



LITERATURE REVIEW ON THE PRIVATIZATION OF CHILD WELFARE SERVICES

August 25, 2006

Planning and Learning Technologies, Inc.[®]

and

The University of Kentucky

This report was written as part of the Quality Improvement Center on the Privatization of Child Welfare Services (QIC PCW) on behalf of the Children's Bureau, US Department of Health and Human Services.

ABOUT THE QUALITY IMPROVEMENT CENTER ON THE PRIVATIZATION OF CHILD WELFARE SERVICES

The Quality Improvement Center on the Privatization of Child Welfare Services (QIC PCW) is a five year project to promote and support an evidence-based and outcome focused approach to the development and delivery of child welfare services. Funded by the Children’s Bureau, U.S. Department of Health and Human Services, the QIC PCW is being carried out by a partnership between the University of Kentucky College of Social Work and Planning and Learning Technologies, Inc.

Funded in the fall of 2005, the QIC PCW has two phases. The first phase is a national needs assessment involving discussions with state child welfare administrators and other state and private providers during regional forums, and national advisory board meetings. Information was also gained from focus groups with other stakeholders including judges, tribal representatives and families involved in the child welfare system. The needs assessment also involved two iterative literature reviews, including this first one. The second phase of the QIC PCW will involve the administration of sub grants testing select privatization models, completion of a project evaluation and the dissemination of information to the field.

The purpose of this literature review is to describe the major themes in child welfare privatization focusing on areas that state officials identified as questions they face in considering and/or implementing reforms. The review presents information on how the field defines privatization, the history of privatization efforts, why states are exploring this reform and in what capacity. It also highlights lessons learned and recommendations about privatization efforts from those that have implemented child welfare reforms and those that have studied them.

TABLE OF CONTENTS

ABOUT THE QUALITY IMPROVEMENT CENTER ON THE PRIVATIZATION OF CHILD WELFARE SERVICES	i
TABLE OF CONTENTS	ii
CHAPTER I: BACKGROUND AND HISTORY OF CHILD WELFARE PRIVATIZATION	1
1. Introduction	1
2. Defining Privatization	1
3. History and Recent Trends in Child Welfare Privatization	2
4. Remainder of this Report.....	3
CHAPTER II: APPLICATION OF MANAGED CARE IN OTHER FIELDS	4
1. Background.....	4
2. History and Emergence of Managed Care	4
3. Managed Care Definition	4
4. Managed Care Successes & Challenges.....	5
5. Lessons Learned from Managed Care	7
CHAPTER III: CHILD WELFARE TODAY – STATE PERFORMANCE ON CHILD AND FAMILY SERVICES REVIEWS.....	9
1. Background.....	9
2. Summary of State Performance on the CFSR Data and Program Improvement Plan Responses	10
CHAPTER IV: CHILD WELFARE PRIVATIZATION	13
1. Reasons States Have Privatized Child Welfare Services.....	13
2. Concerns about the Efficacy of Privatization Efforts.....	14
3. Will Privatizing Services Address Local Needs?.....	15
4. Scope of Privatization Efforts Today and Services Typically Privatized.....	15
5. Organizational Structure of Service Delivery.....	16
CHAPTER V: CROSS CUTTING THEMES IN PLANNING FOR AND MANAGING PRIVATIZATION EFFORTS.....	18
1. Planning for Privatization Efforts	18
2. Role of Public and Private Provider in Key Decisions.....	20
3. Contract Payment Systems Used for Privatized Services.....	22
4. Performance Standards and Measures	26
5. Contract Monitoring.....	30
6. Issues Affecting Native American Children and Families within Privatized Systems	32
CHAPTER VI: OUTCOME EVALUATIONS: FINDINGS, CHALLENGES AND RECOMMENDATIONS	33
1. Introduction	33
2. Overview of the current state of evaluation of child welfare privatization.....	33
3. Challenges for the Evaluation of Privatization of Child Welfare Services.....	36

CHAPTER VIII: CONCLUSION AND FUTURE STUDY40

- 1. Major Themes 40
- 2. Lessons Learned and Recommendations from the Field 41
- 3. What Information is Being Collected? 42
- 4. Opportunities for Future Study 43

REFERENCES.....45

BACKGROUND AND HISTORY OF CHILD WELFARE PRIVATIZATION

1. Introduction

Public child welfare agencies have long relied on the private, not-for-profit sector to deliver discrete child welfare services. This reliance has increased in the last two decades due to escalating costs of out-of-home care driven by increases in both the numbers served and the unit cost of care and a renewed focus on client outcomes. With the passage of the **Adoption and Safe Families Act** in 1997, and the implementation of the Federal Child and Family Services Reviews, states are exploring new ways to improve child and family outcomes including safety and timely permanence. State and local child welfare administrators have implemented a range of reforms to both contain costs and improve outcomes. Privatization and the application of managed care principles and performance-based contracts have been viewed as mechanisms to fuse programmatic reforms with fiscal reforms (Wulczyn & Orlebeke, 1998; Embry, Buddenhagen, & Bolles, 2000; McCullough, 2003).

2. Defining Privatization

Although the term is widely used today, the literature does not provide a single definition of “privatization” in child welfare services, nor does it always use the term privatization when referring to contracting efforts. The term is sometimes used broadly to include all contracted services. In other situations it is used more narrowly to include only broad based reforms where core child welfare services and often case management, have been shifted to the private sector. The matter is further complicated by the fact that some states use different labels for large scale contracting efforts such as “community based care” (Florida) or “outsourcing” (Texas).

In its most general sense, privatization means the “provision of publicly funded services and activities by non-government entities” (Nightingale & Pindus, 1997). Privatization is a process where functions and responsibilities in whole or in part are shifted from government to the private sector. Privatization can take various forms including vouchers and public-private partnerships. Its most common form, “contracting out,” is where the government seeks competition among private bidders to perform government activities. With contracting, the government remains the financier and is responsible for managing and setting policies on the type and quality of service to be provided (GAO, 1997).

Historically, contracting out services has been the principle form of privatization in the child welfare system. Where once this involved a private agency agreeing to serve a certain number of children, based on a pre-agreed upon per diem payment for care, current models of privatization often involve the use of managed care principles and performance-based contracts and incentives (Freundlich & Gerstenzang, 2003). A brief history of privatization is provided below.

3. History and Recent Trends in Child Welfare Privatization

Child welfare services originated in the private sector (Embry et al., 2000). States and local governments in some parts of the country have relied on child welfare services in the private, voluntary sector since at least the early 1800s. This is because child welfare was not viewed as a public sector responsibility to the extent that it is today and private, philanthropic organizations filled the void in a piecemeal fashion.¹

Until well into the 20th century, mutual aid and religious charities provided child protection, institutional placements and foster homes. Governments gave grants or subsidies, but these programs were privately operated. Between the 1930s and 1970s, federal social security and public social service systems including a child welfare component emerged. The federal government expanded its public assistance programs and most of the states invested their own funds in services and facilities for dependent, neglected, abused, delinquent and disabled children (Kahn & Kamerman, 1999).

Between 1962 and 1974, amendments to the **Social Security Act** stemming from the War on Poverty greatly expanded the use of privately delivered services. These amendments authorized the use of federal funding for health and social services by nongovernmental charitable agencies. With the War on Poverty, the government invested additional funds, making health and social services more broadly available primarily through the purchase of service arrangements (Rosenthal, 2000). A second expansion took place in the 1980s with the enactment of the **Adoption Assistance and Child Welfare Act** and the concurrent increase in federal funding for child welfare services.

The third major expansion in privatization took place in the 1990s in child welfare and other health and social services. National surveys found that during the 1990s, between 50 percent to 80 percent of states had increased their reliance on contracted social services to cope with new constraints on public resources (GAO, 1997). As opposed to earlier increases in the private sector driven by overall service expansion, in the 1990s, the shift to privatize services was the result of efforts to downsize government, improve service quality and contain costs (Rosenthal, 2000).

Since the 1990s, privatization and related fiscal reforms including managed care, performance-based contracting and integrated funding, have played significant roles in child welfare reform efforts. In their 2000-2001 national survey, McCullough and Schmitt found that at least 50 percent of states were planning or had already implemented managed care reforms alone (McCullough and Schmitt, 2003).

During the 1990s, the Federal Children's Bureau was also exploring ways to improve program outcomes with existing funds. Because the majority of federal child welfare funding is directed at supporting out-of-home placements (title IV-E), the Bureau supported efforts to blend existing federal funding streams and use them more flexibly. The approval of child welfare demonstration waivers in 1994 was one of the most significant shifts in federal child welfare fiscal policy since the enactment of the **Adoption Assistance and Child Welfare Act** in 1980

¹ Use and reliance of public child welfare agencies on privately delivered services has always varied across the country. Rural, western states have had less reliance on private sector agencies than other regions (Rosenthal, 2000).

(Cornerstone Consulting Group, 1999). The federal waiver program has allowed select states to waive certain requirements under title IV-B (that funds prevention services) and IV-E (that funds costs associated with out-of-home placements and adoption) and design and deliver alternative models of child welfare services. The waiver program allowed states to redirect the existing incentives of title IV-E toward a wider range of prevention and permanency options. Among the waivers, five states piloted programs that used the waiver process to support applications of managed care principles in contracted child welfare services (McHugh, 2000).

4. Remainder of this Report

Recent reforms in the child welfare system are being designed to address chronic challenges in the child welfare system -- specifically state's capacity to achieve child permanence, safety and well-being. One strategy has been the application of managed care principles in program models and financing. Prior to discussing the overarching themes of recent privatization efforts, this report will briefly discuss the lessons learned from other fields that have applied managed care practices to the delivery and financing of services. This report also provides a brief description of the current state of child welfare systems based on information gained from federal Child and Family Services Reviews and state Program Improvement Plans.

It had been the intention of this literature review to provide promising models in child welfare privatization. However, there is little rigorous evaluation on the efficacy of one approach in relation to others (e.g. managed care contracts versus purchase of service or more fundamentally, privately versus publicly delivered services). As will be described later in this report, while there is evidence of expanded service availability and improved outcomes for children and families, much of this information is still anecdotal and it is very difficult to attribute outcome changes found in children and families served to the new service systems. Chapter VI explores some of the challenges in conducting rigorous evaluations of privatized efforts and presents findings from a small number of evaluations that appear to have been rigorously conducted.

The remainder of this report explores the:

- Lessons learned from the public health care system's experience with managed care;
- States' performance on Child and Family Service Reviews and summary of Program Improvement Plans;
- Child Welfare Privatization: services and models;
- Lessons learned about planning for and implementing child welfare privatization reforms;
- Findings from select outcome evaluations and challenges to evaluating privatization initiatives; and
- Conclusion and future study options.

APPLICATION OF MANAGED CARE IN OTHER FIELDS

1. Background

The mounting desire to control government spending, increase access to services and accountability of public services led to the development of managed care. This chapter will examine managed care and how it has transformed the public health care system, mainly through the Medicaid program.² It will also examine managed care's successes, challenges, and lessons learned in order to inform the child welfare field, which is beginning to embrace this strategy.

2. History and Emergence of Managed Care

In the 1960s and 1970s there was much interest in reforming the health care system due to rising costs of care, limited access to services for underprivileged populations, and the need for more efficient delivery systems (Tufts Managed Care Institute, 1998). Out of these concerns, managed care developed as a financing and structural reform that integrates primary care service delivery to patients, administered and monitored by an overarching organization. This reform was intended to contain costs for services, improve quality and access to health providers, increase accountability of the health care system, and create more flexibility in the service delivery system. In the public health field, managed care helped transform the operation of community health centers. Managed care has also played a large role in reforming the behavioral health care field -- both mental health and substance abuse services.

3. Managed Care Definition

Managed care does not have a standardized model, and is often adapted to fit local circumstances. At a very basic level, managed care is a "variety of mechanisms designed to control service utilization and costs of services" (Kamerman & Kahn, 1998, p. 1). The common aspects across all managed care systems are:

- *Gate-keeping and monitoring functions.* In order to control entry into the system, the managed care organization (MCO) is a gatekeeper. Using level of care and placement criteria, and utilization reviews, the MCO provides case management and case coordination for all patients, and authorizes payments to providers.
- *Capitation and Assumption of Risk.* The MCO is paid a capitated fee or a case rate for either the entire life of the case, or a determined time frame that serves a person, family, or group of people. Financial risk is generally shared between the purchaser (state agency) and the MCO.
- *Financial controls to limit benefits and limit service utilization.* Capitated payments place MCOs at considerable financial risk, so in turn, they have the incentive to enact certain financial controls that limit particular benefits and services. The array of services, length of time services are offered, number of treatments and services that providers recommend can all be limited to assist in restricting cost.

² As discussed earlier, the Medicaid Program provides medical assistance to poor and low income individuals. For decades, state child welfare agencies and individual providers have used Medicaid funds to help support the medical needs of these children.

- *Carve-outs*. Carving out allows the state to pay separately for specialized services that may incur higher than normal costs. These services are mainly mental health and substance abuse plans, but can also include dental care, pharmacy, and vision, along with other services (Holahan & Suzuki, 2003). States can pay with capitated payments or arrange fee-for-service payments. The term carve-outs is also used to refer to Managed Behavioral Health Organizations (MBHOs) that specialize in administering behavioral health benefits separate from comprehensive health care plans (Sturm, 1999). States either contract directly with MBHOs for specialized services or managed care organizations subcontract these services within their health care plans.

4. Managed Care Successes & Challenges

While several studies have been conducted on managed care programs, it can be difficult to generalize findings because managed care reforms have not been implemented uniformly. Just focusing on behavioral health, studies on managed care initiatives have found both strengths and weaknesses (Forquer & Sabin, 2002). This section will briefly describe some of these successes and challenges.

