Child Welfare Privatization Initiatives—
Assessing Their Implications for the Child Welfare Field and for Federal Child Welfare Programs

Topical Paper #2

Program and Fiscal Design Elements of Child Welfare Privatization Initiatives

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I. Introduction

In 2006, the Office of the Assistant Secretary for Planning and Evaluation, of the U.S. Department of Health and Human Services (ASPE, DHHS), funded the ***Child Welfare Privatization Initiatives Project*** to provide information to state and local child welfare administrators who are considering or implementing privatization reforms. The project will produce six technical assistance papers on a range of topics about planning for and implementing privatization initiatives in child welfare systems.

Although widely used, the term "privatization" has no single definition in child welfare or in other human services. In child welfare, some use the term broadly to refer to all contracted service arrangements while others use it more narrowly. Further, some states and jurisdictions use other terms such as community based care in Florida. The term privatization took on new dimensions in child welfare during the mid-to late- 1990's when two states, Kansas and Florida, privatized most of their child welfare programs and a broader number of states began to outsource the case management function and introduce fiscal risks and rewards linked to performance. For some states, the percent of a state's overall budget that is allocated to contracted services may not dramatically increase with the launch of a privatization reform. For example, performance based contract reforms in Illinois and the District of Columbia do not significantly increase the proportion of services that are outsourced. However, contract expectations, roles and responsibilities of public and private agency workers, and contract payment arrangements, change in these sites.

Research indicates that while all states contract out for some form of direct child welfare services, until a decade ago public agencies retained virtually all case management decision making authority (McCullough, 2003). This is shifting in some states and jurisdictions. Two research efforts conducted in the last five years (Westat & Chapin Hall, 2002; Collins-Camargo, Ensign & Flaherty, in press) have identified a limited number of state and local initiatives where for certain contracts, primary case management authority has been shifted to private providers.

For the purpose of this paper series, "privatization" is defined as the contracting out of the case management function, with the result that contractors make the day-to-day decisions regarding the child and family's case. Typically, such decisions are subject to public agency and court review and approval, either at periodic intervals or at key points during the case. For our purposes, it is not the geographic size of the initiative that defines privatization, but the degree to which this essential case management function is transferred.

Underlying many discussions about privatization today is the matter of financial risk. Typically, the full cost of providing child welfare services is uncertain. It is also difficult to forecast the speed or rate that children will successfully move toward permanency. The payment structure in contracts affects how the financial risk associated with these uncertainties is distributed between the public agency and contractors. Under traditional cost-reimbursement or fee for service contracts, private providers are reimbursed for allowable service expenditures. In these arrangements, the public agency bears all of the risks and retains all of the responsibilities for managing its resources to meet state and federal requirements. When public agencies began to contract for case management services, an opportunity was created to stimulate innovation and improve results by aligning some payments to performance. These fiscal and purchasing changes reflect recognition of the power of financial incentives to change practice (McCullough & Schmitt, 2003; Wulczyn, 1998).

Ultimately, privatization (or public/private partnerships more generally) are about shared risk and shared responsibility for children's lives. Privatization requires ongoing work to effectively "partner" within a contracting relationship. Privatization offers an opportunity to innovate. It also requires that public and private agencies openly discuss what is known and not known about service delivery, service costs and the impact of services on children and families. Systems must work together to improve their knowledge in these areas because each has a complementary perspective. Ongoing and open communication is key, as is flexibility in contracting relationships to address new needs and challenges as they arise.

This paper, the second in this technical assistance series, is based on knowledge gained from field experience, the literature on child welfare privatization and on prior research conducted by the Quality Improvement Center on the Privatization of Child Welfare Services funded by the Children's Bureau, U.S. Department of Health and Human Services. It will describe variations and similarities in program and fiscal design elements of current privatization initiatives. As described in the first paper in this series, privatizing a service or a service system is complex and politically charged. System goals must be established, target populations selected, contract services and administrative systems designed, and contract payment methods tailored to the needs of the public agency and abilities of the private provider community. Each component must be aligned to meet agency goals. This paper presents a range of program and fiscal design elements for public agency administrators to consider, and highlights some lessons learned from state and private agency administrators that have privatized child welfare services.

The other five papers in this series focus on:

- *Assessing Site Readiness: Considerations about Transitioning to a Privatized Child Welfare System [Already released; available at http://aspe.hhs.gov/hsp/07/CWPI/].*
- *Evolving Roles of Public and Private Agencies in Child Welfare Privatization Initiatives*
- *Developing Effective Contracts for Child Welfare Services*
- *Contract Monitoring and Accountability in Child Welfare Privatization Initiatives*
- *Evaluating Child Welfare Privatization Initiatives*

It is important to note that information in this and the remaining papers about lessons learned from child welfare privatization initiatives is largely anecdotal. In fact, there has been very little rigorous research to confirm that one privatization model, contracting method, or management model outperforms another (McCullough, 2005; Lee, Allen and Metz, 2006). Moreover, there is very little research that rigorously compares publicly and privately delivered services systems on client-level child welfare outcomes. In short, the information contained in this technical assistance series should serve as a starting point for a site's own research and assessment about design considerations and fiscal models.

This paper begins with brief discussions about key program design elements, noting the inter-relationship of decisions about program goals, the scope of services, and expected benefits. The next section more fully describes contract payment models and mechanisms, highlighting challenges and promising strategies. What is stressed throughout this paper is the need to consider each program and fiscal design element in conjunction with others. Privatization is first and foremost a systemic reform, which has implications for, and requirements of, multiple features of a social service system.

II. Program Design Considerations

This section summarizes program design elements including: establishing program goals, selecting services and a target population, determining size and scope, accessing needed services, defining case management elements, designing oversight and accountability systems, and weighing the merits of different contracting structures.

A. Establishing System Goals

In a 1998 study, the Government Accountability Office (GAO) found that privatization in human services has generally been prompted by political leaders and top program managers responding to an increased demand for improved performance of government services and a belief that contractors can provide higher quality services more cost effectively (GAO, 1998). Two national surveys of child welfare privatization initiatives found that despite differences across models, most initiatives have been implemented to achieve three broad objectives: (1) better outcomes for children and families; (2) attainment of system performance goals, including but not limited to the expansion of services, increased flexibility, more local community control, and cost effectiveness; and, (3) the alignment of fiscal and programmatic goals through the introduction of fiscal risk and/or performance-based payment mechanisms (McCullough & Schmitt, 1999; McCullough & Schmitt, 2003).

All design elements (including program model, target population, payment method and oversight mechanism) should be selected and aligned to meet system goals. Once in place, public agency administrators must be prepared to re-visit these decisions as system priorities shift, privatization initiatives mature, and as information becomes available about what works and what does not work in their contracting methods.

In order to help ensure that the contracts are designed to address system needs and that there is sufficient financial, political and community support, administrators who have gone through this process advise building in mechanisms for broad-based stakeholder involvement in the initial design phase, in the ongoing evaluation of performance, and in the revision of approaches as needs change.

B. Selecting a Target Population, Services, and Program Scope

While all states continue to have public agency staff investigate allegations of child maltreatment, there is wide variation in the privatization of other child welfare services. Individual contracts often focus on a subset of the child welfare population; however, many states have multiple privatization contracts, each targeting a different population or set of services.

The Community Alliance in Florida *is an example of a promising strategy for ensuring that a statewide privatization effort remains responsive to the needs and priorities of local communities. Reinforcing the concept of community ownership, in 2000, the Florida Legislature added Community Alliances as a mandatory component of community-based care (the state's privatization initiative) for each county or grouping of counties in order to prepare for the transition of services to the private community-based agency.*

The Alliances are composed of mandated partners including representatives of local public agencies, law enforcement, local funding agencies (Children's Service Boards), the courts, and other locally appointed community stakeholders such as foster and adoptive parents, CASA volunteers, and other child and family advocates. They are charged by statute with a range of responsibilities that include joint planning for resource utilization in the community; needs assessment and establishment of community priorities for service delivery; determining community outcome goals to supplement state-required outcomes; serving as a catalyst for community resource development (local community dollars are used as match for various federal funds); providing for community education and advocacy on issues related to delivery of services; and promoting prevention and early intervention services.

