence abuse assessment, the Mullen Scale of Early Learning/Developmental Profile, the Family Resources Scale, and the Family Support Scale.

A plan of care is also developed during the home visit. For children with signs of developmental disabilities, the plan of care includes a Level 2 screening which is also performed by a public health nurse. If the child is determined through the screening to be developmentally disabled, public health nurses and specialty physicians develop a plan of care through the state's Part H program. In theory, primary care Medicaid providers must agree to participate with any plan of care developed through these screenings. Due to the large role of the public health department in this risk assessment process, the Part H program is responsible for financing the Level 1 and Level 2 screenings.

2. Mental Health

Three states, Arizona, Hawaii and Tennessee, assign responsibility for screening children for mental health problems to a state agency. Tennessee uses this approach to identify seriously emotionally disturbed (SED) children, as described below.

Tennessee

In Tennessee, a risk assessment form for identifying SED children was developed and is used by the Tennessee Department of Mental Health and Mental Retardation (MHMR) for all children they serve. Children may be referred to MHMR from a variety of sources, including TennCare managed care plans, schools, and parents. Using the risk assessment form, providers are required to list children's diagnoses and to confirm whether or not their patients have the ability to achieve or maintain one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. For children identified as non-SED, the form asks questions to determine patients' *risk* of SED. Poverty, family dysfunction, traumatic events and physical or sexual abuse are all considered factors that could place a child at risk for SED.

During assessments, providers must check off whether or not children fit the definition of SED given on the form, and whether or not they have a DSM-III-R diagnosis other than substance abuse or developmental delay. If a provider checks "yes" to both of these criteria, the child is considered to be SED. MHMR must then contact TennCare, which

pays a supplemental premium to the plan in which the child is enrolled. Plans are responsible for developing plans of care for all children with SED and for providing all mental health services needed by these children.

IV. Conclusion

States implementing Medicaid managed care programs can choose from a range of policy options in designing risk assessment systems for pregnant women, children, and children with special health care needs. These options range from those in which states assume a "hands off" role and managed care plans are given free rein to establish their own risk assessment protocols, to those in which states carefully prescribe how plans are to conduct assessments of selected populations. Based on HSR's analysis of 13 state Medicaid 1115 waiver programs, states are playing a more aggressive role in shaping managed care plans' systems for identifying high-risk pregnant women than they are for either children with special health care needs or children at risk of mental illness. Specifically, it was found that:

- For pregnant women, ten of 13 states place some requirement on managed care plans to assess for risk of poor outcomes, and five of these actually impose uniform forms and protocols upon plans participating in the waivers;
- For children with special health care needs, six of 13 states require some level of assessment, and four of these actually require that plans refer children needing detailed assessments out to an outside agency, usually a state or local health department; and
- For children at risk of mental illness, six of 13 states place any requirements upon managed care entities regarding the performance of risk assessments, with three of these requiring that these assessments be performed by outside agencies.

Resources did not permit HSR to examine in detail the reasons why states adopted various policy strategies. Preliminary observations, however, seem to indicate that states with more experience working with managed care systems (e.g., Arizona, Massachusetts, Minnesota, and Rhode Island) have tended to adopt more aggressive policies regarding how risk

assessments are conducted for managed care enrollees. Perhaps their prior experiences with managed care systems have taught these states that it is advisable to impose certain requirements on plans to help ensure that the needs of high-risk populations are adequately met.

At this time, South Carolina MCH and Medicaid officials are working to restructure systems of care in anticipation of managed care. And while the future of the Palmetto Health Initiative is uncertain,[2] the state is moving ahead with plans for facilitating voluntary enrollment in managed care among current Medicaid recipients. Therefore, officials will continue to address a broad range of design issues in working to integrate public and private systems of care.

In designing risk assessment systems for high-risk populations under managed care, it will be important for South Carolina to build upon the strengths of its current system. Clearly, one of these strengths is the state's well-established public health infrastructure; nearly 150 local health departments have a long history of effectively providing risk-appropriate care to low-income and high-risk pregnant women and children with special health care needs. Given this, and the fact that South Carolina has had little experience with managed care in the past, it seems appropriate for MCH and Medicaid officials to consider adopting either Option #3 or Option #4 as presented in this paper. For example:

- Under Option #3, South Carolina could require managed care plans to conduct risk assessments following state-established protocols for the High Risk Channeling Project (for pregnant women) and the Children with Special Health Care Needs and Part H/Early Intervention Program (for children). Under this option, plans would also have the flexibility to contract with local health departments to perform of these assessments.

- Under Option #4, the state could require that plans refer all pregnant women and those children suspected to be "at risk" to local health departments for appropriate risk assessments.

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[2] In April 1995, the South Carolina Legislative Oversight Task Force, made up of key members of the state legislature's health and budget committees and representatives of the state medical and hospital associations, voted to withdraw the state's 1115 waiver request. Numerous factors, including changes in gubernatorial leadership as well as the statewide managed care environment, led to this decision.

Under either scenario, South Carolina's evolving health care system could retain and build on the expertise that has been gained in the public health sector. At the same time, state officials could feel secure in knowing that they would be helping the state's fledgling managed care sector to deliver risk-appropriate care to vulnerable mothers and children.

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