- There are examples where, *Managed Care has performed better than the previous fee-for-service system*. In North Carolina, a managed care carve-out for youth produced reductions in costs and inpatient settings compared to an existing Medicaid fee-for-service system (Cook et al., 2004). Also in Colorado, a managed care system reduced inpatient utilization and lowered costs for children compared to another existing fee-for-service system (Cook et al., 2004). A survey of 36 states that implemented managed care found that initial access to behavioral health services improved in 85 percent of the systems, compared to the previous system (Stroul, Pires, & Armstrong, 2003). Shorter waiting lists were reported in half of the systems, patients experienced increased initial access to inpatient services in 63 percent of the systems, and average lengths of stay are reportedly shorter in 80 percent of the systems, in comparison to the previous system (Stroul et al.).
- There are also examples where, *Managed Care has reduced costs by creating less restrictive placements for high-need populations*. Reductions of cost in many Medicaid managed care plans have been attributed to the systems' ability to reduce costly inpatient admissions and increase availability and access to more community-based, outpatient settings. A Massachusetts Medicaid mental health plan decreased expenditures 22 percent below expected levels, having no apparent impact on quality or access to services, by reducing lengths of stay, lowering service prices, and having fewer expensive inpatient placements (Oliver, 2002). Also, a Medicaid managed care program in Arizona also achieved cost savings without impairing access or services (Fossett et al., 2000). Massachusetts had savings estimated at \$47 million for a children's wraparound managed care program by shifting to lower-cost community treatments (Cook et al., 2004; Nicholson, Young, Simon, Fisher, & Bateman, 1998). California, Colorado, Iowa, Nebraska, and Utah all have experienced substantial savings in program expenditures by placing patients in more low-cost community settings (Bouchery & Harwood, 2003; Cook et al., 2004; Donohue & Frank, 2000).

The literature also provides examples of challenges of managed care initiatives:

- *Reduction in Services*. The amount of financial risk the public sector has shifted to the private sector may produce "adverse incentives" in service delivery. In efforts to retain profits, MCOs may be motivated to provide the bare minimum of services. MCOs may also conserve profits by shifting costs to other public systems or other public funding streams

that serve similar populations. The majority of MCOs are for-profit organizations, and therefore have a strong motivation to retain profits (Oliver, 2002). An introduction of a managed care substance abuse benefit in Maryland was found to reduce treatment revenues and inhibited a number of patients from receiving drug treatment services (McCarty, Dionard, & Argeriou, 2003). A survey of 36 states that have implemented managed care found challenges associated with shortened lengths of stays such as placement in “community services without the clinical capacity to serve them, premature discharge before stabilization, and increased use of residential placements” (Stroul et al., 2003, p. xiii). Reductions in services may become an increasing problem, given the current unstable fiscal climate. A large percentage of public managed care systems (78%) are experiencing difficulties maintaining services as a result of the fiscal climate in the country” (Stroul et al.).

- *Gaps in services for high need populations.* Patients who require intensive mental health and substance abuse treatment services, as well as children and adolescents with severe emotional disturbance and substance abuse dependency in Medicaid programs, have been documented as the most difficult to treat; they consistently require more services, and are the most expensive to serve (McCarty et al., 2003). It has been a practice of private insurers to shift the cost of people with severe mental illness and substance dependency to the public sector, in which many private insurers also serve now (Nicholson et al., 1998). Children and adolescents with severe emotional disturbance and substance abuse dependency are also vulnerable in managed care systems because they have needs that span across many systems. A multi-site study of six states evaluating managed care’s effect on children with high needs found that “regardless of age, gender, ethnicity, or juvenile justice system involvement, and despite parents’ levels of education, caregiver strain, or mental/physical health, low-income children with severe emotional disturbance (SED) were less likely to receive services if they were enrolled in managed care behavioral health plans” (Cook et al., 2004, p. 399). In the literature, there are few empirical studies which document the success of Managed Behavioral Health Organizations (MBHOs) in serving the complex needs of people who need intensive, costly treatments (Oliver, 2002; Sturm, 1999). Medicaid managed care’s issues with serving high-need populations reflects a similar and even more pertinent challenge in child welfare, due to the fact that child welfare systems are unable to “unload” clients and must address the needs of all children who enter the system, not just those with less-intensive needs.
- While not unique to managed care initiatives, there is a *lack of adequate data that measure performance and assess quality of care.* The managed care field is lacking the development of standardized, measurable outcomes, which assess the performance of managed care organizations related to the quality of care. Some have argued that there is an unbalanced focus on outcomes that demonstrate success related to cost, but very few related to patient and client outcomes. Few states have performance measures in their managed care contracts, and even though performance data is collected, they are “unevenly collected, analyzed, and used” (Fossett et al, 2000, p. 45).

The National Committee for Quality Assurance (NCQA) has established standards which require measurement of consumer satisfaction through surveys and provide guidelines for grievance and appeals processes, but these standards and quality indicators have been identified as “crude” (Strum, 1999, p. 370). With no standardized benchmarks and quality indicators established, it is difficult to measure the quality of care under managed care arrangements. This explains the lack of research which examines the qualitative impact of

managed care (McCarty et al., 2003; Oliver, 2002; Sullivan et al., 2001). Most of the studies that have been conducted have focused on limited information such as provider surveys, claims data, and review of managed care organization structure and procedures, which have varied findings, “with some studies asserting that quality of care has been at least maintained if not improved and another citing specific concerns about quality” (Bouchery & Harwood, 2003, p.94).

5. Lessons Learned from Managed Care

Recent managed care reforms in the child welfare system have much in common with those taking place in the health and behavioral health fields. For instance, while for the most part, the public child welfare agency continues to serve as gatekeeper, private, lead agencies are increasingly serving as care coordinators, monitoring and assessing service delivery. Further, a private child welfare provider assumes different levels of risk depending on the method and timing of payment—capitated payments produces more financial risk because providers have to provide all necessary services for all children and families based on the set payment the public agency supplies. Child welfare contracts are increasingly using fiscal incentives and disincentives that encourage providers to provide services efficiently and to correctly assess the needs of their clients. The translation of these managed care concepts into child welfare contracting methods are further explored in Chapter V.

The child welfare system can gain valuable information from the early experience of managed care in the health and behavioral health fields. One fundamental lesson appears to be that there is no standardized model that ensures success. Some additional lessons include:

- a. *Involve consumers and other community stakeholders in planning, implementation, and monitoring.* Consumers should be involved in the design of the system. Consumer participation should be sustained over time and have a focus on other key aspects of the system including implementation, monitoring, goal setting and planning, and quality assurance (Be'champs, Bialek, & Chaulk, 1999; Cook et al., 2004; Forquer & Sabin, 2002). The public must maintain a presence in the community as well, by continuously providing information, insight, and guidance (Be'champs et al., 1999).
- b. *Develop financing based on accurate historical data.* When using historical fee-for-service data to set capitation or case rates, the public agency should use at least three years of historical data. This allows the baseline period to be comparable to the time period and the populations that the managed care program is currently serving (Tucker Alan Inc., 2000).
- c. *Establish performance standards that measure quality and impact.* Performance standards should be developed using both process and outcome measures. Process measures should assess the provider's program operations and examine the quality of the provider's work with clients. Outcome measures should assess the provider's impact on the patient's quality of care and access to services (Rosenbaum & Teitalbaum, 1998). Standards should be tied to financial rewards and continuance of contracts; the state should not micro-manage, but must ensure that there is access to important information on their contractors' performance at all times (Donohue & Frank, 2000; Fossett et al, 2000).
- d. *Develop adequate information management (MIS) systems.* It is helpful to involve the MCOs in the development of the performance outcomes so that there is agreement up front. In this way, states know the performance outcomes that will be measured before designing and implementing management information systems. States should also begin preparing at the state level at least a year before contracting to ensure that the information management system is in place; seek the input of all community stakeholders in the

planning stage (advocates, county government, legislators, consumers/families, and providers); and create a system that allows continuous feedback to the patients, MCOs, providers, and the community; and be cautious about making changes once the system is in place (Armstrong, 2003).

- e. *Institute a third-party evaluation.* The public agency should establish evaluation as a priority for all MCOs and resources should be set aside explicitly for an independent third-party evaluation (Fossettt et al., 2000; Nicholson et al., 1998).

The next chapter discusses state performance on the federal Child and Family Services Review as well as proposed reforms described in the state Program Improvement Plans.

CHILD WELFARE TODAY – STATE PERFORMANCE ON CHILD AND FAMILY SERVICES REVIEWS

1. Background

During the late 1990s, the Children’s Bureau of the Federal Department of Health and Human Services developed a set of child welfare outcomes and measures which would be used to assess each state’s performance on select child and family outcomes. This was a departure from traditional reviews of title IV-B and IV-E requirements, authorized through the 1994 amendments to the **Social Security Act**, which primarily focused on assessing state’s compliance with procedural requirements. Published in January 2000, the final rule established procedures for a Child and Family Review Services Review (CFSR) process. The following table lists the key outcomes and indicators used for the 2002-2004 Reviews.³

**Table 1
CFSR Outcomes and Indicators**

Outcome	Indicator
SAFETY	
1. Children are first and foremost protected from abuse and neglect	<ul style="list-style-type: none"> • Timeliness of initiating investigations on reports of child maltreatment • Recurrence of maltreatment
2. Children are safely maintained in their homes when possible	<ul style="list-style-type: none"> • Services to family to protect children in home and prevent removal • Risk of harm to child
PERMANENCY	
1. Children have permanency and stability in their living situations.	<ul style="list-style-type: none"> • Incidence of foster care re-entries • Stability of foster care placement • Length of time to achieve reunification • Length of time to achieve adoption • Permanency goals for child • Permanency goal of other planned living arrangement
2. The continuity of family relationships and connections is preserved.	<ul style="list-style-type: none"> • Proximity of foster care placement • Placement with siblings • Visiting with parents and siblings in foster care • Preserving connections • Relative placement • Relationship of child in care with parents
WELL-BEING	
1. Families have enhanced capacity to provide for children’s needs.	<ul style="list-style-type: none"> • Needs and services of child, parents, foster parents • Child and family involvement in case planning • Worker visits with child • Worker visits with parents
2. Children receive services to meet their educational needs.	<ul style="list-style-type: none"> • Educational needs of the child
3. Children receive services to meet their physical and mental health needs.	<ul style="list-style-type: none"> • Physical health of the child • Mental health of the child

³ A small number of indicators changed after the first round of reviews were completed in 2001.

The reviews are conducted to ensure “substantial conformity” with federal child welfare regulations and assess nationally, the current status of agency performance on select outcomes for children families involved in the children welfare system. The Reviews are also designed to assist states identify where they need to enhance their program capacity to achieve child safety, permanency, and well-being.

The CFSR process involves three phases:

- **State Self-Assessment.** Each state conducts a comprehensive self-assessment of its child welfare system, which includes state data from the National Child Abuse and Neglect Data System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS). Once complete, the state submits its Assessment Report to the Children’s Bureau for review.
- **Onsite assessments of each state’s child welfare system centrally and three sites within the state.** This process involves case reviews of foster care and in-home services cases and interviews or focus groups with parents, children, foster and adoptive parents, private service providers, child welfare agency caseworkers and supervisors, state and local child welfare agency administrators, and other stakeholders at either the state or local level.
- **Program Improvement Plan (PIP).** Once a state has completed a self-assessment and onsite reviews are complete, the state has to develop a Program Improvement Plan (PIP) that addresses the areas that have been identified as needing improvement. PIPs are developed in consultation with the federal regional office, which ultimately approves the plan along with the Children’s Bureau. The Bureau also monitors progress on an ongoing basis over the 2-year implementation period for the PIP.

The first round of CFSRs has been completed for all 50 states, the District of Columbia and Puerto Rico. Some states have completed their PIPs, while others are in the process of implementing them. Planning for the second round of CFSRs is currently underway.

2. Summary of State Performance on the CFSR Data and Program Improvement Plan Responses⁴

The Children’s Bureau found that only a small percentage of states achieved substantial conformity with any of the seven outcomes. States performed relatively well on some key indicators such as: “proximity of placement,” “placement with siblings,” and “low rates of re-entry into the foster care system.” However, no state achieved substantial conformity with the outcomes of “Children have permanence and stability in their living arrangement” and “Families have enhanced capacity to provide for children’s needs.”⁵

The Bureau conducted a content analysis of information gained during the CFSRs to determine challenges states face in achieving the select outcomes and indicators. Results from this analysis confirm that states share similar challenges in their efforts to ensure the safety, permanency, and well-being of children. The following section presents some of the key challenges within the areas of safety, permanency and well-being as well as some of the most common reforms states are implementing within their Program Improvement Plans (PIPs).

⁴ Chapter V Summary: State Performance on the Seven National Child Welfare Outcomes (U.S. DHHS, n.d.)

⁵ General Findings from the Federal Child and Family Services Review, 2004

a. Safety

The most common challenges in achieving the four indicators for child safety were found to be:

- Agency risk and safety assessments are not sufficiently comprehensive to capture underlying family problems that might be contributing factors to child maltreatment; and
- Child welfare agencies do not consistently provide sufficient services to address risk of harm to children who remain in their own homes and are not consistently monitoring families to assess their service participation and risk.

In response to these findings, states have implemented a range of initiatives to improve child safety including:

- Developing new practices or processes such as revising risk and safety assessment tools; implementing best practice models and specialized trainings; developing alternative/differential response systems; engaging and planning with families; enhancing practices and processes to improve practice and consistency; and creating specialized units or reorganizing existing units;
- Developing or clarifying related policies;
- Delivering additional training both for agency staff and cross-training with stakeholders (community partners, foster parents, residential staff and law enforcement); and
- Developing or improving information systems.

b. Permanency

As mentioned above, no states obtained substantial conformity on permanency outcome 1 (children have permanency and stability in their living situations), and only seven states achieved substantial conformity on permanency outcome 2 (the continuity of family relationships and connections is preserved).

The most common challenges experienced by states in achieving the permanency indicators included:

- Inconsistent implementation of concurrent planning efforts;
- Goal of reunification is often not reconsidered in a timely fashion;
- Inconsistent service delivery to foster parents to prevent placement disruptions;
- Out-of-home placements often based on availability rather than appropriateness due to scarcity of appropriate placement options;
- Inconsistent efforts to ensure family connections when child is in foster care; and
- Inconsistent efforts to seek relative placements for children entering custody.

The following are common strategies that states are applying in response to permanency concerns:

- Developing or enhancing policies.
- Developing new practices/procedures for general casework, incorporating “best practice” models, targeting services or producing practice guidelines.

- Developing quality assurance and monitoring mechanisms including improvements to data systems; supervision; reviewing specific populations; or establishing new practice standards.
- Implementing collaborative activities with courts and other stakeholders (community based organizations, tribes, youth, etc.).
- Developing cross-disciplinary and other trainings.
- Increasing resources including staff hiring and retention initiatives and expanding existing services or developing new ones.

c. Child well-being

The CFSRs found that nearly all states are also struggling to meet the well-being outcomes. In fact, no state was able to achieve substantial conformity with outcome 1 (families have enhanced capacity to provide for children’s needs), and while 16 states were in substantial conformity on well-being outcome 2 (children receive services to meet their education needs), only one state was in substantial conformity on well-being outcome 3 (children receive services to meet their physical and mental health needs).