(Florida Statute §20.19(6)(b)).

Therefore, the scope and fiscal approach may vary across contracts within the same state and within a particular contract over time.

Selection of a service and a target population will depend on a site's overarching goals. As illustrated in the following examples, states often have explicit assumptions about how the contracts will address fiscal or programmatic challenges associated with specific target populations (McCullough, 2005):

- *Children with complex clinical needs who are placed in therapeutic or residential care.* Many of the early privatization models focused on the small percent of cases that consumed a disproportionate share of resources. The goals of these initiatives are to step children down to less intensive levels of care or services and/or to achieve more timely permanency. Generally, money saved by preventing or shortening high-cost placements is not used to reduce child welfare spending; instead, it is used to enhance services, serve more children, or improve the system's capacity in another way.

- *Children and families without findings of abuse or neglect or with low risk levels.* In some states, the privatization initiative is intended to enhance the "front-end" of the system in order to safely divert children and their families (before, during or following a protective service investigation). In 2005, Iowa launched such a community diversion initiative for children and families in need of services but without findings of abuse or neglect. The public agency hoped that diverting low risk families would result in improved services for children and families, reducing the likelihood of subsequent and more serious allegations of abuse or neglect, while also lowering caseloads for public agency workers who retained case management for all other cases.

- *Children who could be diverted from foster care.* In Milwaukee County, Wisconsin, the county is divided into five service regions, with a contract in each region for a lead agency (called a "partner"). State workers do intake and investigative reports of child abuse and neglect, while contractors provide case management and develop and maintain networks of providers to deliver safety services to children at-risk of placement (similar to family preservation services) and case management for children who are placed in out-of-home care. Contractors also track services used, authorize and arrange for payment for services (Westat & Chapin Hall, 2002).

- *Children in traditional foster care*. Many states focused privatization efforts on the large number of children in traditional foster care who experience instability in their placements, fail to achieve permanency in a timely manner, and/or re-enter care. The performance-based foster care contracts in Illinois address these concerns, and focus on the entire foster care caseload (excluding children in residential treatment centers and specialized foster care).[1] The initiative uses performance based contracts to promote improved outcomes.

- *Children in need of adoption services*: Many states have successfully privatized case management and services for children with adoption as a permanency goal—with variation in the time the transfer of case management occurs (pre- or post termination of parental rights) and in the financing mechanism. Michigan was one of the earliest states to structure its payments to private agencies to reward timely achievement of finalized adoptions.

[1] Under the federally funded Quality Improvement Center on the Privatization of Child Welfare Services project, Illinois is currently working to design performance based contracts for its residential care, independent living and transitional living programs. At the time this paper went to press, public and private agency representatives had agreed on the performance measures to be used in the new contracts. This process, and the resulting outcome measures, will be discussed more fully in the fifth paper of this series: *Contract Monitoring and Accountability in Child Welfare Privatization Initiatives.*

- *Children who are served by multiple systems*: These initiatives, often known as systems of care, emphasize collaboration across systems. They involve efforts to blend funding streams in order to support coordinated case management services delivered by private providers. The Missouri Interdepartmental Initiative is an example of this approach. In that model, a private agency was given total case management responsibility for a limited number of children referred by several public agencies in the St. Louis region. The goal was to shorten the length of stay and reduce reliance on highly restrictive placement settings. The Dawn Project in Indiana and Wraparound Milwaukee are other well-known system of care models which rely upon private agencies to deliver case management and other services through blended funds.

- *Full child welfare caseload:* Two states (Kansas and Florida) chose to privatize all child welfare programs and services to achieve system improvements and better outcomes for children and families. By cutting across traditional programs, these states hope to achieve wide scale improvements in safety, permanency, and well-being outcomes.

Selecting a target population requires an assessment of the potential benefits of privatization within the context of: (a) current performance in attaining safety, permanency, and well-being outcomes for different subsets of children served under the traditional system; (b) the interests and capacities of current providers; (c) the degree of support or opposition expressed by internal and external stakeholders to a particular population or program area being privatized; and (d) funding sources that can be tapped to achieve fiscal and programmatic goals. In order to improve performance, it may be necessary to seek new funding, blend existing funding, or work to expand the flexibility of funding streams (more on this in Section III).

Selecting the size and scope of the initiative is another important decision. As discussed above, only two states, Florida and Kansas have chosen to privatize nearly all child welfare services. Other initiatives are statewide, but confined to a predefined number of children or to a particular type of service. Most privatization initiatives are limited to a particular region of a state and to a subgroup of the child welfare population.

Some initiatives are small pilots that stay small, while other pilots eventually expand. Scale is an issue in both directions. When the scale is large, such as in broad-based statewide initiatives, quality control is a challenge, especially during transition. For this reason, some observers advise a gradual roll-out of services. For instance, the Florida transition to community based care took over five years for full implementation (McCullough& Schmitt, 2003).

On the other hand, small scale initiatives present challenges with regard to financial risk. If planners are considering introducing financial risk into contracts, the size, case mix and scope of services matters. By including a broad and heterogeneous group of persons and broad array of services, the risk of the most severe and costly cases can be spread over a large number of less costly cases. The more risk the contractor bears, the more important it becomes to ensure an adequate caseload size.

It is important for planners to use accurate data to weigh various target population and service options, including data that captures demographic characteristics, service utilization patterns, expenditures, and outcomes for the proposed population. This information is essential in defining the scope of services and establishing the funding needed to develop contracts and to assess the merits and risks of different fiscal models (e.g., case rates or performance based payments).

C. Accessing Needed Services

Flexibility in service provision and service capacity are key elements to help initiatives meet program goals. In traditional fee for service contracts, states authorized providers to use or purchase a specific service or a bundle of services. Providers were required to seek permission to use (or purchase) services not explicitly mentioned in the contract before providing them. These arrangements greatly restricted the flexibility of contractors in serving their clients. Many of the privatization initiatives undertaken over the past decade have sought to ease these restrictions and empower contractors to take more responsibility for their cases by providing or procuring services the private agency determines are necessary (Westat & Chapin Hall, 2002).

In 2001, the Child Welfare League of America conducted a national survey of child welfare contracting initiatives. An explicit goal reported by nearly half of the initiatives studied was to expand the current array of services available to children and their families. The public agency, through contract language, typically specified the required services and supports but they allowed the contractor flexibility in determining which services would be provided directly and which would be procured through subcontracts with network providers (McCullough & Schmitt, 2003).

In Florida, for example, from the time of referral, the community-based lead agency is responsible for ensuring that all children and their families have access to the level and type of services needed to meet case plan goals. To accomplish this, the lead agency creates a provider network that may include placement and non-placement services, as specified in its department-approved network development plan. Through a global budget, the lead agency pays for all child welfare services provided through the network. The lead agency is also responsible for accessing services that fall outside their child welfare budget through various interagency agreements (McCullough, 2003).

Flexibility in selecting services is essential, but is not sufficient to address capacity issues in all areas, particularly for services funded and managed outside the child welfare system. Despite the higher prevalence of poor physical health, mental health and substance abuse issues among children and families served by the child welfare system and the impact of those issues on the timely achievement of permanency, many child welfare contracts are funded primarily with child welfare funds. These contracts often lack provisions specifying how contractors can access health, dental, and behavioral health services that fall outside the contract. Research studies have documented that many private agencies struggle to gain access to community services, especially adequate and appropriate mental health services for children, even though their contracts mandate that service be provided, and often within strict timelines (Maurey, et al, 2003; James Bell Associates, 2001; Freundlich & Gerstenzang, 2003; McCarthy & McCullough, 2003). It is incumbent upon public agencies to have agreements in place to ensure that private agencies can navigate multiple public agencies or public managed care systems.

D. Defining Case Management Requirements

Case management, care coordination activities, and the decisions made as part of the case planning process directly impact a contractor's ability to manage its financial risks and achieve programmatic goals. Across the country, there is great variability in how the case management function is handled in contracted services. In some initiatives, private agencies have assumed some or all of the core case management functions with periodic review by public agency staff and courts from the time of referral until the achievement of permanency or some other specified time. In other initiatives, the public and private agencies share some case

management responsibilities, particularly related to establishing permanency goals and managing court-related duties, but the private agencies have primary decision-making authority over other decisions such as determining appropriate services and placements. Several states have created dual case management systems with overlapping public-private responsibilities in virtually all decision making areas.

While dual approaches are costly and duplicative, many states choose this approach, at least initially, in lieu of a total transfer of case management to the private contractor. In some instances the maintenance of a dual case management model is necessary under existing labor agreements (McCullough, 2005). Additionally, some states and jurisdictions continue to use a dual case management system to satisfy what the state believes is necessary to meet its oversight obligations under federal funding rules for children in out-of-home care.

The next paper in this technical assistance series, *Evolving Roles of Public and Private Agencies,* will focus on how states have transitioned to a privatized system and, once privatized, how the roles and responsibilities of public and private agency workers are divided.

E. Designing Oversight and Accountability Systems

Contract monitoring assesses compliance with statutes, regulations and the specific terms of the contract agreement. Today, with the new emphasis on performance contracting, there is an expanded interest in moving beyond compliance with process or practice standards to also monitor major outcomes for children and families. What is emphasized here is that as contracts need to be designed to promote system goals, oversight and accountability systems must be designed to monitor these performance goals and standards.

Researchers note that state monitoring systems (and quality assurance systems more broadly) are growing more sophisticated (O'Brien, 2002). However, many states continue to struggle to strike the right balance in providing sufficient oversight to ensure compliance with regulations and performance on select outcomes without overburdening providers and taking resources away from direct service to clients. In statewide efforts, the approach is often uneven from one locale to another. For instance, until Florida developed a standardized approach to quality assurance and contract monitoring, it was not uncommon for different lead agencies to have vastly different outcome requirements and experiences with public agency oversight (McCullough, 2005; GAO, 1997; Freundlich & Gerstenzang, 2003).[2]

Another way to ensure program quality is to write contracts with detailed specifications related to agency operations. For instance, some states require private agencies to follow established day-to-day operating procedures and adhere to rules that govern the conduct of public agency staff in order to ensure that the introduction of financial risk-sharing or performance-based payments do not jeopardize service quality or access to care. However, requiring rigid adherence to doing business as it has always been done may inadvertently stifle innovation. Many providers maintain that merely transitioning activities and procedures from a public agency to a private agency will not result in improved outcomes or efficiencies (McCullough, 2005) and that the flexibility to innovate is essential to success.

A broader discussion of how states and communities are monitoring their privatization initiatives and how federal policies and rules impact this work will be included in Issue Paper 5 in this series: *Contract Monitoring and Accountability in Child Welfare Privatization Initiatives.*

[2] In recent months, Florida has also begun to pilot a new type of contract in two of its 22 community-based care sites (Miami and Ft Lauderdale). This pilot program, among other things, transfers the current department oversight responsibilities to an independent non-governmental third-party entity which will monitor programmatic, fiscal, and administrative performance (Florida Department of Children and Families, 2006).

F. Clarifying Outcomes and Defining "Success"

Key to oversight activities are decisions about which outcome measures and performance indicators should be monitored. Decisions about performance measures must be based on a realistic assessment of what can be achieved given the target population, the scope of the services and contract, and the funding available. Some states and communities negotiate these measures with the provider community.

According to the 2001 CWLA contracting survey of public administrators, most respondents (87%) indicated that their requests for proposals and resulting contracts specified some performance standards and client outcomes, including indicators of improved client functioning. States were most likely to include outcomes and indicators related to child safety, recidivism/reentry, and achievement of permanency in the timeframes required by the Adoption and Safe Families Act (ASFA). There was, however, great variability in the number of outcomes included in contracts, how outcomes were defined and measured, and how fiscal incentives/disincentives (if any) were linked to specific performance indicators or outcomes (McCullough & Schmitt, 2003).

In addition to child and family outcomes, many states also include a variety of requirements to ensure overall program quality. Illinois, Missouri, Kansas, and Florida require that contractors meet national accreditation standards. Florida also requires its lead agencies to pass a readiness assessment process before the state transitions cases. Florida, Kansas, and the District of Columbia all require contractors to measure and report on client and other stakeholder satisfaction with services.

G. Weighing the Merits of Different Contracting Models

When developing or re-structuring contracting models, an important consideration is how the public agency wants the program designed and administered. For instance, the government might contract with a single lead agency or with multiple providers. This decision has implications for several features of contract oversight.

From the mid-1990s until the early 2000s, the majority of initiatives described themselves as using a lead agency model. Under this type of arrangement, the public agency contracts with one or a limited number of agencies within a designated region to provide or purchase all specified services for the target population from the time of referral to case closure or at some other point specified in the contract. One goal of some lead agency contracts is to ensure a single point of accountability for the operation of the privatized services at the local level. Another explicit goal of many lead agency initiatives is to build greater service capacity and service coordination in order to tailor placements and services to identified needs of the children and families served (McCullough & Schmitt, 2003; McCullough, 2005).

There are variations in the lead agency model. Some lead agencies provide most, if not all, services with few or no subcontracts. Others may procure most services from other community-based agencies and directly provide case management and/or other limited services. Some contracts limit the services that the lead agency can deliver if it assumes case management, while others do not. A few lead agencies do not provide any direct services, focusing instead on the development and management of a provider network and the oversight of the overall operation of the system (McCullough, 2005).

Some lead agencies are single agencies that have long histories as child welfare service providers, while others are newly formed corporations that were created by multiple private agencies for the sole purpose of responding to the contract opportunity. A few lead

agencies were created through collaboration between nonprofit agencies and one or more for-profit organizations, but the overwhelming majority of lead agency contracts are held by nonprofit entities (McCullough & Schmitt, 2003). Florida and Kansas provide two examples of the diversity in the lead agency model.

- ***Lead Agency Contracts in Kansas:*** Kansas was the first state to implement statewide privatization of child welfare services. Between July 1996 and February 1997, Kansas issued three RFPs to select regionally based not-for-profit contractors to serve as the lead agencies for the provision of specific services — family preservation services, adoption services, and foster care and group home care services (McCullough & Schmitt, 1999, Kansas Action for Children, 2003).

  As a result of the contracting process, not-for-profit agencies undertook responsibility for service delivery (and the necessary day-to-day decision-making). The public agency continued to establish and manage policies concerning the type and quality of services to be provided. In most cases, the public agency retained legal custody of the children and continued its role of advising the court of disposition recommendations for children in foster care, including recommendations regarding children's return to the custody of their parents or their being freed for adoption (Freundlich & Gerstenzang, 2003).

- ***Community-Based Care (CBC) Agencies in Florida:*** Privatization was the legislative solution to address statewide, systemic problems in the public child welfare system in Florida. Rather than competitively procuring specific services, Florida used an Invitation to Negotiate process to select twenty lead agencies now operating across 22 geographically defined sites. These lead agencies differ in organizational and governance structures, as well as across specific child welfare practices such as case management, and levels of funding. All lead agencies are responsible for providing or procuring all services needed by a child and family from the time of referral until the child achieves permanency. Their approaches to meeting this objective are varied. Statewide, lead agencies have established 500 subcontracts. The vast majority of these are for placements and other direct services, and the remainder are for case management. Direct service subcontracts include but are not limited to: in-home services and supports, placement in all levels of out-of-home care, adoption and post-adoption services, independent living services, and substance abuse and mental health intervention[3] (OPPAGA, 2006).

A lead agency model is not the only structural design option used by privatization initiatives. Many states and jurisdictions contract with multiple providers and now use some form of performance based contracts for various child welfare services. The goal of the performance based contract is to purchase clearly defined results rather than services (McCullough, 2005). Establishing new requirements, standards, and payment methods makes for a more competitive environment, and can result in a system where only the best performing providers survive. A more complete description of performance based contracting and several examples are provided in Section III of this paper, on fiscal design considerations.