Common challenges in this area include:

- Providing services that are sufficient to meet the identified needs of children and their parents;
- Involving parents and children in the case planning process;
- Providing sufficient face-to-face contact between agency caseworkers and the children and parents in their caseloads;
- Matching of services to needs;
- Lack of support services to foster and relative caretakers; and
- Failure to engage fathers; and multiple school placements.

The most common strategies to improve state performance on the well-being outcomes include:

- Encouraging more consistency in practice; improving engagement of family members and stakeholders; implementing practice models and/or processes;
- Training staff on completing more comprehensive needs assessments;
- Establishing minimum visit requirements;
- Providing supervisory oversight and monitoring performance through quality assurance/continuous quality improvement;
- Training managers, staff and providers;
- Focusing on quality of visits; and
- Focusing on recruitment and retention.

As discussed earlier, some states and communities are looking at privatization as a mechanism to implement these reforms and thereby improve performance on client outcomes.

CHAPTER IV

CHILD WELFARE PRIVATIZATION

This chapter presents some of the arguments for and against privatization reforms. It then presents findings from national studies about the scope of current privatization efforts and the types of services typically privatized.

1. Reasons States Have Privatized Child Welfare Services

The literature lists a variety of reasons to contract out services, most common among these involve themes of efficiency, service quality and innovation.

One recent study on child welfare privatization (Westat and Chapin Hall, 2002) describes the experience of 23 initiatives in 22 states. The study found that among these initiatives, states and jurisdictions were motivated by a variety of factors including court and state mandates to change practice, and agency goals to improve outcomes and/or reduce the cost of care. Other states designed their systems to try to reduce the growing permanency backlogs that persisted and the mounting challenges due to ASFA requirements. Some states focused on reducing their reliance on restrictive placements. The study authors explained that two overriding themes emerged: states hoped to improve outcomes for children and families and offer systems that were more flexible and spent funding more effectively and efficiently (Westat & Chapin Hall, 2002).

Much has been written about the fact that many states and communities have turned to private providers because of the assumption that they can deliver services more efficiently than the public sector. States have increasingly been concerned about escalating child welfare costs, and/or are directed to downsize government by state officials (Kahn & Kamerman, 1999; Unruh & Hodgkin, 2004). In its own national study of privatization reforms the General Accounting Office (1997) found that “the recent increases in privatization were most often prompted by political leaders and top program managers who were responding to an increasing demand for public services and a belief that contractors can provide higher quality services more cost-effectively than public agencies” (p.2). This was the case in Kansas, Florida, and is guiding more recent efforts in Texas.

Kretman’s (2003) study of Florida’s privatization efforts found that many in the state legislature favored limited government and limited spending, particularly in social services. Moving towards privatization was considered a means of limiting the government’s involvement in child welfare matters and delivering services more efficiently.

Some states, such as Kansas, choose to privatize services because it is assumed that the private sector will improve services and meet program targets set in court decisions or settlements (Mahoney, 2000; James Bell Associates, 2001). The Kansas Department of Social and Rehabilitation Services (SRS), the public agency in charge of child welfare services, had struggled for a long time to provide adequate services to children and families. Many stakeholders -- judges, attorneys, advocates, schools, and private providers-- had been dissatisfied with service quality and availability. In 1990, the American Civil Liberties Union filed a class action lawsuit against SRS which resulted in a settlement in 1993 and a series of criteria for the state to meet in order to improve their services. In 1995, SRS was still falling short of meeting the standards set by the settlement so the legislature recommended that SRS move to privatize its child welfare system (Mahoney, 2000).

2. Concerns about the Efficacy of Privatization Efforts

The literature also points to barriers to privatization as well as concerns that privatization will not improve state performance on select outcomes or achieve the efficiencies and innovations expected.

On the matter of efficiencies, one common concern is that there are insufficient numbers of providers to deliver services. This belies the argument that privatization will produce cost savings through competition (Freundlich & Gerstenzang, 2003; GAO, 1997). Others argue that there are hidden costs to delivering and monitoring contracts. While some sites have produced savings in one area (by, for example, reducing the number of days in residential treatment facilities or in out of home care), privatization has required additional investments in other areas including service array, information and management systems, and staff training (O'Brien, 2005).

There are other concerns that privatization will not work as planned because the child welfare system is chronically under funded, caseloads are too high and other resources and services needed by families are often unavailable in communities (Westat & Chapin Hall, 2002). The argument is that privatizing services will not address the larger systemic shortcomings of the child welfare system and the lack of community supports available to families in many communities.

More recently, with the new reliance on managed care models, critics argue that unlike the medical model of managed care which focuses on the health needs of a single client, the overarching goals of the child welfare system, safety, permanence and well-being, involve not only the child but their families. In addition to clinical needs, agencies must try to address the problems associated with poverty, community and family vulnerability, and the lack of basic social supports. These needs generally extend past traditional child welfare funding streams and services and require community wide collaboration. There is concern that managed care models focused on limiting costs will not address these wider needs of families and systems (McCullough, 2003).

Some have suggested that without restructuring current federal funding streams, private agencies will be unable to deliver the expected innovations in service delivery. They argue that the restrictive nature of title IV-E funds, which continue to serve as the primary funding stream in child welfare services, limits the ability of private providers to deliver flexible, wraparound services to prevent or reduce time in out-of-home placement. While Congress intended to address this concern by creating state grants under title IV-B Child Welfare Service Program in 1980 and the Family Preservation and Family Support Program (or the Promoting Safe and Stable Families program) in 1993, federal funding available to states for preventive services continues to be considerably less than that provided under title IV-E. In short, the categorical nature of federal funds continues to create challenges for states and localities to provide a well coordinated continuum of services (McHugh, 2000).

Others have argued that the very nature of social services makes them inappropriate for privatization and expressed concerns particularly about the use of for-profit providers. However, national studies have found that there is still a relatively small reliance on the for-profit sector. Only three of the lead agencies studied in CWLA's 2000-2001 national survey were for-profit firms. These include: a child welfare limited liability corporation in Missouri which serves as the care management organization; a private hospital in Connecticut that serves as a lead organization in the state's Continuum of Care contract, and a for-profit behavioral health organization that manages services in Hamilton County, Ohio (McCullough, 2003). It is unknown whether this limited reliance on the for profit sector results from the unwillingness of that sector to take on these

cases or inversely, the unwillingness of the public system to transition families to the for-profit sector. By way of example, Federal IV-E waivers limited the use of for-profit agencies in the administration and delivery of the federal pilots (McCullough, 2003).

3. Will Privatizing Services Address Local Needs?

While much has been written by advocates for, and critics against privatization, privatization is not inherently good or bad (Nightingale and Pindus, 1997). More to the point is that privatization alone will not likely improve agency performance. In most cases, children and families enter the child welfare system because they have difficult problems. The Center for Public Policy Priorities (2005) points to the fact that states that have privatized services struggle with the same issues that public agencies do including obtaining adequate services, reducing caseloads and reducing staff turnover. Transferring day-to-day management to the private sector will not likely improve case outcomes without adequate social, health and mental health resources in communities as well as sufficient numbers of qualified staff and foster and adoptive homes.

4. Scope of Privatization Efforts Today and Services Typically Privatized

Without a clear definition of privatization it is difficult to establish a firm estimate of the number of current initiatives. This section begins with estimates of all contracted services and then provides estimates of more narrow definitions. The National Survey of Child and Adolescent Well-Being (2001) provides one of the few national estimates of the use of private providers to deliver publicly funded child welfare service. The study involved telephone interviews with 46 state administrators conducted between March and August, 2000. The study found that on a pilot or statewide basis:

- Over 90 percent of states surveyed used private providers to deliver residential treatment services;
- Over 90 percent of states also used private providers to deliver family preservation or family support services;
- Approximately 90 percent of states used private providers to provide other foster care placement services;
- Over 80 percent of states used private providers to recruit foster and adoptive families;
- Over 80 percent of states used private providers to deliver family reunification services; and
- Approximately 75 percent of states surveyed used private providers to deliver special needs adoption services (U.S. DHHS, ACYF, 2001).

The CWLA's 2000-2001 Management, Finance, and Contracting Survey was designed to gather information about child welfare initiatives that were implementing reforms consistent with managed care concepts and practices. Forty-five states and the District of Columbia participated in the survey. Of those, 25 states had or were planning one or more child welfare managed care initiatives (McCullough & Schmitt, 2003).

Compared to their 1998 survey on the same topic (McCullough & Schmitt, 1999), the study found that states were generally investing more funding into managed care efforts, and initiatives were generally serving larger groups of children and families than they had in 1998. While most states were still targeting children in out-of-home care, many others were expanding services to

include all children involved in the child welfare system and some states were including children and families at risk of involvement.⁶

In their national study on child welfare managed care reforms, Westat and Chapin Hall (2002) found that the scope of fiscal reforms vary widely across states from statewide reforms to a range of smaller reforms covering specific geographic regions of the state or specific service populations. Some reforms are expanding, others are pulling back. Some initiatives include children and families in other systems than child welfare (Westat & Chapin Hall, 2002).

The least likely child welfare functions to be transferred to private agencies are child protection and investigation activities. In four major studies of privatization and managed care reforms (McCullough & Schmitt, 1999 and 2001; U.S. DHHS, ACYF 2001; and Westat & Chapin Hall, 2002) child protective intake and investigations remained largely under the purview of the public agency. After these functions, the contracting models varied widely.⁷

As will be described more fully in the following chapter, it is important to make the distinction between service delivery and decision making authority. While most states have contracted out direct services for some portion of their child welfare caseload, they have done so by delegating restrictive case decision making. The term “case management” is not consistently used in child welfare services, especially when directly provided services are contracted out to private agencies. Traditionally and by law, the public agency and courts make case planning decisions about child protection, placement, reunification and termination of parental rights. These decisions fall under the rubric of case management decisions. On the other hand, “case managers” in the private sector provide placement management and day-to-day case planning for the children and families in their care. In most cases and in most states, there continues to be a public agency worker who oversees the case, reviews private agency decisions and represents the case in court.

5. Organizational Structure of Service Delivery

The organizational structure of privatized services varies widely depending on, among other things, the types of services that are privatized and the functions retained by the public agency versus those contracted out. On one end of the continuum, an agency can contract out for foster boarding homes and continue to provide most of the case management themselves. Alternatively, a public agency might contract out all foster care services in a region to a lead agency, which then locates and coordinates services associated with the particular contract. This is how it is done in Kansas. In another model, the public agency can contract with a single lead agency to coordinate and procure most child welfare services from in-home to adoption services through a network of community providers and case manage these services. This is the model used in Florida where a lead agency is responsible for all children after the investigation determines the need for state custody. Regardless of its scope, typically, when a lead agency is used, it is required to coordinate all of the necessary care to the covered population. It manages subcontracts, delivers

⁶ This is in direct contrast to the growth and expansion of Medicaid managed health reforms which began by serving low needs families and have expanded to cover more individuals with greater, more costly service needs (Collins, 2004).

⁷ There are instances where the state child welfare system transfers investigation functions to another government agency, specifically law enforcement. In Florida, for example, the Sheriff’s office is responsible for conducting protective investigations in five counties. In Arkansas, the state trooper’s department has assumed responsibility for all hotline and child protective investigation functions (Snell, 2000).

or contracts for services, monitors subcontractor performance and manages resources (McCullough, 2003).

In their 2000-2001 Management, Finance, and Contracting Survey, McCullough and Schmitt (2003) found that the most common organizational structure for managed care models was the lead agency/network model where a public agency contracts with a lead agency which in turn creates a self sufficient service network by subcontracts and agreements. Networks build off of an old best practice concept in child welfare service delivery – that of creating seamless services for children and families that are community based. If this service delivery system is combined with a capitated rate, it falls within the managed care rubric. Networks can be horizontal, where similar types of providers collaborate together or vertical, where different types of providers collaborate. In either case, one central goal of the network is improved coordination of services as well as enhanced economic efficiency (McHugh, 2000). One possible drawback to these models of privatization involves the decentralization of service delivery and accountability. These “horizontal partnerships of coequals” can present certain challenges to both the public agency and the courts that are held ultimately accountable for decisions and outcomes (Kahn & Kamerman, 1999).

Ultimately, the effectiveness of privatization efforts depends on the quality of planning and implementation activities carried out by the public and private sectors (Nightingale & Pindus 1997, Freundlich & Gerstenzang, 2003). Planning must look carefully at not only program models, target population and payment structure, but also at the larger systems issues that plague the child welfare system – how will child welfare programs offer adequate social, health and mental health services and maintain reliable foster homes? How will programs recruit qualified staff and train them? How will programs reduce staff turnover? The following chapter focuses on lessons learned about reform planning and implementation in privatization efforts.

CHAPTER V

CROSS CUTTING THEMES IN PLANNING FOR AND MANAGING PRIVATIZATION EFFORTS

This chapter describes some of the major lessons learned by the field in planning for and implementing privatization efforts. It begins with a discussion of who should participate and what states should consider and decide prior to undertaking reforms. The remainder of this chapter explores some of these themes in more detail namely: the role of the public and private providers in case decision making, contract payment systems, performance measures and contract monitoring.

1. Planning for Privatization Efforts

The process of program planning and design should be iterative. It takes place when privatization efforts are first being considered, again when decisions have been made to implement reforms and again, repeatedly, as the system is re-examined, fine tuned and restructured. This section describes some of the lessons learned by the field about who should be invited to the table, and the decisions that should be made before launching privatization efforts.

a. Who Should be Involved

It is widely suggested that the first step in planning privatization efforts is to pull together a broad group of key stakeholders and reach consensus on a shared vision for the child welfare system (Kahn & Kamerman, 1999; McCullough, 2003, McEwen, 2006). Whether a state – or a community has committed to contracting out some or all of its services, or is still in the exploratory phase and is looking at privatization as a potential tool, the best practice literature recommends an inclusive planning process. Further, once the decision is made to proceed, there should be commitment from the leadership of both the public and private sectors to initiate and sustain efforts.

To varying degrees, those encouraged to participate in initial discussions include:

- The service provider community that would be affected and would be involved in bidding and ultimately delivering target services;
- Representatives of all levels of the public agency (caseworkers, supervisors, managers and top administration);
- Juvenile and family court judges;
- Parents of children who depend on the services;
- Monitors of court negotiated agreements or implementation of court decisions;
- Unions of employee organizations or their professional organization;
- Members of the state legislature and legislative committees;
- County commissioners;

- Auditors; and
- The broader service community e.g. mental health and substance abuse providers.