Today, aside from the decision about the number of providers with which to contract, it is very difficult to draw clear distinctions between structural models of privatization initiatives because many of the other distinguishing features are shared. For instance, some agencies currently operating under performance based contracts have had to procure services from other community agencies in order to meet contract requirements — functionally operating as a

[3] The number of subcontracts held by each lead agency ranges from 0 to 77. All but one of the 20 lead agencies subcontract for some services and all but five lead agencies subcontract for case management (OPPAGA, 2006).

lead agency. Additionally, many states and local jurisdictions that use lead agencies have clear performance expectations that are aligned with contract payments.

Each structural design has its advantages and disadvantages. In selecting a lead agency contracting model, a public agency is making a determination that fewer contracts are preferable to many. Issuing a few large lead agency contracts has several inherent advantages. First, it limits the cost of contract administration and monitoring. Second, there may be economies of scale in providing services — the costs of the infrastructure and management can be spread across a larger number of clients. Third, it allows for greater coordination and service integration — if there are many contracts divided by function, rather than region, clients may "fall between the cracks." Finally, variability in performance may be reduced with fewer contractors (McConnell, et al, 2003). But there are potential disadvantages to a lead agency model as well. The public agency is relying heavily on a single, or a small number, of contractors. This can create serious problems if the contractor fails to perform, and is often a source of concern at the time the model is first announced.

Issuing more numerous, smaller performance based contracts also has both advantages and disadvantages. On the positive side, it allows contractors to specialize by service or by population and tends to preserve smaller, community based providers. Another advantage is increased competition that may, in turn, lead to higher quality or less costly services. The greater the number of contracts, the more incumbent contractors there will be. This increases competition because the fiercest competition at contract renewal usually comes from other incumbent contractors. In addition, a wider range — and, as a result, a greater number — of organizations can compete for smaller contracts (McConnell, et al, 2003). On the other hand, with numerous contracts, public agencies will incur added administrative costs, and face additional challenges effectively monitoring the contracts. Using multiple providers also increases the likelihood of variability in performance across providers.

When considering how to structure (or re-structure) a contracting initiative, it is also important to keep in mind that lead agency and non-lead agency contracts face a common set of implementation challenges. These include issues related to: role clarity; service capacity; the alignment of resources with expectations; payment issues; inadequate practice and business expertise; duplicative or inadequate data collection capacity; and, staff capacity. Similarly, innovative practices and improved results have been noted in both lead agency models and in other performance based contracting structures. Success appears to relate to the cohesiveness and alignment of the various design and payment decisions and the contractor’s capacity and flexibility to introduce or enhance business and casework practices that promote improved performance.

III. Fiscal Design Considerations

Similarly to designing the program model, there are several fiscal design features that must be considered when planning a privatization initiative. These include: pricing the overall system, selecting a payment model and payment schedule, establishing payment rates for contractors, determining when to introduce financial risk into contracts, and deciding when and how decisions will be made to adjust payment rates, when needed. Research has found that these fiscal design features may vary within the same contract over time and between different types of contracts within the same state.

As previously described, an explicit goal for many privatization initiatives is to improve the effectiveness and efficiency of services, with an implicit goal of containing or re-directing

overall costs. For many today, a key strategy for attaining these objectives is to replace per diem and fee for service arrangements with the introduction of risk or performance based payments that better align fiscal incentives with desired program outcomes (Kahn & Kamerman, 1999; GAO, 2000; McCullough, 2003).

This section presents several fiscal design considerations including the timing of payments and when and how new contracting arrangements introduce financial risk. Within child welfare contracts, financial risk can be driven by: (1) the characteristics of the target population of children who will potentially use services (i.e., the case mix), (2) the rate of referral and size of the population; (3) the intensity/duration/level of services per case (the number and type of service units per unit of time); (4) the performance expectations and level of control over decisions that affect performance and reimbursement; and, (5) the cost per unit of service. Risk-sharing is a function of determining who is responsible for each type of risk (McCullough, 2005).

A. Fiscal Designs

1. Global Budget Transfers

The legislatively mandated payment arrangement for Florida's community based care (CBC) system is an example of a global budget transfer. Each lead agency is given a predetermined percentage of the state's annual operating budget for child welfare services and the community-based care agencies are required to provide all services, in whatever amount needed, regardless of how many children and families in their geographic area may require services. The allocation is based, in part, on historic caseload size and previous spending for the geographic area covered, and, in part, on assumptions about how the new privatized systems will affect future utilization patterns and outcomes. The payment system is cost reimbursement within the parameters of the budget transfer allocated for the site, and the CBC agency's approved cost allocation plan (McCullough & Schmitt, 2003).

In this example, the contractor bears the risk for serving all referrals and providing ongoing care within the allocated budget amount. The contractor has an opportunity for gain if it can undertake activities that reduce the caseload, reduce the length of stay over historical averages on which the premium is based, or reduce the intensity or price of services. In short, under a fixed global budget, if there is no risk-mitigating provision (described later), the contractor holds all the risk. In return, the CBC agencies are given control over all key decisions (within limits of the statutes and regulations). Florida is the only state that uses a global budget transfer for its child welfare initiative. However, some states have used global budgets for various Medicaid managed care reforms.

2. Case Rates

Since the first privatization initiatives emerged, the case rate has been the most common payment arrangement for child welfare contractors. The private agency is paid a predetermined amount for each child referred. This reduces the contractor's risk with respect to absorbing increases in referrals. However, the contractor remains at risk for the amount or level of services used and the costs of those services. A provider operating under this type of reimbursement with a sufficient volume of cases and the authority to make decisions that affect risk (e.g., type and duration of placements and services) has an incentive to find the lowest cost service that will achieve the desired outcomes. The contractor's opportunity for gain is proportional to the degree to which the cost per case can be reduced relative to the rate being paid. Thus, gains can be achieved by reducing or changing the intensity and mix of services (Broskowski, 2006).

There are variations in how case rates are calculated and structured. In child welfare contracts, the case rate can be episodic or annual. In both episodic and annual case rate, states have used either case-level or aggregate expenditure data to calculate the amount of the per child case rate. In some initiatives the public agency includes an estimated range and the private agency proposes a rate which is finalized through negotiations. In other initiatives, the public agency specifies the case rate in procurement documents.

To develop an episode of care case rate the public agency estimates the cost of the proposed services for children in the target population from the time the case is referred to the private agency until the contractually defined episode ends, which might be when a child achieves permanency and the dependency is dismissed or, it might be some point after case closure to ensure the stability of the permanency solution. The payments continue until the episode ends, regardless of how long the child is actually served.

A contractor operating under an episode of care case rate must use this rate to pay for all services from the time the child is referred until the episode ends. The point at which the episode ends (and therefore the financial risk ends) varies from one initiative to another. It is common for contractors to bear some risk until specified goals are achieved, whether it takes days, weeks, or years. For example, a typical case rate contract for foster care services might extend financial risks for up to 12 months after a child leaves the foster care system. Dollars not spent on one child may be retained and used to pay the costs for other children when costs exceed the case rate. If a child reenters care during that time, the contractor may be responsible for a portion (or all) of the cost of placement and/or case management services.

*A case rate foster care pilot in **Cuyahoga County, Ohio** illustrates how episode of care case rates are typically structured.*

In 2001, the county launched a lead agency pilot using an episode of care case rate for children, birth to age 14, who were in specialized foster care or in higher levels of care. Only children who have behavioral or health care needs and their siblings are included in the pilot. The case rate amount was established through a request for proposals (RFP) process. The case rate covers the period of custody to permanency, plus 9 months (12 months for children who are adopted) and assumes that at least 50% of children achieve permanency within 12 months. The payment schedule for contractors calls for 18 equal monthly payments for each child/family. The payments are made whether the child remains in care the entire 18 months or longer or achieves permanency sooner. If the child achieves permanency and remains stable for nine months, the financial obligation of the contractor ends. If the child reenters care within nine months of permanency, the contractor must take responsibility for the child's care and services within the original case rate (McCullough & Schmitt, 2003).