If all of the above players are invited to participate in planning, and consensus is reached on the core components, the initiative will at a minimum have “insurance against missing important issues and considerations” (Kahn & Kamerman, 1999).

Two studies on privatization in Kansas (James Bell Associates, 2001; Figgs and Ashlock, 2001) underscore the importance of inclusive planning. Many key stakeholders were not involved in planning and design efforts and studies have found that because of this, they did not understand key components of the new program model. After implementation, key stakeholders, including the courts, were unclear about the roles and responsibilities of the public and private agencies. Figgs and Ashlock (2001) found that without this initial buy-in and involvement, the courts, schools, and other local agencies did not trust that the private providers would deliver adequate services. Well into implementation, the private agencies had to conduct aggressive public relations campaigns to acquire the trust of the public, adding another stressor to the private providers.

Snell (2000) among others stresses the important role of the courts when changing service delivery models. The courts serve as a critical set of checks and balances to the child welfare system; they must be brought into the planning and ongoing oversight of state privatization efforts to ensure that judges feel confident in recommendations made about entering and exiting care. Inversely, prior to implementing privatization reforms, private agencies must be trained on the information needed by judges to help them make timely, safe and appropriate decisions about the children and families that come before them (Snell, 2000).

b. How Much Time is Required and What Should be Considered?

While there is broad consensus on the value of listening to a broad spectrum of stakeholders prior to launching efforts, there is less consensus about the amount of time needed to plan the reforms. Studies report that most states that have privatized services were under a great deal of pressure to plan and release RFPs (Kahn & Kamerman, 1999; Mahoney, 2000; U.S. DHHS, n.d.). When planning privatization efforts, several issues must be considered and thought through including:

- Program goals and desired outcomes based on baseline data and performance targets;
- The needs and service utilization patterns of the target population;
- Whether privatizing services will address the program goals better than the existing system;
- How new systems will interface with community services available to children and families without extensive waitlists and other barriers;
- Costs for all the services that make up the service array;
- Funding sources and community resources that support the needs of families;
- Contract risk arrangements and case rates based on actuarial data;
- Strategies to monitor contracts and hold agencies accountable;
- Roles and responsibilities of public and private agency case managers and administrators;
- Private agency qualifications (e.g. credentialing) and readiness (e.g. do agency staff have sufficient clinical expertise in working with families and communities);

- How case information will be efficiently transferred from the public to the private agency to avoid significant delays;
- Agency grievance and appeal processes; and
- If working with tribal children, roles and responsibilities of public and private agencies in matters of notification and service coordination between tribal child welfare systems and state systems.

One of the most widely reported obstacles in planning for privatization efforts is the lack of accurate data on costs, caseload trends, service utilization and outcomes in the current child welfare system. McCullough (2003) reports that often times states used “guesstimates” about actual costs and service patterns because the actual data was not available. This was especially the case on the use of external services outside of the child welfare system most commonly, mental health and substance abuse treatment. This information is critical to redesigning both program and fiscal models.

Due to unreliable administrative data on both caseload trends and costs, Kansas faced significant barriers to its privatization efforts because it was unable to establish a baseline for the pricing of foster care (James Bell Associates, 2001; Snell, 2000; Westat & Chapin Hall, 2002). This problem was confounded when all of the foster care cases that were already in the system were transferred to the new contractors and were mislabeled “new referrals” rather than identified as older, more deeply entrenched cases which would likely require more intensive and a longer duration of service delivery. Good data systems are important for successful management of any organization and critical for managed care models. Substantial software, hardware and training is needed to ensure that information technology is available and used for system implementation and improvement (Westat & Chapin Hall, 2002).

Another critical topic that must be carefully thought through and addressed is the preparation of appropriate contracts to specify service arrangements and outcome expectations. A 1997 GAO study (p.14) reported that:

“One of the most important and often most difficult tasks in privatizing government activities is writing clear contracts with specific goals against which contracts can be held accountable. Although some program officials told us that they had an ample number of staff who were experienced with these tasks, others said that they had an insufficient number of staff with the requisite skills to prepare and negotiate contracts. When contract requirements are vague, both the government and contractor are left uncertain as to what the contractor is expected to achieve.”

The remainder of this chapter will explore some of the issues listed above that must be considered and addressed in planning and implementation efforts.

2. Role of Public and Private Provider in Key Decisions

Clearly establishing roles and responsibilities of public and private agency workers is key to program success and has been one of the more complex activities faced by states and jurisdictions in implementing reforms (ORC Macro, 2003; Kansas Action for Kids, 2003; Figgs & Ashlock, 2001; U.S. DHHS, 2003). States have selected various models of case decision making and as with other elements of privatization, roles and responsibilities evolve over time. What seems critical is to be clear about expectations and responsibilities to ensure that key activities are

carried out, services and activities are not duplicated, and that all stakeholders, including families and children understand who they are working with and who to turn to for answers and assistance.

National studies have found that in most cases, states and localities that had privatized service had contracted the day-to-day management of care and service delivery for children and families (GAO, 2000; Westat & Chapin Hall, 2002; McCullough, 2003). States and localities had retained the child investigation and protection functions that officials believed to be critical to meeting their legal responsibility for the safety and well-being of children in the child welfare system. In many cases, the state or locality also retained authority for approving contractors' decisions related to reducing a child's level of care.

One important aspect of agency roles and responsibilities is the matter of preauthorization of services. Traditionally, private agencies engaged in fee-for-service contracts were generally required to get preauthorization for providing new services for the children and families in their care. In their study of 23 managed care initiatives in 22 states, Westat and Chapin Hall (2002) found that none of the programs surveyed used a formal process for attaining pre-approval before initiating these services. The study authors found that many of the managed care initiatives begun over the past decade have eased these restrictions and limitations and have in fact "empowered" private contractors to take more responsibility for their cases. Of the 22 states surveyed, three states continue to require some form of preauthorization (California, Connecticut and Oklahoma); however, in each case, pre-authorization was only required to meet federal Medicaid requirements for medical or mental health services, not as part of traditional reporting requirements in child welfare case management (Westat & Chapin Hall, 2002).

The Westat and Chapin Hall study also found a broad continuum of collaborative arrangements between public and private agency staff from states that only monitored outcomes to states that met regularly with private agency workers to consult on casework decisions.⁸ As shown by the following exhibit, the study authors divided the 22 states into four categories of collaboration.

- **Only Monitors Outcomes:** On one pole of the continuum, this group includes states where public agency case workers, for the most part, are not assigned to individual cases. Instead, state workers evaluate the aggregate performance of a contract based on pre-established performance measures.
- **Monitoring on a Case-Specific Basis:** In the second category, state workers monitor casework and participate in court appearances. The authors found that in the majority of states, due to legal reasons, state caseworkers appear in court even if they play a minimum role in case monitoring.
- **Monthly or Quarterly Reviews:** The third category involves states that hold regularly scheduled team meetings of the public and private agency workers to formulate case plans.
- **Frequent and Continuous Oversight:** The final group involves states where there is ongoing shared case management, such as weekly utilization review meetings where state and private agency staff discuss cases and outcomes (Westat & Chapin Hall, 2002).

⁸ The study authors note that there was no research collected at the state level to determine if child and family outcomes differ based on the degree and model of collaborative decision making (Westat & Chapin Hall, 2002).

Table 1
Degree of Public Agency Involvement in Ongoing Service Delivery⁹

Only Monitoring Outcomes Across Cases		Monitoring on a Case-Specific Basis	Monthly or Quarterly Reviews of Case Progress	Frequent or Continuous Oversight
Florida	New York	Connecticut	Arizona	Colorado
Illinois	Ohio	Georgia	California	Minnesota
Kansas	Oklahoma	Kentucky	Maryland	Pennsylvania
Michigan	Wisconsin	Texas	Massachusetts	Tennessee
Missouri				Washington

Several factors complicate establishing clear roles and responsibilities of public and private agency staff. One factor is that the field uses terms that are ill-defined, including “case management.” To some this is day-to-day care management, limited to service decisions. To others this includes primary responsibility for case planning including decisions about placements and visitation.

In a report published by the National Resource Center for Foster Care and Permanency Planning (NRCFCPP), the author explains that: “Federal law applicable to child welfare is silent as to whether the case management function can be privatized.” Instead, states are held “ultimately responsible for the placement and care of children in foster care and for all of the federal mandates under IV-E and other provisions of the Social Security Act.” While federal law is silent, some state laws prohibit privatization of certain child welfare functions and others do not (McHugh, 2000 p.13).

In their 2002 national study of child welfare privatization reforms, Westat and Chapin Hall offer an explanation of why decision-making and shared decision making in particular is difficult in child welfare. The researchers argue that unlike the medical model of managed care, in child welfare there is rarely a clear method for determining the most effective treatment. In child welfare, practitioners struggle over definitions of problems and needs and there is still relatively little concrete research on best practice and the correctness of decisions. In fact, there is evidence that there is considerable disagreement among experts in the field as to the correct decision in any particular case (Westat & Chapin Hall, 2002).

Another complication in child welfare decision making is that the caseworker, located in either the public or private agency is not the final decision maker in major decisions for children in state custody; this authority lies with the courts. This matter becomes particularly difficult for private agencies funded by case rates because judges have the right and authority to order additional services, refuse a recommendation to return a child home, and delay termination proceedings. In short, the private agency does not have final control over how it directs services and resources. This disconnect between the financial risk that private providers assume, and the actual control they have over casework will continue to challenge privatization efforts (Westat & Chapin Hall, 2002).

3. Contract Payment Systems Used for Privatized Services

There is currently a broad spectrum of contracting mechanisms in child welfare services. These range from at one end, “no-risk” purchase-of-service contracts where agencies are reimbursed for services, to higher risk capitated rate models or performance-based contracts where

⁹ Table adopted from: Westat & Chapin Hall Center for Children, **State Innovations in Child Welfare Financing**, April 2002, p32.

providers may only be paid after having achieved certain milestones. In both cases, full risk is shared with the private agencies. This said, it appears that currently no state uses a pure managed care financing model (Kahn & Kamerman, 1999).

Until recently, purchase-of-service (POS) or fee-for-service contracting were the dominant forms of contracting for child welfare services. Under purchase-of-service or fee-for-service arrangements, private agencies and the government contractor would agree on a rate for the delivery of a given service for specified types of clients and sometimes, for how long. The agencies agreed to bill at agreed upon times for services rendered. In essence, agencies were reimbursed for all allowable expenditures. One of the largest complaints about these contracts in child welfare services is that they can create perverse incentives that encourage providers to deliver certain services that are reimbursable or reimbursable at a higher level than other services (e.g. foster care versus in-home or reunification services). It has been argued that this payment approach does not encourage providers to control costs, or build a more suitable array of services as an alternative to placement or to more quickly return children home (GAO, 2000; McCullough, 2003; Kahn & Kamerman, 1999).

Beginning in the early 1990s, some child welfare professionals began advocating for the adoption of managed care financing and delivery models and many state child welfare systems began to explore these new strategies. Based on its national survey, by 1998, the Child Welfare League of America estimated that approximately 10 percent of the nation's child welfare population was being served by managed care programs (McCullough & Schmitt, 1999). These contracts often give providers greater flexibility and autonomy in determining how funds will be used to meet client needs.

Today, many states are working to implement some form of managed care contracts with private providers. McCullough and Schmitt (2003) found that 25 states were piloting managed care child welfare reforms. While some states have implemented managed care reforms, many more states have incorporated managed care strategies into their contracts. These include:

- prospective payments: where agencies are paid a pre-established rate prior to service delivery, to address all case needs;
- utilization management: this is generally accomplished by the use of clinical protocols or other decision support tools that help to match service needs with appropriate services and care; and
- service coordination and management by a lead provider.

Kahn and Kamerman observed that unlike companies that turn over full medical services to health maintenance organizations or insurance companies, child welfare agencies do not contract out for full case management responsibilities. Unlike the community health field discussed in Chapter III, in nearly all cases, the public agencies serve as the Managed Care Organization by providing the gate keeping and rate setting functions. Public agencies still investigate abuse and neglect, accept referrals, and most often, oversee case plans and represent the cases in court. In most cases, it is only the service provision that is fully relegated to the private provider (Kahn & Kamerman, 1999).

The 2000-2001 CWLA survey of managed care strategies demonstrates the wide variation between financing models in child welfare initiatives. The study authors found that the arrangements vary for the same initiative over time and between initiatives in the same state. The CWLA survey uses three categories of payment models which represent a continuum rather than distinct groups:

- 1) **Capitation:** This is a prepayment system that funds all contracted services for an entire, defined population on a monthly basis, generally based on an annual fixed fee. The rate remains fixed regardless of the number of children served and a new client does not generate new income. While giving providers' tremendous flexibility in the use of the funds. In this type of arrangement, the contractor is at risk for both the number of clients that enter the system as well as the intensity (level or amount) of services that they need. The study found that this model is used rarely because the lack of available administrative data discussed above makes estimating the true costs of care for an entire population of cases extremely difficult.¹⁰
- 2) **Case Rates:** Under this arrangement, the contractor is paid a set amount for each child that is referred to the contract. Because these payments are per child, the contractor is again at risk for the level of service needs or intensity, but not at risk for the numbers served. This was the most common form of contracting used in the CWLA's 1998 and 2000-2001 surveys. In many cases, these contracts specified goals to be achieved and divided the payments such that they were linked to attainment of various outcomes.
- 3) **Performance-Based Contracts:** These contracts specify expected levels of performance, most commonly in the way of service or client outcomes. In many cases, providers are paid and/or the payment amount is linked to specific outcomes or results. In these cases, contract agencies receive some or all of their payments only after they have achieved certain milestones (e.g. shortened length of stay, certain types of placements). McCullough found that performance contracting methods were even being used within more traditional fee-for-service contracts in the form of bonuses and penalties. The following section provides examples of performance standards and measures used within contracts.

Due to inherent risks of several funding mechanisms, states are increasingly using risk sharing methodologies in setting rates. Risk sharing refers to the procedures used to share financial risk between the public and private systems when service costs exceed the budgeted amounts. The 1999 CWLA survey found that 74 percent of states with privatization models were using risk sharing methodologies and by 2001, nearly 95 percent were designing risk-sharing payment systems (Freundlich & Gerstenzang, 2003).

a. Rate Setting and Risk Management

Rate setting in managed care arrangements has proved to be one of the biggest challenges in privatization efforts (Kretman, 2003; U.S. DHHS, 2003). Wulczyn and Orlebeke (1998) define rate setting as "the specific policy and contractual agreements that determine the amount of operating revenue a provider could expect to receive, including the use of prospective payments" (p. 3). There are three factors that drive financial risk of contract providers:

- intensity (the level and/or costliness of services),
- duration (the length of time that the service must be provided to achieve its objective) and
- volume (the number of clients who must be served).

To establish accurate case rates, states must have reliable information about the size and service needs of the target population, the costs of services to be funded, and projected utilization

¹⁰ Some states such as Kansas and Michigan have moved away from the use of capitated rates and now rely on case rates (Snell, 2000; U.S. DHHS, 2003).

of these services. While this information is critical to establishing fair and reasonable rates, this information is in most cases poor (Westat & Chapin Hall 2002).

The Westat and Chapin Hall study found that in setting rates, states use a combination of some historical cost data for the services and target population and sometimes the geographic area served. Because it is rare for states to have accurate cost data, once costs have been estimated, some states agencies negotiate further with the private providers to come to an agreed upon cost of care. Other states automatically increased the payment rate by some percentage to take into account the possibility that rate-setting methods underestimate cost (Westat & Chapin Hall, 2002).

b. Mechanisms for Limiting Private Agency Risk

Within all contracting arrangements, other than basic fee-for-service contracts, private providers take on a certain amount of financial risk. On one end of the continuum, the contractor absorbs all losses related to costs above those estimated in the rate setting agreement. Depending on the nature of the contract, these additional costs can involve serving more cases, providing more services, providing more expensive services and/or providing services for a longer period than originally estimated.

Risk sharing can be done by establishing risk pools where contractors can pull down funds if needed, based on agreed upon formulas. This is the case in Florida where additional funding is available if the number of children entering care is over 5 percent of the original estimate. Other states have created contracts that use a stop-loss provision. In these cases, there is predetermined floor to the level of loss for which the contractor is liable (Westat & Chapin Hall, 2002).

There are also ways to regulate or control risks. For instance, to regulate volume, a contract can specify the number of children the provider will serve. To regulate intensity, a contract can specify the kinds of children or families that it will serve and the nature of services provided. However, many contracts now contain a “no-reject, no eject” clause which prohibits the refusal of clients without state approval (Freundlich & Gerstenzang, 2003). This exposes the contractor to greater risk for costs associated with both volume and duration.

c. Blended Funding and Case Rates

There are many examples of sites that have blended funds across systems, redirecting dollars used for residential, acute care to programs that develop community based, wraparound services for children with multiple needs either in or at risk of out-of-home placement. These initiatives have reshaped or re-directed funding to support program goals.¹¹

d. Incentives, Bonuses and Penalties

Finally, many states are turning to the use of incentives, bonuses and penalties as part of their payment structure. This is a relatively simple way to reward good, or penalize bad performance. In the 2000-2001 CWLA survey, McCullough and Schmitt (2003) found that 25 percent of the managed care initiatives studied had incorporated some form of incentives program into their financing model.

One of the states with the longest history in this area is Michigan which has long relied on private agencies to locate adoptive homes and place foster children. Until 1992, its reimbursed

¹¹ For examples of these program models look at the Dawn Project in Indiana and the Kinship Center in Monterey, California profiled in *Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems--Making Interagency Initiatives Work for Children and Families in the Child Welfare System*, from the National Technical Assistance Center for Children's Mental Health (McCarthy & McCullough, 2003).

providers for actual expenses. In 1992 it began an incentives program that rewarded agencies different payments based on the special needs of the child placed and the speed with which they made the placement. For instance, agencies that successfully placed children in an adoptive home directly out of an institutional setting were reimbursed at the highest level (\$10,000 in 2000). Agencies that placed a child within 5 months of termination were awarded higher rates than those that placed the child within nine months (Snell, 2000). Michigan would later use this experience with performance based contracting and incentives to develop its Foster Care Permanency Initiative in Wayne County.

In conclusion, states and jurisdictions have many choices to make when it comes to designing contracts and financing mechanisms. In an issue paper prepared for the state of Iowa as they consider privatization reforms, McCullough describes what is known and not known about the impact of different contracting mechanisms:

“Every child welfare initiative 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. There is little in the way of comparative analysis of risk based initiatives with different structural designs to indicate that a private model is superior to a public one or that lead agency contracts are preferable to contracts with individual service providers. Likewise, because initiatives have varied in so many ways, it is not possible to state that case rates are better or worse than lower risk performance-based contracts in meeting fiscal and programmatic objectives. It is important, however, that the state fully understands the pros and cons of each type of risk-based option and the potential opportunities afforded by different structural designs before making decisions” (McCullough , 2003 p.24).

4. Performance Standards and Measures

Increasingly, states are using performance measures to direct providers to achieve certain outcomes (Martin, 2000). As with other components of privatization efforts, states vary widely in how they utilize performance on these measures. While many states base contract renewal decisions on agency performance, other states have adopted performance-based contracts (discussed above) which directly link payment (or components of payment) to achievement of specified measures.

In its most general sense, performance contracting clarifies or spells out the desired results for contractors. Not surprisingly, studies have found that the most frequently used outcome measures in child welfare contracts involve child safety, permanency and well-being. Within each of these broad outcomes, states use a range of indicators and standards to measure success.

In addition to traditional child welfare outcomes, many initiatives are adopting some features of managed care performance indicators, including the collection of customer satisfaction data and access to services. One study found that among those initiatives studied: 88 percent measured indicators of child safety, 79 percent measured recidivism or re-entry standards; and 71 percent measured indicators of permanence within certain timeframes. About two thirds of the initiatives measured client satisfaction and child functioning outcomes (Collins, 2004).

In its national survey of 27 child welfare managed care sites, the GAO (2000) found that the following outcomes and measures to be most common.

Table 2
Examples of Child and Family Outcome Measures

Category	Outcome	Measure
Safety	Children are safe from maltreatment	<ul style="list-style-type: none"> • Confirmed reports of abuse and neglect in the general population • Recurrence of abuse or neglect while children are receiving in-home services • Reports of abuse or neglect while the children are in out-of-home care • Recurrence of physical abuse, sexual abuse, or neglect after children have left care
Permanency	Children are placed in a permanent home in a timely manner	<ul style="list-style-type: none"> • Children who are returned to their parents or relatives within a specified time • Finalized adoptions • Children who achieve permanency within a specified time • Average length of stay in out-of-home care • Children who are maintained in their home and do not enter out-of-home care
	Children maintain the permanent placement	<ul style="list-style-type: none"> • Children who reenter care within a specified time
Well-being	Children function adequately in their families and communities	<ul style="list-style-type: none"> • Children's emotional and behavior crises that result in hospital use or police calls • Children's behaviors related to sexual misconduct, running away, and suicide • Children's scores on standardized tests of childhood functioning • Children's movement to less restrictive placement settings

General Accounting Office (2000), **Child Welfare: New Financing and Service Strategies Hold Promise, but Effects Unknown**

Many states have developed contracts that include both performance measures and performance standards that contractors must meet to re-compete for contracts. Kansas is a state that has adopted an extensive list of performance measures.

Performances standards in Kansas (Mahoney, 2000, 72-74):

Family Preservation

- 97% of all families referred shall be engaged in the treatment process.
- 90% of families will not have a substantiated abuse or neglect report during program participation.
- 80% of families successfully completing the program (no child removed from the home) will have no substantiated reports of abuse or neglect within six months of case closure.
- 80% of families will not have a child placed outside the home during program participation.
- 80% of families successfully completing the program (no children removed from the home) will not have a child placed outside the home within six months of case closure.
- Participants (parents and youth ages 14-21) living in the home will report 80% satisfaction as measured by the Client Satisfaction with SRS Service Survey 30 days from the start of the program.

Foster Care

- 98% of children in the care and supervision of the contractor will not experience substantiated abuse/neglect while in placement.
- 80% of children will not experience substantiated abuse/neglect within 12 months of reintegration.
- 70% of children referred to the contractor will have no more than three moves subsequent to referral.
- 70% of all children will be placed with at least one sibling.
- 70% of children referred are placed within their home county or contiguous county.
- 75% of youth, 16 and over, released from custody will have completed high school, obtained a graduate equivalency diploma or are participating in an educational or job training program.
- 40% of children placed in out-of-home care are returned to the family, achieve permanency or are referred for adoption within six months of referral to contractor.
- 80% of children who are reintegrated do not re-enter out-of-home placement within one year of reintegration.
- 65% of children placed in out-of-home care are returned to the family, achieve permanency or are referred for adoption within 12 months of referral to contractor.
- Participants (parents and youth age 16-21 years) will report 80% of satisfaction as measured by the Client Satisfaction with Family Reunification Services Survey 180 days after referral or at case closure.

Adoption

- 55% of children will be placed with adoptive families within 180 days of the referral for adoption.
- 70% of children will be placed within adoptive families within 365 days of the receipt of the referral for adoption.
- 90% of adoptive placements shall be finalized within 12 months.
- 90% of adoptive children shall continue to have adoptive parents as their legal guardians 18 months after finalization.
- 90% of families (parents and youth age 14 and older living in the home) shall report satisfaction with the adoption processes at the time the adoption is finalized.
- 65% of children will be placed with at least one sibling.
- 90% of all children placed for adoption shall experience no more than two moves from the point in time parental rights are terminated until the adoption is finalized.
- 95% of children in the care and supervision of the contractor will not experience confirmed

In Kansas, performance on these measures is used as one factor to determine if contracts are renewed. Other states, including Michigan's adoption program described above, have implemented performance-based contracts that directly reward or penalize performance on select measures.

Illinois offers another example of performance contracting. In 1997, Illinois had approximately 51,000 children in out-of-home care. Anticipating the impact of the upcoming federal **Adoption and Safe Families Act**, the state sought a new way to deliver services that directly rewarded performance on key permanency outcomes. First piloted in Cook County (Chicago), agencies under the new performance based contracts were required to accept a certain percentage of their caseload in new referrals, and move a certain percentage to permanency each year. By exceeding the permanency expectations, an agency could secure caseload reductions without a loss in revenue. Falling short of the permanency goals meant serving more children without an increase in payment.

The new state system also involved investing more in services that support permanency, including reunification/after care services and therapeutic services (O'Brien, 2005). In conjunction with the new contracting model, the state implemented a new risk assessment protocol, redefined relative placements and implemented an extended family support program.

By 2006, Illinois' foster care caseload had fallen to 18,000, or by 65 percent. The number of private agencies delivering services also declined because of the reduced number of children in care. Blackstone, Buck & Hakim (2004) found that the state retains better performing agencies and eliminates ineffective ones based on agency performance data.

The National Child Welfare Resource Center for Organizational Improvement (NCWRCOI) has tracked several child welfare performance-based contracting initiatives and provides the following suggestions about contract oversight and management of performance based contracting (O'Brien, 2005):

- **Expect to change and adjust contracts over time:** They suggest that once agencies and providers decide on some mutual outcomes and indicators and the performance they would like to see on these, conduct a sample data run to ensure the information is available and is measuring what was intended. "Similarly, if sites want to try performance-based payments, there should be a 'hold harmless' period in which the new payment scheme is tried and monitored jointly by the agency and providers. Constant communication between the agency and providers and continual adjustments to contract provisions are a feature of all enduring outcomes focused contracts in child welfare" (p. 1).
- **"Planning with contractors:** All efforts to develop performance based contracts (PBCs) that have had some success have involved extensive collaboration with providers. Agencies need to meet regularly with contractors and genuinely engage them in a planning process. This should include all the critical steps in a planning process – looking at what each party's outcomes/goals are, looking jointly at information and data on where performance is at the moment, discussing the barriers and steps that could be taken to make improvements, developing a mutually agreed upon plan for how to make improvements, and working together over time to review progress and make adjustments" (p. 1).
- **"Focus on data:** A major obstacle to outcomes focused contracting is the poor quality of data on performance in child welfare, and difficulties in defining data indicators, data

sources and reporting methods that are seen as reliable and valid by both agencies and providers. It is critical to talk about this issue at the very beginning of negotiations with providers, to understand that it will be difficult, and to expect to invest significant resources (of both time and money) into developing good data to guide negotiations on assessing current performance and planning for improvements” (p. 1).

- **“Realize that contractor’s ability to perform will be limited by barriers to performance in the larger child welfare system.** An agency working to ensure that contractors are focused on outcomes needs to realize that their ability to achieve outcomes will be impacted by barriers to performance in systems that are not directly in their control. For contractors to perform well on outcomes over time the barriers to improved performance in the system as a whole must be addressed” (p. 2).

While performance on select measures is not always tied to payments, McCullough found that between her 1998 and 2000-2001 national surveys, over 90 percent of the initiatives had made changes in their financing or contracting practices to create incentives for performance. Most initiatives used more than one mechanism to align payment with desired results, e.g. bonuses, incentives, penalties, and/or payment structure (McCullough, 2003).

5. Contract Monitoring

As contract arrangements between the public and private systems continue to evolve, so does the manner in which these contracts are monitored. Contract monitoring should assess compliance with statutes, regulations and the specific terms of the contract agreement. It should evaluate the contractor’s performance in delivering services, achieving program goals and avoiding unintended results. While a critical component of any privatization effort, a 1997 GAO study found that monitoring contractors’ performance “was the weakest link in the privatization process” (p.14).

As a result of continued concern about whether states were adequately monitoring contract services within Congress and the Federal Office of Management and Budget, in 2004, the U.S. DHHS Office of the Inspector General (OIG) assessed six states’ compliance with federal grants management requirements (specifically, 45 CFR Part 74). These requirements direct states in how they should ensure that “subgrantees” (or private providers) comply with federal program and fiscal regulations, use funds appropriately and achieve performance goals.

The OIG found that while in all six states, state officials conduct on-site visits to monitor contractors, in three of these states, monitoring mechanisms were not implemented as planned. Planned visits did not take place at all or did not take place as scheduled. Further, in all six sites, fiscal monitoring was found to be “minimal;” states most often relied on a single independent audit. In noting that all six states were using case rates to fund providers, a system that reimburses contractors for the number of children served rather than the cost of their care, the OIG recommended that states increase the amount of monitoring that they do in order to ensure that children and families are getting quality services and that they are not receiving inadequate care due to insufficient agency payments (U.S. DHHS OIG, 2004).

Traditionally, contracts specified process measures -- who and how many should be served and day-to-day operations of the program. They measured outputs (number of children or families served or number of hours spent on families) rather than service quality and results (the impact of services). As discussed, increasingly, as contracts are written to include performance measures,

private agencies are tying agency performance to payment mechanisms and payment schedules. Contracts are being monitored, and in many cases, rewarded on child and family outcomes in addition to their compliance with process or practice standards.