On the other hand, an annual case rate requires an estimate of costs of the proposed services for children in the target population from the beginning to the end of a year. The provider gets a payment only when a child is receiving services. Under an annual case rate, the provider receives the case rate amount for as long as the child receives services. Just as in episode rate contracts, an annual rate contract might also hold contractors responsible for sustaining permanency for some period of time after reunification (McCullough, 2003).

There are also variations in how payments are made. In both annual and episodic case rate arrangements, the payment schedule might be a monthly per child amount or it may be divided into lump sum payments that could be linked to attainment of various outcomes. With an annual rate, the payment is made for each day a child receives services, (i.e., the monthly payment equals the unit rate (1/365th of the case rate) multiplied by the number of children by the number of days served). Under an episode of care rate, the monthly payments are spread across a specified number of months—often based upon the average or median number of months that children in the target population are in the system. If the contractor succeeds in

moving children into permanency or achieving other specified goals in less time, the monthly rate continues for all of the remaining months and the contractor can retain some or all savings to support the costs of care for children who remain in care for months (or years) beyond the time the episode of care payments have stopped.

An episode of care case rate is attractive to public agencies because the contractor bears the fiscal risk for children remaining in care for prolonged periods. It is attractive to contractors because savings from one case can be used to offset costs of another. However, it is far riskier for the contractor than an annual case rate due to the many factors outside of the contractor's control that may extend the time it takes for the episode to end. It is also far more difficult for states to accurately estimate episode of care rates because many administrative data systems do not have the capacity to track expenditures for individual children across fiscal years (or programs) until they exit to permanency.

*The **Kansas family preservation contracts** illustrate how lump sum payments can be combined with case rate payments.*

Case rates for family preservation in Kansas (in the 2000 contracts) varied by region and ranged from $3,412 to $4,481. One-third of the case rate was paid at the time of referral, and the lead agency was allowed to retain this sum even if the family did not use the services. The remainder of the case rate was paid in two installments, at 45 and 60 days after referral, and was paid in full if the family signed the case plan, regardless of whether they completed the plan (James Bell Associates, 2001).

Increasingly, it is as difficult to draw distinct lines between fiscal design models as it is to draw distinct lines between structural designs, discussed previously. For example, some states divide their annual or episodic case rates into lump sum payments that are paid at specific events. In some contracts, the first lump sum payment is made when the child is referred to the contractor, providing flexibility and resources at a time when interventions might be most effective. Additional payments are made only when particular milestones are achieved – a form of performance based contracting. In this example, payment levels are *calculated* using case rates but *payment schedules* use principles of performance based contracting.

Case rates may be "blended" (a rate set at the average cost per case blended over all cases) or "stratified" (the rate varies by the type of case). Stratified rates protect the contractor from the risk of adverse selection, but they also add administrative complexity. One major disadvantage is the increased possibility of disputes, and grievances related to the proper assignment of a case to payment strata. If rates are tied to interpretive factors, e.g., severity ratings or level of functioning test scores, there is a high probability that disagreements will emerge regarding the assignment. When the strata are more objectively defined such as by age of child or whether the case is a new referral or a child returning to care, the potential for disputes is less (McCullough, 2005; Broskowski, 2006).

3. Performance Based Payment (PBC) Models

Public child welfare agencies are increasingly aligning payment amounts or schedules and/or bonuses or penalties to results. In these models, some (or all) of the payments will only occur if contractors are successful at meeting the contract's performance goals. The risk for the contractor is that success may depend at least partly on factors that may fall outside of their control, such as judicial actions and the availability of services. Performance based payments differ in the events that trigger payments, and in the assumptions underlying the fiscal model (Martin, 2003). Performance based payments can be used in contracts with single providers and with lead agencies (McCullough, 2005).

Following are examples of several PBC contracts used for different services. Each uses different payment methods.

***Michigan (Adoption Program)*:** In 1992, Michigan incentivized its adoption contracts by awarding agencies different payments based on the special needs of the children placed and the speed with which they made the placement (McCullough & Schmitt, 1999; McCullough & Schmitt, 2003). Children eligible for adoption and not placed within six months had to be registered on the Michigan Adoption Resource Exchange (MARE). In this way, children become available on a statewide basis for placement by any private adoption agency contracted by the state. Under the state's PBC model, providers were rewarded for achieving specific outcomes or were rewarded for unique recruitment efforts. Sample payment levels in 2002 were as follows:

- Residential rate (placing a child for adoption directly from residential care within 120 days): $10,000
- Five-month premium rate (paid to an agency that places a child in its care in an adoptive placement within five months of termination of parental rights (TPR)): $8,660
- Enhanced rate (paid to an agency that places a child in its care in adoption within seven months of TPR): $6,520

North Carolina: Martin (2003) describes another state that has linked payment schedules to milestones across its adoption contracts. Providers are paid percentages of an "average placement cost" at certain milestones:

- 60% of the average placement cost if a child is placed in an adoptive home,
- 20% when the decree of adoption is finalized, and
- 20% when the placement child has been in the home for 12 months. (Vinson, 1999).

The author points out that North Carolina is unique in that it bases all contract payments on achievement of specific outcomes. Other contracts link payment schedules to case milestones but also include an up-front payment not linked to performance.

***Michigan (Wayne County Foster Care Pilot)*:** The goal of Wayne County's Foster Care Permanency Initiative was to reduce the length of stay in foster care by increasing the numbers of children who achieved permanency within specified time frames. The planners created the funding structure to provide foster care providers with flexibility. The principal design was a reduced per diem rate and a reallocation of the resulting savings into three lump sum incentive payments tied to performance goals. There were few strings attached to the lump sum payments—allowing providers to purchase or provide whatever services or supports were needed to achieve the results. The daily rates and the incentive amounts changed multiple times, illustrating the difficulty in calculating and balancing daily payments with incentives. In 2003 the following rates were in place:

- Initial lump sum of $2,210 paid at the time of referral;
- A second payment of $1,900 was made when a child was reunited or placed with relative within 315 days of placement, or a court terminated parental rights within specified timeframes;

- A sustainment payment of $1,200 to $1,600 was awarded once the placement was sustained for a defined period—the lower amount was paid if post placement was stable at 6 months, the higher amount if it remained stable at 12 months; and
- The discounted per diem, a blended foster care rate, of $13.20 (Freundlich & Gerstenzang, 2003).

In 2004, the state ended the pilot initiative and returned to the former payment system. The state was facing system-wide budget constraints at the time and an evaluation of the initiative's first 300 days (Meezan & McBeath, 2003) found no measurable difference between placement rates for children in the pilot relative to children being served by the traditional contracts.[4]

Illinois has implemented another form of performance based contracting that links payments to provider caseloads. Illinois was the first state to take this approach. Since that time, other localities and states have adapted and replicated the Illinois model.

Illinois Performance Based Payments Based upon Caseloads: First piloted in Cook County (Chicago) in 1997, foster and kinship care agencies are required to accept a certain percentage of their caseload in new referrals, and move a certain percentage to permanency each year. Agencies are expected to manage their cases by balancing the cases flowing in with those flowing out. If the standards are not met, caseloads increase, but the level of payment remains steady. Agencies that move more than the contracted number of children (29 percent of their caseload) into permanent living arrangements do not experience a reduction in case management payments and they may receive a bonus above the standard payment. Agencies that fail to achieve the standards set under the contract risk having their new intakes placed on hold (McEwen, 2006).

Illinois' Performance Based Contracts and Other Systemic Reforms During the mid-1990s, Illinois reported that 17.1 out of every 1,000 children in the state were living in foster care, the highest rate in the nation. Foster care caseloads averaged 50 to 60 per social worker. By 1996, children in Illinois spent an average of 56 months in foster care, and by 1997, there were approximately 51,000 children in out-of-home care (McDonald, 2000).

The state converted its existing foster care contracts to reward performance and simultaneously implemented a number of other reforms (including securing three title IV-E waivers and becoming nationally accredited). All of these reforms were intended to reduce the number of children entering the system and to provide support for all permanency options. By 2005, Illinois' foster care caseload had fallen by 65 percent, to approximately 18,000 children. Blackstone, Buck & Hakim (2004) found that with the caseload reductions, the state retains better performing agencies and eliminates ineffective ones based on agency performance data.