Westat and Chapin Hall (2002) found that among the 22 states it studied, the two most common forms of contract monitoring were the use of collaborative case reviews and analysis of management information systems. Case reviews can take the forms of ongoing collaborative decision making meetings or periodic case reviews where public agency staff look over a sample of cases to examine service provision and costs. Discussions are held between public and private agency staff about service quality, patterns of expenditures and permanency plans. Other states are increasingly relying on management information systems to monitor services. For instance, New York had implemented a new interactive system that allows the public agency to tie reimbursement to child outcomes (Westat & Chapin Hall, 2002).

States continue to refine their monitoring and quality assurance systems, even those that have extensive efforts in place. For instance, Florida provides broad oversight to its network of community based grantees including:

- Annual monitoring by the Contract Oversight Unit that can last up to three weeks per site;
- Monthly monitoring by contract managers who review spending plans, invoices, staffing reports and performance;
- Two annual Child Welfare Quality Assurance reviews that involve sample case file reviews to assess administrative and personnel matters;
- An annual independent audit performed by a licensed CPA to review financial states, compliance with federal and state requirements;
- Analysis of administrative data generated by the state's MIS (Homesafenet) on client outcomes; and
- Each lead agency must undergo an on site accreditation process conducted by a national organization. (Florida Tax Watch, 2006)

While extensive, upon review of the current system, the state's Office of Program Policy Analysis and Government Accountability found there to be several quality control issues. These problems included:

- quality and consistency of site reviews;
- the State's MIS (Homesafenet) was not recording several performance measure so the Department could not adequately monitor providers;
- insufficient training for contract monitors (in part due to high turnover among staff); and
- Inconsistent data collection measures used by lead agencies of their subcontractors (Florida Legislature OPPGA, 2006)

The monitoring of large scale privatization efforts requires sophisticated MIS and contract monitoring abilities. The data collection and data management requirements for monitoring these contracts require sophistication, large scale investment in computers, software and training on both the side of the public and private sectors (Embry et al., 2000). As discussed throughout this report, this is an area where states continue to struggle.

6. Issues Affecting Native American Children and Families within Privatized Systems

As sovereign nations, tribes have responsibility for providing child welfare services to tribal children and families living on the reservations in conjunction with tribal courts or other governing entities. Tribes make key decisions such as substantiating abuse or neglect allegations, removing or returning children, and terminating parental rights.¹² Additionally, the Indian Child Welfare Act (ICWA) of 1978 gave tribes dual jurisdiction for children off of the reservation and established procedures for tribal notification and other activities for tribal children and families residing off tribal lands. Mannes (1993) found that since ICWA was passed, tribal child welfare agencies may have focused on monitoring state agency compliance with ICWA provisions to the detriment of developing their own preventive and supportive services for children and families.

ICWA impacts privatization efforts in two distinct ways. First, privatization efforts of child welfare services within state systems must plan how (and who) will interface with tribes when a Native American child comes into custody. Private agencies will need to be fully informed about intergovernmental relations, and the specific regulations governing the identification, care and supervision of Native children.

The second matter involves the tribe's own capacity to contract and monitor services delivered by private agencies. In its 2004 study on the use of Promoting Safe and Stable Families (PSSF or Title IV-B subpart 2) funds by tribes, James Bell Associates found "tribes were limited in their ability to evaluate and monitor the PSSF services developed. Staff dedicated to providing direct services, and resources for evaluation were generally not available" (p. ix). The authors note that some tribes were more sophisticated than others with contracting procedures and much could be learned and shared across tribes.

The next chapter presents research designs and findings from a small number of outcome studies conducted on child welfare privatization reforms. It then discusses challenges in conducting rigorous evaluations of privatization efforts.

¹² For a more detailed description of the many laws, statutes and funding streams that support and direct services, see **Implementation of Promoting Safe and Stable Families by American Indian Tribes: Final Report – Volume 1**, James Bell Associates, 2004.

CHAPTER VI

OUTCOME EVALUATIONS: FINDINGS, CHALLENGES AND RECOMMENDATIONS

1. Introduction

As an increasing number of states and localities turn to private providers for the delivery of child welfare services and, in some cases, for greater responsibilities associated with case planning and decision-making, they do so without solid evidence of the impact of privatization on child and family outcomes. Due to this, states and communities have begun to focus attention on the need for rigorous, outcome-focused research on the impacts of privatizing child welfare services. Unfortunately, few jurisdictions have the capacity to conduct such evaluations. In particular, how do the outcomes of children and families served by the private sector differ from those served by the public sector? This chapter will identify the current state of evaluation of child welfare privatization and describe challenges in conducting methodologically sound evaluations of privatization models.

In order to examine the current state of evaluation on the privatization of child welfare services, we conducted a review of rigorous, external evaluations that have assessed child welfare privatization efforts around the country. Various sources were utilized such as the Child Welfare Information Gateway¹³, the QIC PCW National Advisory Board members, the Children's Bureau website, state websites, child welfare research websites, and reviews of scholarly child welfare journals. In this process, we identified evaluations of Title IV-E Waiver Demonstration Projects, small pilot initiatives, and large-scale privatization efforts.

In conducting this review, we found that evaluations of child welfare privatization models have focused mainly on describing program models and assessing process outcomes. In particular, many evaluations have focused on describing the implementation of public-private partnerships, decision-making responsibilities, contracting mechanisms, and service delivery as described throughout this report. However, there have been very few empirical studies of privatization which assess child and family outcomes. For the purpose of this chapter, we only considered evaluations that compared child-level outcomes related to safety, permanency, and well-being for children served by public welfare agencies compared to children served by private agencies.

2. Overview of the current state of evaluation of child welfare privatization

Following is a description of the six evaluations reviewed along with the major child-level findings.

a. Florida's Community-Based Care (CBC) Initiative.

In 1999, as part of Florida's CBC initiative, Florida expanded their privatization of the child welfare system by implementing community-based systems of care where private-non-profit agencies served as lead agencies in each county, responsible for overall case management of all child welfare cases. The state also implemented an external evaluation of the privatization of their

¹³ Formerly, the National Clearinghouse on Child Abuse and Neglect

child welfare system to assess both process findings and outcomes. Using a quasi-experimental cohort design, CBC counties were compared to counties that had not yet implemented CBC, which were referred to as 'rest of state' (ROS). Baseline data for the CBC counties were also collected. The six indicators used to assess outcomes were a) the proportion of children exiting out-of-home care; b) rates of reentry into out-of-home care; c) rates of recurrence of maltreatment; d) rates of reunification with parents; e) rates of custodial placement with relatives; f) and the proportion of children with finalized adoption.

The evaluation found that there was great variability in the performance of counties that had implemented the CBC program. Evaluators noted that this variability may be a reflection of the different stages of implementation experienced by the CBC counties. Specifically, the evaluators reported that Sarasota and Manatee Counties, which had experienced the CBC program for the longest time, performed well on achieving permanency compared to the rest of the state (ROS). Sarasota and Manatee counties also performed better or the same as the ROS counties on the percentage of children who reentered care, as well as for children who had adoptions finalized. However, evaluators noted that findings should be interpreted with caution due to a switch in the administrative data source during the evaluation timeframe. Evaluators also noted that there was insufficient evidence to draw conclusions regarding the effectiveness of the CBC model due to varying levels of program maturity throughout the CBC counties (Paulson et al., 2003).

b. Connecticut's Title IV-E Waiver Demonstration project

In 1999, Connecticut implemented a demonstration project to test whether providing community agencies with case rate payments to organize and manage a comprehensive continuum of services for children ages 7-15 who had serious emotional disturbances (SED) and were approved for residential out-of-home placement, would result in improvements in child well-being and decreased lengths of stay in restrictive placements. The evaluation was an experimental design with children randomly assigned to either demonstration or non-demonstration sites.

The evaluation concluded that all children, whether they received services at a demonstration or non-demonstration site, progressed in the three outcome domains (reduction in symptoms, decreases in the level of functional impairment, and increases in strengths) over the first 12 months (ORC MACRO, 2003, iv). However, the demonstration agencies were able to move a higher percentage of children to in-home placement settings and reduced the length of stay in restrictive settings (ORC MACRO, 2003). The project ended early due to a statewide roll-out of a new comprehensive children's behavioral health system.

c. Michigan's Title IV-E Waiver Demonstration Project

In 1999, Michigan implemented a demonstration project to test two policy innovations: 1) the use of community-based "wraparound" services for Title IV-E eligible families; and 2) a managed care model that replaced targeted fee-for-service funding for out-of-home placements and other services with case rate payments. The demonstration initially targeted children ages 0 to 18 who were in out-of-home care or were determined to be at imminent risk for placement. However, in 2001, the state decided to exclude children who were at imminent risk of placement and focus only on children in out-of-home care. The main purpose of the study was to test the effectiveness of using a managed care model for the provision of foster care services. An experimental design was used, and children were randomly assigned to treatment and control groups.

The evaluation found that there were no statistically significant differences between both groups on all of the outcome measures (the likelihood of out-of-home placement; the average length of time in out-of-home placement; the average number of placement episodes; rates of substantiated maltreatment; and exits to permanency) (U.S. DHHS, 2003). Evaluators noted that there was not a clear distinction in services provided to the treatment and control groups because “wraparound services” was already the prevailing service model in many Michigan counties prior to the implementation of the IV-E Waiver Demonstration project. The lack of distinction in treatment models reduced the likelihood of observing differences in child welfare outcomes for the treatment and control groups.

d. Kellogg Foundation Kansas Families for Kids (KFFK) Program and Privatized Managed Care

In 1995, the Kellogg Foundation funded Kansas Families for Kids (KFFK), a 3 year reform that aimed to reduce the backlog of children in state custody who were in need of permanent placements by increasing public awareness and conducting education activities. One year following the implementation of this program, The Kansas Department of Social Services began planning the privatization of family preservation, foster care and adoption services. A major feature of the privatized system was the contracting out of services using a capitated rate for each family and child served.

The current evaluation assessed adoption trends with a quasi-experimental design using three cohorts: 1) children who became registered for adoption prior to the implementation of the KFFK initiative; 2) children who became registered for adoption after the KFFK initiative, but before the implementation of the privatized model; and 3) children who became registered for adoption after the implementation of privatization. The outcome variable of interest was the number of adoption service days (time between becoming available for adoption and the adoptive placement if there was one).

The evaluation found that significant improvements were made under the KFFK initiative and were maintained by the privatized managed care system. The evaluation concluded that children were twice as likely to be adopted after the implementation of both initiatives than they were under the previous state operated system (McDonald et al., 2000). However, the evaluators note that these changes took place after the implementation of the KFFK initiative and were simply maintained under a privatized model.

e. Milwaukee Foster Care Program

This evaluation conducted in Milwaukee, Wisconsin, assessed the likelihood of obtaining a permanent placement for children placed in out-of-home care based on origin of the worker (public or private); the type of non-profit (younger, community-based agencies or older, financially secured traditional agencies); and type of out-of-home placement. The evaluation used a cohort design tracking children that experienced a first time out-of-home placement during 1994. The observation period ended in December 1997.

Overall, the study found that private foster care was associated with less permanent placements for children removed from their homes. The study also found that the public agency moved children to permanent placements more rapidly than the private agencies, with no occurrence of a high rate of inappropriate family reunification. However, when older and newer private agencies were compared, newer private agencies achieved permanency at a rate comparable with the public agency rate (Zullo, 2002).

f. Kansas' Topeka, Shawnee County Child Welfare Pilot Project: Prevention, Protection, and Preservation Program Evaluation

In 2004, after privatizing the majority of its child welfare services, Kansas sought to further reform its case management and monitoring practices. Kansas implemented a pilot initiative in one of its five regions which ended case-by-case monitoring and supportive case management provided by public agency workers and shifted these responsibilities to the private agency. The initiative also gave the private agency more authority in overseeing the cases such as directly working with the courts. An evaluation of this pilot was conducted using a quasi-experimental pre-post design. A historical comparison group was created using outcome data from two years prior to the implementation of the pilot initiative. Outcome measures included time to permanency and re-entry into foster care.

The evaluation reported that although children achieved permanency more quickly during the pilot initiative than they did prior to the initiative, these findings were not significant. When using entry cohort data the findings did not indicate an increased number of children achieving permanency within six months; findings did indicate a significant increase in the number of children achieving permanency within 12 months pre and post the pilot initiative. The evaluators also found that the re-entry rate into foster care remained low during the pilot year with a rate of 5.3% compared to the reentry rate of 4.8% from the year before, and 16.9% from two years prior (Moore & Akin, 2005).

Almost all of the evaluations assessed privatized models which provided foster care and/or adoption services to all children in out-of-home placements. In terms of target population, only the evaluation of Connecticut's Title IV-E Waiver Demonstration project evaluated a privatized model which served a subset of children in the child welfare system (children ages 7-15 with serious emotional disturbances who were approved for residential out-of-home placement). In terms of privatized services, only the evaluation of Florida's Community-Based Care Initiative assessed the privatization of broader child welfare services including case management.

Finally, almost all of the evaluations compared outcomes for children served by the private sector with those served by the public sector. The evaluation of Kansas' Topeka, Shawnee County Child Welfare Pilot Project did not make comparisons between the public and private systems, but instead focused assessing the impact of an additional component to the state's already privatized system.

The variability and contextual differences of the privatization models described here, coupled with the limited number of evaluations included in this review, impeded our ability to synthesize outcomes, generalize findings, or draw any conclusions regarding the impact of privatization on children and families served by the child welfare system.

3. Challenges for the Evaluation of Privatization of Child Welfare Services

This review of the evaluation literature unveils several common challenges associated with conducting research on the effectiveness of privatizing child welfare services. These include the following:

Length of time needed to fully implement and evaluate client-level change. The implementation of privatization models takes considerable time, which makes it challenging to assess child and family-level outcomes unless there is an extended evaluation period. Before change can be impacted at the child and family level, there must first be systems-level change, which requires substantial time for implementation. If an outcome evaluation takes place before systems-level change is able to occur, child-level outcomes may be assessed prematurely. As

noted above, the evaluation of Florida's Community-Based Care (CBC) found that there was great variability in the performance of counties which had implemented the CBC program. Specifically, the evaluators reported that Sarasota and Manatee Counties, which had experienced the CBC program for the longest time, performed well on achieving permanency, finalized adoptions, and percentage of children who re-entered care compared to the rest of the state (ROS). The evaluators further noted that the CBC program was fully operational in Sarasota County in June 1997 and that only Sarasota and Manatee counties had been operational for more than two years during the evaluation period because data were collected from FY 2001-2002. These findings underscore the challenge associated with evaluating a program model that takes many years to be fully implemented. Since typical evaluation timeframes range from 3 to 5 years, many evaluations are not long enough to capture both systems-level changes and the subsequent family and child-level changes that are expected.

Also, some initiatives end before they can reach full implementation due to budget cuts, unexpected shifts in the target population, shifts in the prioritization for reform, or the introduction of new or competing reforms.

For example, Connecticut's Title IV-E Waiver Demonstration project ended early due to a statewide rollout of their redesigned children's behavioral health system. As a result, few conclusions could be drawn on the effectiveness of a managed care system in serving high-need children within the child welfare system.

Variability in privatization models limits ability to make appropriate comparisons and draw conclusions. Some privatization models involve the privatization of a certain set of services such as family preservation or foster care services for all children, while other models target a sub-set of the child welfare population and provide all services, including case management for this sub-set. For instance, Connecticut's Title IV-E Waiver Demonstration Program targeted children in need of residential mental health services, while Kansas and Florida privatized a certain set of child welfare services for all children. As well, approaches and models of privatization are implemented to meet local needs, resulting in even greater variability among privatization models. This variability makes it challenging to compare privatization models or identify replicable privatization models or components, synthesize outcomes across privatization studies, or draw conclusions about the effectiveness of privatization.

Availability and appropriateness of administrative data. As noted earlier in this literature review, it has been a challenge for many states to implement and maintain fully functioning management information systems (MIS). These systems are essential to evaluation because outcome data are typically collected from state child welfare data systems. Many times administrative data are limited, the quality of data is questionable, or there are shifts in the MIS during the course of the study which causes a challenge for collecting and interpreting outcome data. For example, Florida transitioned to its new State Automated Child Welfare Information System (SACWIS), HomeSafenet in 2001, four years after the first county had fully implemented CBC. Consequently, Florida's transition to HomeSafenet created challenges for the evaluation because outcome indicators were defined differently in the new system. Evaluators questioned the reliability of findings based on this data system change.

Lack of baseline data. The challenge of obtaining appropriate administrative data also impacts the availability of reliable baseline data. The lack of pre-privatization data available from state data systems impedes evaluators' ability to make comparisons between privatized and non-privatized systems. For example, the lack of baseline data in Kansas made it difficult to compare the performance of the new privatized system to the previous public system (Snell, 2000). Also, the incompatibility of the two MIS systems in Florida (HomeSafenet and the previous Client

Information System), made it difficult to compare child welfare outcomes under the previous public system to outcomes in privatized CBC counties based on the indicators that the evaluators initially developed.

Variability in the indicators used to measure outcomes. Data collection methodologies and research designs across evaluations demonstrate the lack of consistency in the ways in which researchers measure outcomes and define common outcome indicators making it difficult to draw conclusions about the effectiveness of child welfare privatization. Many of the decisions made regarding how an outcome will be measured are based on the availability of state administrative data (Yampolskaya, Paulson, Armstrong, Jordan, & Vargo, 2004). For example, some evaluations measure outcomes using entry cohorts, while other studies use exit cohort data. If an exit cohort is used to assess permanency, children are not counted until they exit the system, while an entry cohort tracks children entering the system during a specified timeframe and assesses whether they achieved permanency during the study's observation period. Other studies do not use cohort data at all and simply count all children in care during the study timeframe, regardless of when they entered or exited the system. The interpretation of outcome data is greatly impacted by the approach taken by evaluators.

Definitions of outcome indicators also vary across studies. For example, the assessment of child safety may be measured by yearly rates of substantiated abuse/neglect cases for children in out of home care, the absence of abuse or neglect during placement, or the recurrence of abuse.

In addition, the type of data used to assess outcomes varies across evaluations. For example, some studies assess outcomes using aggregated data, while others use disaggregated data. All of these variations limit the fields' ability to generalize data regarding child outcomes for children engaged in the child welfare system, regardless of whether they are served by a public or private agency.

Small sample sizes. Many pilot privatization initiatives are conducted in a single county or for a single service population. Evaluations conducted of these initiatives typically have small sample sizes which makes it challenging to obtain significant differences on comparisons or to generalize findings. For example, the evaluation of the pilot initiative conducted in Topeka, Kansas had small sample sizes and while the evaluators reported trends in the data, many pre-post differences were not significant.

Limited studies with random assignment. Evaluation designs with random assignment are the most rigorous of designs allowing for treatment interventions to be compared between equivalent groups. However, the random assignment of children and families engaged in the child welfare system is difficult to implement based on ethical, logistical, and resource constraints. Many program administrators are reluctant to randomly assign children to treatment and control groups, where better services may be anticipated for a particular group. It is also costly and time-intensive to implement a system for randomly assigning clients. As well, because multiple reforms are typically being implemented during the course of an evaluation, many times a control group becomes "tainted" by receiving services similar to those of the treatment group. For example, during Michigan's IV-E Waiver Demonstration project, the state was providing wraparound services in some counties similar to that being tested by the demonstration project. Families in both the treatment and control groups were exposed to this intervention, limiting the ability of evaluators to observe different child welfare outcomes in the waiver demonstration for treatment and control groups (U.S. DHHS, 2003). Finally, if preliminary outcomes indicate positive results for a treatment group, program and state administrators may call for the statewide roll-out of a reform before the evaluation period ends, thereby ending the ability of evaluators to continue randomly assign clients.

Isolating independent effects of privatization from multiple child welfare reforms. There are typically multiple reforms that are in effect at the same time in child welfare and other state systems which impact the delivery, availability, and costs of services for children and families engaged in the child welfare system. Consequently, it is difficult to assess which outcomes can be directly attributed to privatization. For example, the evaluation of the privatization of Kansas' family preservation, foster care, and adoption services was complicated by the implementation of the Kansas Families for Kids Initiative approximately one year prior to the privatized managed care system, with both systems operating simultaneously for two years.

CHAPTER VIII

CONCLUSION AND FUTURE STUDY

This literature review was completed as part of the national needs assessment for the Quality Improvement Center for the Privatization of Child Welfare Services (QIC PCW). It complements other efforts conducted for the needs assessment including informal discussions held with state child welfare administrators and three forums convened across the country involving public and private agency representatives from states with a range of experience with privatization reforms.

1. Major Themes

The public child welfare system has long relied on privately delivered services for the children and families in their care. The literature explains that over the past 15 years, with new fiscal and programmatic demands, many states and communities have placed a renewed emphasis on privatizing services. In particular, the field has focused on the experiences of a few states that have recently privatized major portions of their child welfare system, most notably Florida and Kansas.

These reforms have occurred against a backdrop of new performance standards established by the federal government in the areas of safety, permanency, and well-being. States are now required to submit data on their performance in these areas on a quarterly basis, participate in comprehensive Child and Family Services Reviews (CFSRs) and address identified deficiencies through the development of Program Improvement Plans (PIPs).

Results from the CFSRs confirm that few states are achieving timely permanency for children and all are struggling to meet several indicators of child and family well-being. CFSR results also underscore the chronic barriers and challenges states continue to face designing, delivering and monitoring services.

To improve outcomes, several states have expanded contracting efforts incorporating many lessons learned from managed care strategies. States are experimenting with contracts that use prospective payments that give providers more flexibility, utilization management that help to better match client needs with services and service coordination through a lead agency provider.

A second major development has been the use of performance-based contracts which can link payments to the achievement of certain outcomes or results. Outcomes are most often based on federal requirements of child safety, permanency and well-being but also can involve process measures such as increased access to community services and broader availability (and use) of foster homes rather than institutional settings. Borrowing from the managed care model, some contracts are also measuring performance on client satisfaction with service delivery and tracking costs of care over time.

During discussions with key informants for the QIC PCW project, several state administrators asked if there was any empirical evidence on the efficacy of child welfare privatization. The short answer is: very little. Only six outcome evaluations were identified that compared child-level outcomes achieved by the public versus new privatized systems. Among

these, program models and target populations vary too much to draw any generalizations about the efficacy of privatization.

One reason that it is difficult to generalize findings is that there is no single model of privatization; privatization (or contracting) is a mechanism for delivering services. Moreover, states are at different stages of privatizing case management and what is privatized, how service models are designed, who they target, how contracts are structured and monitored, is all driven by the needs, sophistication and resources available to a given community or state. At the same time, the field continues to evolve, learning and adapting to new needs, challenges, resources and program goals.

2. Lessons Learned and Recommendations from the Field

While there is little rigorous evaluation on the subject of privatization involving sound comparisons, the literature does provide information from case studies about lessons learned from the experience of states and communities to date. The following summarizes many of the recommendations about planning for and implementing privatization reforms, which together, may support smoother implementation of reforms.

- Clearly define the problems that need to be addressed in the current system and ensure that privatizing services can address these needs. Based on the experience of other states, initiating contracted services will likely be only one component of systems reform.
- When planning reforms, include a broad group of stakeholders that will be involved with implementation, or impacted by reforms, to develop a shared vision of the program, its goals, and structure. A key participant is the courts because judicial decisions can supersede public and private agencies and therefore play a significant role in the success or failure of contract performance.
- Ensure there is commitment from the leadership of both the public and private sectors to initiate and sustain privatization efforts.
- Clearly define and understand the target population to be served, their needs, service utilization patterns in both directly provided and community based services.
- Fully explore what is known about the costs of services by the target group and within the geographic region to be served.
- Because it has proved to be so difficult to accurately predict contract costs to provide services, consider any financial data that is generated in the early stages of implementation to be a general guide but not factual. States and communities are also learning more about risk sharing methodologies – means of compensating for the risk factors (case volume, service intensity and duration) that can lead to unanticipated costs of care.
- Select providers that have the needed experience to deliver the target services and will be able to hire and train sufficient numbers of professional staff. If a program goal is to utilize and strengthen community providers with less experience with the targeted services, ensure that they receive the level of support they need (technical and financial) to meet the contract obligations.
- Develop contracts with private providers that clearly define:
 - Target population;
 - Contract referral criteria and exit criteria;

- Services to be provided;
 - Roles and responsibilities of public and private agency workers in key case decisions (among these service referrals, changes in placement);
 - Contract performance and case outcome expectations; and
 - Incentives to meet program goals.
- Determine how clients will access community based services, how private providers will engage other services or form local service networks, develop subcontracts and share information and supervision of children and families.
 - Develop contract monitoring and evaluation procedures that will ensure that children and families are receiving timely and quality services and contract terms are being implemented.
 - Ensure that the public agency has sufficiently trained and experienced staff to conduct contract monitoring and management -- staff that understand both the substance of the services and the contracting process.
 - Ensure that the management information system used to track case progress and aggregate performance has the capacity to produce timely data and track information on service utilization, costs, client status and outcomes. Systems should be modified so that they can be accessed and used by both the public and private agencies to track contract performance in a timely manner.
 - Consider pooling funds from other than child welfare sources within contracts in order to expand the availability of services to clients more seamlessly.
 - Conduct ongoing management meetings where public and private agencies can problem-solve particular cases and/or structural barriers and participate in joint training.

3. What Information is Being Collected?

Published state reports and case studies include a range of information on program performance. The information can be grouped into four categories:

- Systems outcomes – examples of these include availability of community based services, accessibility to caseworkers, recruitment of foster parents;
- Case level data especially related to ASFA outcomes;
- Information on client satisfaction; and
- Cost data.

Much of the information on contract performance is from case studies using anecdotal information. While states and localities are collecting information and tracking progress on most initiatives, few use meaningful comparison data (GAO, 2000). The focus of research conducted by most states and jurisdictions is how well children and families are faring within the privatized system in place, rather than against an outside marker.

There continues to be limited information from rigorous evaluations about the performance of privatized models on systems and case level outcomes. Findings from studies that do compare public versus privately delivered services are mixed or are too limited to draw general conclusions.

One area that deserves noting is the matter of cost containment. National studies reviewed for this project suggest that, unlike the assumptions in the early literature that privatization would lead to efficiencies and cost savings, in most cases overall spending for projects has increased over previous levels due to a range of expenses including costs of monitoring and administering services (Freundlich and Gerstenzang, 2003; Kahn and Kamerman, 1999; GAO, 2000). Perhaps the most notable exception has been Illinois where state officials attribute the use of performance-based contracting in conjunction with concurrent planning, redefining relative placements as a permanency option and expanded funding for support services, to reducing the state's out-of-home caseload from 52,000 in 1997 to approximately 18,000 today. Part of the savings generated from these reductions has been re-invested back into the system to reduce worker caseloads and increase support services.

4. Opportunities for Future Study

There is broad consensus among those that have studied the field of privatization reforms that much more can be done in the way of assessing the implementation and impact of privatization efforts. Building on the literature, the QIC PCW has the following recommendations about future research efforts.

- ***Sites should commit to undertaking rigorous evaluation in conjunction with reform efforts.***

Comparisons can be made between:

- Publicly and privately operated systems;
 - Contracting arrangements (purchase-of-services, managed care and performance based contracts); and
 - Structural designs (lead agencies/network models versus simple publicly administered single service contracts).
-
- ***The field needs rigorous process and outcome studies.*** Process and outcome studies are equally important when undertaking an evaluation of a privatization model for child welfare services. Process studies are critical because local circumstances, implementation processes, and other contextual issues are key factors in whether or not privatization models lead to systems-level change, and consequently changes in child-level outcomes.
 - ***Work with MIS programmers to ensure quality data available for end users.*** The availability and reliability of MIS data is a key determinant to the data collection methodology, and, consequently the evaluation design. Evaluators need to work closely with state data administrators and programmers to ensure the availability of critical data elements. When data are not available, evaluators need to identify alternate data source early on to ensure that outcomes can be assessed.
 - ***Extended period for evaluation.*** Evaluators should allow for an extended period of time for the evaluation so that a full implementation study can be conducted. This will allow enough time for systems-level change to take place before evaluating the impact of privatization on child-level outcomes.

The literature reminds us that state child welfare systems have a long history of contracting for individual services. Today, a renewed emphasis on performance, results, and accountability at

both a federal and state levels has prompted many states to consider larger scale initiatives or the shifting of greater decision making authority to non-government entities. Yet little is known about the efficacy or cost of reforms as very few rigorous evaluations have been conducted.

The literature also underscores the fact that privatization is controversial and is frequently politicized. It is a complex and potentially difficult undertaking requiring close and careful attention to every stage of the process, from initial assessment of the relevance of reform, through planning, and implementation. Much has been learned already by those implementing efforts and much more can be done in the way of rigorously assessing performance, replicating strong models and promoting best practice.