Payments to providers are made in two parts: maintenance payments which are passed through to foster parents or relatives caring for children, and administrative payments. Administrative payments are designed to cover all costs of case management; services provided to the child, the child's family, and the foster family/relative caregiver; and administration costs.[5] Administrative payment rates are based on expected

[4] From personal communication with Mary Mehren, Director, Division of Children's Protective Services and Foster Care, Michigan Department of Human Services.

[5] Agencies also receive lump-sum payments for reunification/aftercare. Traditional (non-relative) foster care agencies receive additional resources for the recruitment and training of foster parents and the provision of emergency foster care.

caseload ratios of 22.5 cases per worker. Contract expectations differ slightly depending on whether the agency is in, or outside of Cook County and whether the foster care provider is a relative or a traditional foster parent (McEwen, 2006; Westat & Chapin Hall, 2002; McCullough & Schmitt, 2003).

Many other states are considering performance based contracts for some or all services. For instance, in Iowa, the *Better Results for Kids Initiative* calls for the state to move towards performance based contracts with all service providers. Iowa has entered into a performance based contract for safety services and a statewide performance based contract for foster/adoptive home recruitment, training, licensing, and ongoing support. In addition, the District of Columbia Child and Family Services Agency is required to implement performance based contracts to reinforce compliance with established court-ordered standards.[6] Community meetings have been held with stakeholders and procurement planning is underway.

4. Bonuses and Penalties

Finally, many states and jurisdictions are exploring the use of financial incentives and sanctions and applying them to both traditional fee for service contracts and case rates to achieve specific results. Some states and counties include only bonus payments, others include only penalties, and still others include both. Initiatives differ widely in the selection of performance measures and in the amount and balance of incentives and disincentives that are provided. Examples from Ohio and Missouri illustrate diverse approaches:

> ***Cuyahoga County, Ohio Pilot:*** The previously described lead agency contract in Cuyahoga County, Ohio includes penalties that are linked to permanency benchmarks and an adoption bonus in its lead agency contracts. Penalties are imposed if less than 80% of children ages 13 and 14 in high-end, restrictive placements achieve permanency within 36 months; and if less than 87% of children 12 and younger achieve permanency within 36 months. The lead agency is fined $3,600 for every child over the performance benchmark. On the other hand, the lead agency receives a bonus of $5,000 for a finalized adoption.
>
> ***Missouri's Interdepartmental Initiative*:** The state's original contract with the lead agency it calls the Care Management Organization (CMO) included both bonuses and penalties. If, after 120 days following disenrollment, the child was stable and had not experienced an out-of-home care placement, the CMO was eligible for a one-time incentive payment of one-half of the monthly case rate. If, on the other hand, the child required an unplanned out-of-home care placement within 120 days of disenrollment, the CMO was financially responsible for the costs of such care, not to exceed 2 months of case rate payments (McCullough & Schmitt, 2003).

B. Challenges in Designing & Implementing New Fiscal Models

The privatization of child welfare case management and other services under a performance or risk-sharing payment system offers the potential for improved results and overall system improvements, but it also creates the potential for unintended consequences if the fiscal model is not designed or implemented with care. The payment structure can affect both the public agency and the contractor in multiple areas. Researchers have noted a number of challenges that public agencies must address in designing and implementing new fiscal and payment models, including the following:

[6] The 2007 federal court ordered Amended Implementation Plan (AIP) in the District of Columbia defines the actions that must be taken by the Child and Family Services Agency to be in compliance the *LaShawn v. Williams* Modified Final Order resulting from a federal lawsuit that was initially filed in 1990 and a court receivership that ended in 2001.

1. Estimating Costs and Establishing Rates

States have had difficulty estimating the overall costs of a privatization reform and setting rates for providers. There are two basic approaches to developing cost estimates: (a) the actuarial approach, which uses historical data to predict what will happen in the future; and (b) the prospective approach, which includes simulation of future scenarios. The actuarial/historical model relies on retrospective analysis of such factors as patterns of service utilization and cost of units of service. There are two principal drawbacks to this approach. First, historical data are critically important and are generally of poor quality (Westat & Chapin Hall, 2002). Second, since the future service system is almost certain to differ from the one used in the past, the historic analysis may be of limited use in establishing a payment level that accurately reflects the actual level of risk for the contractor (Broskowski, 1997).

Because of these limitations to actuarial/historical modeling, planners sometimes use prospective simulation techniques to estimate risk and establish rates. Statistical modeling, or simulation, is a method of planning and forecasting that allows system designers to be explicit with regard to the probabilities of given values that can influence various outcomes. Using computer software, decision makers can enter any number of critical "input" variables, "output" variables, and formulas that define the relationships among and between inputs and outputs. The program will provide a model of possible outcomes and the probability that each will occur. By changing the size or content of a variable or formula, the decision-maker can simulate the probable effects of making such a change. Simulation software is also used to help states achieve equity in funding across geographic sites prior to implementing a contract reform and to help private agencies set their price and/or develop cost allocation plans.

Several states and jurisdictions have explored this methodology, including Texas,

Kansas reworks payment structure: In its first round of foster care contracts in 1997, Kansas paid lead foster care agencies an episode of care case rate (though it was often referred to as "capitation"). Some of the lead agencies experienced significant losses. The state determined that the contracts were too risky because many factors affecting permanency were beyond the control the contractors.

In 2000, when the contracts were re-bid, Kansas shifted to an annual case rate that reimbursed providers through a standardized per child/per month payment for as long as the child remained in the system. Contractors were no longer at risk for length of stay or the time it took to achieve permanency, because contractors received the monthly rate as long as a child received services. However, providers continued to be at risk for the costs of services across the caseload and were also at risk if children re-entered after achieving permanency. This arrangement reduced incentives for timely permanency and some argued that the monthly payments offered an incentive not to strive for permanency since the contractors were at risk only for children who re-entered the system

Payment structures were changed again in a 2005 recompetition. Under this third structure foster care agencies receive performance-based "tiered" payments with declining rates the longer the child remains in care. The tiered system is designed to reward a more rapid permanency by providing higher rates for the first twelve months of service. The average initial statewide monthly payment is $3,500. That rate is paid out on a monthly basis as follows:

- 100% per month is paid for the first 5 months (Tier 1);
- 66% of the rate is paid for months 6-12 (Tier 2); and
- 29% of the rate is paid for children in care 12 months and longer (Tier 3).

The payment does not include the costs of one year of aftercare or the cost for any child re-referred during the first 12 months after achieving permanency. Contractors must serve those children for no additional payment.

Florida, Washington, DC, and counties in Ohio and Colorado. For example, prior to the introduction of lead agency contracts, Florida acknowledged that there were structural issues in its methodology for allocating funds to districts. The methodology resulted in greater allocations to districts that had higher placement rates and longer lengths of stay. Before passing on those inequities to private agencies under global budget contracts, the State hired a risk modeling consultant to begin to change the allocation formula to apportion funding on the basis of criteria that would more equitably distribute funds and reward districts that achieved better performance related to permanency, safety and well-being (Broskowski, 1997; McCullough, 2003).

There are many benefits of modeling and simulation, not the least of which is that they provide the public agency with the capacity to turn an estimating model into a tracking and trending model that supports comparisons of the assumptions and predictions made when the system was planned and implemented, with the actual results shown in utilization and cost reports (Broskowski, 1997)

For a number of reasons, including those discussed above, payment arrangements often change when contracts are re-bid. For example in Kansas, both fiscal models and payment mechanisms have changed each time the foster care contract was re-bid. (See text box.) Some states, recognizing that their cost data were poor, have phased in risk (and/or actual financial penalties) to their contracts after some period of time. This “hold harmless” technique can benefit both public and private providers because risk based contracts are fully implemented *after* data on actual costs are collected and known. For many sites, this typically happens a year after the initial launch of a reform.