REFERENCES

- Armstrong, M.I. (2003). *Accountability and Quality Assurance in Managed Care Systems: Part of the Promising Approaches of the Health Care Reform Tracking Project for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. Retrieved April 15, 2006, from http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/toc_07.html.
- B•champs, M., Bialek, R., & Chaulk, C.P. (1999). *Privatization and Public Health: A Report of Initiatives and Early Lessons Learned*. Retrieved April 15, 2006, from <http://www.phf.org/Reports/Privatization1/PrivatizationReport2000.pdf>.
- Blackstone, E. A., Buck, A. J., & Hakim, S. (2004). Privatizing Adoption and Foster Care: Applying Auction and Market Solutions. *Children and Youth Services Review*.
- Bouchery, E., & Harwood, H. (2003). The Nebraska Medicaid Managed Behavioral Health Care Initiative: Impacts on Utilization, Expenditures, and Quality of Care for Mental Health. *Journal of Behavioral Health Services & Research*, 301 (1), 93-108.
- Bruner, C. (2000). *Child Welfare, Medicaid, and Managed Care: Lessons Learned in Iowa*. Des Moines: Child and Family Policy Center.
- Center for Public Policy Priorities. (2005). *Privatization of Child Protective Services*. Texas: Author.
- Collins, J. (2004). *Highlights from 2000-2001 CWLA Management, Finance, and Contracting Survey: Implications for Policy and Practice*. Washington, DC: Child Welfare League of America, Inc., Health Care Reform Tracking Project. Retrieved from <http://www.cwla.org/programs/bhd/mhpubhighlights.htm>
- Cook, J.A., Heflinger, C.A., Hoven, C.W., Kelleher, K.J., Mulkern, V., Paulson, R.I., Stein-Seroussi, A., Fitzgibbon, G., Burke-Miller, J., Williams, M., & Kim, J. (2004). A Multi-Site Study of Medicaid-Funded Managed Care versus Fee-for-Service Plans' Effects on Mental Health Service Utilization of Children with Severe Emotional Disturbance. *Journal of Behavioral Health Services & Research*, 28 (2), 155-163.
- Cornerstone Consulting Group, Inc. (1999). *Child Welfare Waivers*. Houston, TX: Author.
- Donohue, J.M. & Frank, R.G. (2000). Medicaid Behavioral Health Carve-outs: A New Generation of Privatization Decisions. *Harvard Review of Psychiatry*, 8 (5), 231-241.
- Embry, R. A., Buddenhagen, P., & Bolles, S. (2000). Managed Care and Child Welfare Challenges to Implementation. *Children and Youth Services Review*, 22, 93-116.
- Figgs, J. & Ashlock, S. (2001). Family Preservation/Foster Care/Adoption: Kansas Public/Private Partnership Initiative. *2001 Better Government Competition*. Retrieved from http://www.pioneerinstitute.org/pdf/bgc01_kansas.pdf

- Florida Legislature: Office of Program Policy Analysis and Government Accountability. (2006). *Additional Improvements are Needed as DCF Redesigns its Lead Agency Oversight Systems*. (Report No. 06-05). Retrieved March 2, 2006, from <http://www.oppaga.state.fl.us/reports/pdf/0605rpt.pdf>
- Florida Taxwatch. (2006, March). *Ensuring the Long-Term Success of Florida's Community-Based Child Welfare System*. Tallahassee: Author.
- Forquer, S.L., & Sabin, J.E. (2002). *Medicaid Behavioral Managed Care: What Lies Ahead*. Working paper. Retrieved April 11, 2006, from http://www.chcs.org/usr_doc/bhforecasting.pdf
- Fossett, J.W., Goggins, M., Hall, J.S., Johnston, J., Plein, L.C., Roper, R. & Weissert, C. (2000). Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers? *Health Affairs*, 19(4), 36-49.
- Freundlich, M., & Gerstenzang, S. (2003). *An Assessment of the Privatization of Child Welfare Services: Challenges and Successes*. Washington, DC: Child Welfare Leagues of America Press.
- Government Accountability Office. (2000). *Child Welfare: New Financing and Service Strategies Hold Promise, but Effects Unknown*. (GAO Publication No. T-HEHS-00-158). Washington, DC: General Accounting Office.
- Government Accountability Office (1997, October). *Social Service Privatization: Expansion Poses Challenges in Ensuring Accountability for Program Results*. (GAO Publication No. GAO/HEHS-98-6). Washington, DC: Author. Retrieved March 1, 2006, from <http://www.gao.gov/archive/1998/he98006.pdf>
- Holahan, J., & Suzuki, S. (2003). *Medicaid Managed Care Payment Methods and Capitation Rates in 2001*. Retrieved April 12, 2006, from <http://www.urban.org/url.cfm?ID=410660>.
- Hutson, R.Q. (2003). *A Vision for Eliminating Poverty and Family Violence: Transforming Child Welfare and TANF in El Paso County, Colorado*. Washington, DC: Center for Law and Social Policy.
- James Bell Associates, Inc. (2001). *External Evaluation of the Kansas Child Welfare System: July 2000-June 2001*. (FY 2001 Final Report). Unpublished.
- James Bell Associates, Inc. (2004). *Implementation of Promoting Safe and Stable Families by American Indian Tribes: Final Report-Volume I*. Unpublished report.
- Kahn, A. J., & Kamerman, S. B. (1999). *Contracting for Child and Family Services: A Mission-Sensitive Guide*. New York, NY: Columbia University, School of Social Work, Cross National Studies Research Program. Retrieved from http://www.caseyfoundation.org/publications/Child_Family.pdf

- Kamerman, S., & Kahn, A. (1998, June). *Privatization, Contracting, and Reform of Child and Family Social Services*. Retrieved January 27, 2006, from <http://www.financeproject.org/Publications/private.htm>
- Kansas Action for Children. (2003). *A Case for Contract Reform: The Development of a Single Regional Contract for Foster Care and Adoption Services in Kansas*. Topeka: Author.
- Kretman, K. P. (2003). *The Privatization of Child Welfare in Florida: Lessons for the Field*. Washington, DC: Georgetown University, Center for Public & Nonprofit Leadership.
- Mahoney, M. (2000). Privatization in Kansas: Where We Were and What is Our Future? *Privatization in the Social Services: Conference Proceedings: Chapter 4*. Philadelphia: University of Pennsylvania, School of Social Work. Retrieved from <http://www.ssw.upenn.edu/crysp/reports/privatization/Chapter4.pdf>
- Mannes, M. (1993). Seeking the Balance Between Child Protection and Family Preservation in Indian Child Welfare. *Child Welfare Journal*, 72(2).
- Martin, L. L. (2000). Performance Contracting in the Human Services: An Analysis of Selected State Practices. *Administration in Social Work*, 24(2), 29-44.
- McCarthy, J., & McCullough, C. (2003). *A View from the Child Welfare System: Part of the Promising Approaches of the Health Care Reform Tracking Project for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems*. Retrieved February 23, 2006, from http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/toc_02.html.
- McCarty, D., Dilonardo, J., & Argeriou, M.(2003). State Substance Abuse and Mental Health Managed Care Evaluation Program. *Journal of Behavioral Health Services & Research*, 30(1), 7-17.
- McCullough, C. (2003). *Better Results for Kids Issue Paper: Financing & Contracting Options & Considerations*. Retrieved March 7, 2006, from <http://basis.caliber.com/cwig/ws/chdocs/docs/canweb/ResultSet?upp=0&rpp=-10&w=NATIVE%28%27TI+ph+is+%27%27Better+results+for+kids+issue+paper%3A+financing+%27%27%26%27%27contracting+options+%27%27%26%27%27considerations%27%27%27%29&r=1>
- McCullough, C., & Schmitt, B. (2003). *2000-2001 Management, Finance, and Contracting Survey Final Report*. Washington, DC: Child Welfare League of America, Inc., Systems Integration Management Institute.
- McCullough, C., & Schmitt, B. (1999). *Managed Care and Privatization Child Welfare Tracking Project: 1998 State and County Survey Results*. Washington, DC: Child Welfare League of America, Inc.
- McDonald, T. P., Berry, M., Patterson, E., & Scott, D. (2000). Adoption Trends in Kansas: Managing Outcomes or Managing Care? *Children and Youth Services Review*, 22(2), 161-174.

- McEwen, E. (2006). *Performance-Based Contracts as a Strategy for Improving Child Welfare: Lessons Learned in Illinois*. Unpublished report.
- McHugh, D. W. (2000). *The Implementation of Managed Care in Child Welfare: The Legal Perspective*. Retrieved from http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/managed_care_report-all.pdf
- Moore, T., & Akin, B. (2005, January). *Topeka Shawnee County Child Welfare Pilot Project: Prevention, Protection and Preservation, Final Program Evaluation*. Retrieved February 23, 2005, from <http://www.socwel.ku.edu/occ/TAOFinalReport.pdf>
- Nicholson, J., Young, S.D., Simon, L., Fisher, W., & Bateman, A. (1998). Privatized Medicaid Managed Care in Massachusetts: Disposition in Child and Adolescent Mental Health Emergencies. *Journal of Behavioral Health Services & Research*, 25(3), 279-293.
- Nightingale, D.S., & Pindus, N. M. (1997). *Privatization of Public Social Services: A Background Paper*. Retrieved February 2, 2006, from <http://www.urban.org/publications/407023.html>
- O'Brien, M. (2005). *Performance Based Contracting (PBC) in Child Welfare*. (Draft). National Child Welfare Resource Center for Organizational Improvement.
- Oliver, M.N.I. (2002). Privatizing Medicaid-funded Mental Health Services: Trading Old Political Challenges for New Ones. *American Journal of Orthopsychiatry*, 72(3), 324-331.
- ORC Macro. (2003). *Connecticut Title IV-E waiver demonstration program: Final Report*.
- Paulson, R.I., Armstrong, M., Fitzpatrick, J., Jordan, N., Kershaw, M.A., Reyes, F., Vargo, A.C., & Yampolskaya, S. (2003). *Evaluation of the Florida Department of Children and Families Community-Based Care Initiative*. Retrieved March 14, 2006, from http://www.dcf.state.fl.us/publications/docs/cbc_report_091503.pdf
- Rosenbaum, S., & Teitelbaum, J.B. (1998). *Coverage Decision-Making in Medicaid Managed Care: Key Issues in Developing Managed Care Contracts: Issue Brief #1. Behavioral Health Issue Brief Series*. Retrieved April 13, 2006, from http://gwhealthpolicy.org/downloads/behavioral_health/bhib-1.pdf.
- Rosenthal, M. G. (2000). Public or Private Children's Services? Privatization in Retrospect. *Social Service Review*, 74(2), 281-305.
- Snell, L. (2000). *Child-Welfare Reform and the Role of Privatization*. Los Angeles, CA: Reason Foundation, Reason Public Policy Institute, Policy Study No. 271.
- Stroul, B.A., Pires, S.A., & Armstrong, M.I. (2003). *Health Care Reform Tracking Project: Tracking State Managed Care Systems as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families-2003 State Survey*. Retrieved March 28, 2006, from http://rtckids.fmhi.usf.edu/rtcpubs/hctraking/pubs/2003_statesurvey/2003%20StateSurvey_Full.pdf

- Sturm, R. (1999). Tracking Changes in Behavioral Health Services: How Have Carve-outs Changed Care? *The Journal of Behavioral Health Sciences and Research*, 26(4), 360-371.
- Sullivan, G., Young, A.S., Fortney, S., Tillipman, D., Murata, D., & Koegel, P. (2001). Managed Care in the Public Sector: Lessons Learned from the Los Angeles PARTNERS Program. *Journal of Behavioral Health Services & Research*, 28(2), 155-163.
- Tucker Alan Inc. (2000). *A Primer on Capitation Rate Setting for Medicaid Toolkit. Part of the Informed Purchasing Series*. Retrieved April 15, 2006, from http://www.chcs.org/usr_doc/TAPrimer.pdf.
- Tufts Managed Care Institute (1998). *A Brief History of Managed Care*. Retrieved April 4, 2006 from <http://www.thci.org/downloads/BriefHist.pdf>.
- U.S. Department of Health and Human Services, Administration for Children and Families. (2001). *National Survey of Child and Adolescent Well-Being (NSCAW). State Child Welfare Agency Survey: Report*. Washington, DC: Author.
- U.S. Department of Health and Human Services, Administration for Children and Families. (2004). *General Findings From the Federal Child and Family Services Review*. Washington, DC: Author.
- U.S. Department of Health and Human Services, Office of Inspector General. (2004). *States' Monitoring of Sub Grantees in the Foster Care Program: A Description of Six States' Systems*. Report No. OEI-05-03-00061. Retrieved April 11, 2006, from <http://oig.hhs.gov/oei/reports/oei-05-03-00061.pdf>.
- U.S. Department of Health and Human Services, Administration for Children and Families. (n.d.). *Chapter V Summary: State Performance on the Seven National Child Welfare Outcomes*. Washington, DC: Author. Retrieved April 21, 2006, from <http://www.acf.hhs.gov/programs/cb/pubs/cwo02/chapters/chapterfive2002.htm>.
- U.S. Department of Health and Human Services, Administration for Children and Families. (n.d.). *Maryland: Managed Care Payment System*. Washington, DC: Author.
- U.S. Department of Health and Human Services, Administration for Children and Families. (2003). *Michigan: Managed Care Payment System*. Washington DC: Author. Retrieved June 23, 2005, from http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2005/michigan.htm
- Unruh, J. K., & Hodgkin, D. (2004). The Role of Contract Design in Privatization of Child Welfare Services: The Kansas Experience. *Children and Youth Services Review*, 26(8), 771-783.
- Westat and Chapin Hall Center for Children, University of Chicago. (2002, April). *State Innovations in Child Welfare Financing*. Retrieved from <http://aspe.hhs.gov/hsp/CW-financing03/report.pdf>

Wulczyn, F., & Orlebeke, B. (1998). *Four State Study of Fiscal Reform*. Chicago, IL: University of Chicago, Chapin Hall, Center for Children. Retrieved February 23, 2006, from http://www.chapinhall.org/article_abstract.aspx?ar=1325&L2=61&L3=129

Yampolskaya, S., Paulson, R. I., Armstrong, M., Jordan, N., & Vargo, A. C. (2004). Child Welfare Privatization: Quantitative Indicators and Policy Issues. *Evaluation Review*.

Zullo, R. (2002). Private Contracting of Out-Of-Home Placements and Child Protection Case Management Outcomes. *Children and Youth Services Review*.