2. Developing Risk-Mitigating Mechanisms

Because of the newness of these payment methods and fiscal models, the challenges in calculating rates, and the likelihood that the contractor will be a nonprofit agency with limited capital reserves, many child welfare risk-based contracts also include mechanisms to ensure that contractors remain solvent and stable (McCullough & Schmitt, 2003). Risk mitigating mechanisms vary within a state for different contracts and even within an initiative over time. The following examples from different Ohio initiatives illustrate risk-mitigating strategies that are most common in child welfare contracts:

- Risk-Reward Corridor -The most common mechanism in child welfare initiatives is a risk-reward corridor, which defines the point at which a contractor' losses and profits will be absorbed by or shared with the public agency. For instance, in the Cuyahoga County, Ohio case rate pilot, one contractor accepted full risk, and two others have a 10% risk corridor/reward. There are limits on how potential retained savings (rewards) are used by all contractors. The contractors may request up to 30% of retained earnings be used for documented, department-approved start-up costs.[7] The remainder must be used based on a joint neighborhood planning process to benefit the community in which the pilot is located.
- Catastrophic Stop-Loss - Some contracts include aggregate or individual catastrophic stop-loss provisions that limit the contractor’s losses when expenditures exceed a certain amount for an individual child or for the entire covered population. In Franklin County, Ohio, for example, lead agency contracts in place in 2001 protected private

[7] In some newer contracts, providers are permitted to use savings to recoup out-of-pocket expenses they had for contract start-up costs. In Cuyahoga, the contractor was not paid for all start-up costs but was allowed to use the contracts reward system to recoup 30% of their out of pocket initial expenses.

agencies from excessive financial risk through the establishment of a stop loss in which the public agency paid 50% of direct service costs if total costs for an individual child exceeded four times the case rate. In another site, Hamilton County contracts included both individual and aggregate stop loss provisions. If the annual aggregate loss was $333,333 or less in Year 1 or $500,000 or less in Years 2 through 4, the lead agency absorbed the entire loss. The lead agency and the purchaser equally shared any losses above the specified amount.

- Risk Pool - Some states have established a risk pool (funding that will be set aside and accessed to cover unexpected costs under the stop loss or risk-reward corridor). The pool can also be used as the repository for penalties that might be collected from providers who fail to meet expectations and to fund the bonuses that might be used to reward providers who achieve certain performance goals. Funds for the pool may be withheld from each provider's payment and set aside; contractors may contribute a percent of retained savings to the pool; and in still other instances, the public agency may fully fund the pool each year of the contract (McCullough, 2003, Unpublished).

The purchaser may also require the contractor to maintain a sufficient sum of money to cover any reasonable costs that may be incurred (risk reserves), or to obtain insurance to protect the financial integrity of the program. Typical child welfare risk-based contracts have had requirements for contractors to maintain 30 to 60 days of operating capital to handle inevitable cash flow challenges (McCullough, 2003).

Finally, given the current state of knowledge about risk-based financing in child welfare, it is important to have mechanisms in place to periodically assess the adequacy of the overall funds and to adjust rates when needed. Even when reforms include risk mitigation strategies, contractors have also become more proactive in managing their risks. Utilization management systems (unheard of in traditional contract arrangements) have become commonplace. While all utilization management systems are designed to help contractors regulate expenditures; these systems range in sophistication from simple to complex. Despite the differing levels of sophistication of contractors' utilization management systems, there is consensus among contractors that budget oversight receives far greater attention under the new payment arrangements (McCullough, 2005).

3. Achieving Funding Flexibility without Foregoing Federal Revenue

The contractor's ability to produce improved outcomes for children and families and manage its risks is directly related to its ability to influence and change the historical pattern of service utilization and administrative processes used by public agencies that have produced the current outcomes and costs. To do this most efficiently, providers need to have flexible funding, which is not guaranteed under various risk-or results-based contracts. Within child welfare, there are several ways that funds can be directed to achieve improved results and contain costs. For example,

- There can be an emphasis on prevention and community-based and in-home services to reduce the number of children who enter out-of-home care.
- There can be an emphasis on more appropriately managing the child's care once a child enters the system to reduce the length of stay. This strategy seeks to ensure a match between child and family needs and appropriate levels of care and services provided throughout an episode of care.

- There can be an emphasis on timely and lasting permanency with a focus on providing services to support reunification, adoption, and guardianship — including the provision of a wide array of supportive services to prevent re-abuse and re-entry.

The challenge is to achieve increased flexibility within the restrictions of federal and state laws governing funding sources. For instance, federal title IV-E funds, the largest source of federal revenue for state child welfare systems, only reimburses states for certain costs and activities related to foster care and adoption services. Restrictions in the use of these funds have been a topic of concern for decades. This systemic problem becomes a challenge for private agencies who strive to create alternate interventions and services, to prevent or reduce stays in out-of-home care (McCullough, 2003a).

Until legislative authority expired in 2006, many states turned to title IV-E waivers to gain flexibility. States without title IV-E waivers sought other means for implementing reforms. Some changed the funding mix—combining child welfare, TANF, Medicaid, and behavioral health block grant dollars in new ways to pay for services for children and families and to create more flexibility over resources without reducing the level of federal revenue (McCullough, 2005). Other states tapped state or local general revenue funds such as New York City's initiative in which the flexible dollars are funded through general operating revenue.

Ironically, achieving better outcomes for clients may produce higher costs for states. Some privatization initiatives report that while they are achieving desired outcomes, the changes have resulted in reduced claims for title IV-E foster care (Vargo et al, 2007). Privatization does not solve the basic challenge faced by all states, namely that title IV-E reimburses states for a share of foster care costs but not for in-home, therapeutic, or preventive services. For many states, serving a child at home is more expensive for the state even if those services are more appropriate and cost less overall.

Some states have tried to work around these restrictions by blending funds to address a range of social service and health needs of clients. In these states, the child welfare system, Medicaid, and the behavioral health care system work together to provide both acute and long-term behavioral health care services. However, this option comes with its own challenges. First, different funding streams come with different eligibility requirements and program restrictions. Also, when coordination between systems is lacking, there is a great potential for duplication of effort, fragmentation, service gaps, cost-shifting, and disagreement about payment responsibilities. This may become particularly problematic if the state also has a managed behavioral health care plan that is not linked to the child welfare initiative (Maurey et al, 2003; McCarthy & McCullough, 2003).

4. Managing Cash Flow

Managing cash flow is another complication related to federal financing and new contracting methods. In traditional fee for service payment arrangements, government purchasers usually pay vendors up to 30 or 60 days after services are invoiced, which occurs only after the actual delivery of services. Cash flow problems can become an issue under new contracting arrangements for both the public purchaser and the nonprofit contractor. The problem for the public agency comes when the public agency pays providers or lead agencies prospectively but can only claim federal reimbursement after services are delivered. On the other side, contractors, who are typically nonprofit agencies with limited financial reserves, face serious cash flow problems if they are not paid prospectively but are required to reimburse network subcontractors before receiving state payments. The question facing both public purchasers and providers is how the benefits of prospective payments—the best option for

front-end flexibility—can be achieved with the retroactive cost reimbursement methodology required by title IV-E and often by state statutes as well.

IV. Lessons Learned

Much of the available information on the efficacy and effectiveness of privatization comes from state reports and administrative data systems which have not been independently verified. The lack of rigorous evaluations makes it difficult with most initiatives to isolate the impact of a privatization effort from other reforms or new policies implemented simultaneously. Without an objective assessment, it is very difficult to know why some initiatives succeed and others fail. A few states have invested significant time and resources into sustained third party evaluations capturing data from the early stages of planning and transition and throughout each stage of implementation of the contract.[8]

States considering a new privatization effort or the revision of a current initiative can benefit from anecdotal reports of lessons learned by both public and private agency administrators. The following peer-to-peer advice comes from a range of states that have implemented both small and large scale initiatives.

In Florida, state officials have developed a top ten list of lessons learned. Among other things the state stresses the importance of readiness for both the contractors and the public agency staff. Site readiness was determined to be so important that the state developed a readiness assessment process for all new providers that had to be completed before accepting cases.[9] Another central lesson for Florida was the need for a spirit of partnership throughout the planning, implementation, and evaluation phases (Florida DCF, 2006).

The importance of trust, open communication, and strong leadership are also mentioned in most articles and case study documents on privatization, across states. Other valuable lessons include the need for administrators to:

- Recognize that while competition may be good, the transitions are hard: If a contract is given to a new provider, the state will face transition hurdles and a range of transaction costs (e.g. hiring and training workers, developing sufficient MIS capacity) associated with shifting service from one provider to another – which can cause delays in service delivery (McCullough, 2003).
- Acknowledge that a contractor's ability to perform will be limited by many of the same barriers faced by the previous public system: Privatization does not remedy all systemic barriers – including but not limited to inadequate funding, staffing shortages, inadequate service capacity, and lack of coordination across systems (Freundlich & Gerstenzang, 2003).
- Plan for inevitable changes: Project models often change in size, scope, financial arrangements or overall design due to changes in the State's overall priorities, changes in leadership, or natural evolution brought about by increased knowledge about what

[8] It is beyond the scope of this paper to fully explore the methodology and findings from the few states that have conducted relatively rigorous multi-year, multi-tiered evaluations. However, for examples of this work, readers are encouraged to review the annual evaluations of Florida's CBC, produced by the University of South Florida available at: http://www.dcf.state.fl.us/publications/pubs.shtml.

[9] For more details on this process, see the first technical assistance paper in this series: *Assessing Site Readiness: Considerations about Transitioning to a Privatized System.*

works and what is working less well. Planning for and managing these changes involves many of the same "readiness" steps described in the first paper in this series.

Private agencies operating under various risk or performance based payment contracts have also weighed in on lessons learned. Illinois has used private providers to serve most of its out of home care population for decades. Changing from traditional contract arrangements to performance based ones presented opportunities, but also challenges both politically and practically. Illinois state officials point to three lessons learned about gaining buy-in for the performance based contracting process:

- Private providers had meaningful input into the planning and design phase. In 1997, providers met with state staff and formed a work group that crafted the plan, policies and implementation strategies of the new system.
- Providers were concerned about the data by which performance would be measured. Providers wanted to be confident that the data would be accurate and reliable. In consequence, the state contracted with Chapin Hall Center for Children at the University of Chicago to administer the management information system used to guide decisions about performance and payments to private agencies.
- The state gained buy-in for the new system by making a commitment to providers that a percentage of any money saved by reducing the number of children in foster care would be reinvested into the system to improve services and protect children. This included increasing staffing of case management teams, recruiting additional foster homes, and expanding the availability of emergency placements and clinical services (McEwen, 2006).

Finally, private agency administrators from five states with experience in performance contracting (MA, MO, FL, KS, and OH) offered advice to others considering risk or results-based contracts (McCullough, 2005). Private agency administrators offered the following ten suggestions to *public agencies* that are considering privatization:

1. Build a real partnership with the private sector to accumulate the political clout needed for hard times.
2. Make sure the financing option gives flexibility in funding and specifies the outcomes/results desired—but make sure you have information technology and quality assurance capacity to monitor both costs and outcomes.
3. Require accreditation as an added protection for quality.
4. Make sure there is clarity in public and private roles/responsibilities.
5. Get "buy in" from all levels of the public agency staff and across all stakeholder groups--including the legislature, the courts, advocates, and caregivers. Success requires mutual understanding and agreement about the goals and direction of the project.
6. Understand the importance of data accuracy, accessibility, and integrity.
7. Understand the complexity of financial reporting (merging governmental accounting into traditional non-profit accounting systems) and the potential impact privatization will have on the federal requirements for documentation and regulation.
8. Use actual cost data rather than "guesstimates" in pricing and setting rates.
9. Ensure adequate resources upfront to handle the transition and implementation process.

10. Take care in developing the specifications and pricing to ensure a balance in expectations and resources.

The same private agency administrators offered the following advice to *fellow private agencies* considering new performance-or risk-based contract opportunities:

1. Know what you don't know and hire experts to guide you through the system's complexities and obstacles.
2. Get a handle on costs and if the money isn't there — don't bid.
3. Re-think the approach to overall staffing, recruitment, training and support to get the flexibility and coverage needed.
4. Hire the best which may mean offering higher salaries for case managers, supervisors, and middle managers.
5. Ensure adequate time and resources for training to ensure staff have the practice philosophy and skills to succeed in the new system.
6. Review liability issues and prepare the agency's Board.
7. Understand risk and carefully look at the basic design to determine if risk is manageable.
8. Be realistic about service capacity and have solid plans for expanding needed services, including prevention and aftercare and the recruitment of foster homes.
9. Build information technology capacity to capture the type of data that is needed to track cases, provide reports to the public agency, develop management reports and capture encounter data to support the case management and a utilization management system.
10. Develop a utilization management system which will provide for authorizations of all out of home placement and services, including both preauthorization and concurrent reviews. (McCullough, 2005).

In order to expand knowledge in the field about effective practices, the sixth paper in this series will provide a "how to" guide for state and agency officials on evaluating their privatization initiatives.

V. Conclusion

Published reports describe great variation in the scope of current child welfare privatization initiatives in terms of geographic reach, target population, the number of clients served, and structural design. While there is variation in financing mechanisms, across these, there is an emerging thread that attempts to link improved performance to reimbursement amounts or payment schedules.

Every child welfare administrator who has led a privatization reform has had to wrestle with basic design and procurement questions relating to the type of risk or results based financing arrangements that will be used and the types of organizations that will be allowed to participate in the bidding process. Prior to determining whether risk-based options are desirable or which payment option would work best, it is important to assess current provider capacity and carefully explore the pros and cons of different models with that capacity and interest in mind. It is equally important to assess the public agency's comfort level in relinquishing control over some decisions in return for the introduction of financial risk. It is unrealistic to embrace a full or partial risk contract and assume that current roles and responsibilities will remain intact. Public

agencies must be cognizant that providers cannot be financially penalized for client outcomes over which they have very limited control. Public officials need to make contract payment design decisions recognizing that this is a system of checks and balances. With necessary oversight from public agency workers and courts, private agencies do not have full control over client outcomes.

Despite an early concern that privatization initiatives would focus on fiscal aspects of the child welfare system to the detriment of client needs and outcomes, studies are reporting that this does not appear to have happened. An integral part of these initiatives seems to be a push to do things better for the children and families served, or at least not to allow things to get worse for them when money is being saved (Westat & Chapin Hall, 2002; McCullough & Schmitt, 2003).

In some states, it appears that cost savings were achieved when case rates or performance based incentive contracts were implemented, and they were achieved without declines in safety or permanency outcomes (Westat & Chapin Hall, 2002; Freundlich & Gerstenzang, 2003). However, after a decade of experimentation, there is still no compelling evidence of the efficacy of one fiscal model or payment method over another. Some believe that the adequacy and flexibility of the funds may be more critical than the particulars of the fiscal model in determining whether fiscal or programmatic goals are met (McCullough, 2003; McCullough, 2005; Freundlich & Gerstenzang, 2003).

Additional research is needed to fully understand and describe what is working and not working in new privatization efforts. The research conducted to date points to a number of key factors for success across different designs. These appear to relate to the sophistication of the purchaser in planning, procurement, and contract oversight; the alignment of resources with expectations; the adequacy of funding and contractor rates; the level of buy-in from stakeholders; the care with which system designs were developed; the clarity and appropriateness of the expected outcomes; and the infrastructure, leadership, and innovation of the contractor and the public purchaser (McCullough, 2005).

In summary, there are many models for privatizing child welfare services. Each is made up of a series of complex design elements. This paper presented many of the elements that must be considered, balanced and aligned when designing and ultimately administering privatization initiatives. The literature in this area repeatedly describes the benefits of basing design decisions on accurate and reliable data and the importance of involving stakeholders in the decision making process. It is also important to realize that planning and implementation are not “one-time” events. Privatization, which is ultimately a partnership between public and private agencies, requires ongoing collaboration, information exchange and adjustment as reforms mature and system goals evolve.

The next paper in this series will present both the challenges and lessons learned about transitioning the case management function to private agencies as well as how case management functions are divided, shared, and how roles evolve once privatization occurs.

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