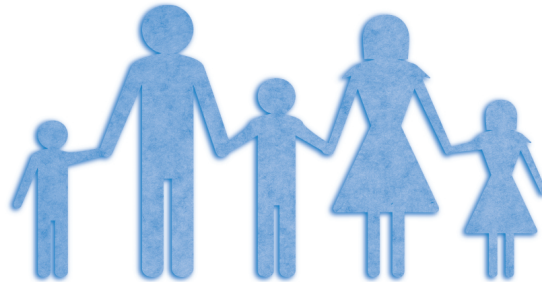




Observations on Performance-based Contracting in Foster Care from the Provider's Point of View

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EXECUTIVE SUMMARY

This paper contains observations on performance-based contracting (PBC) in publicly funded foster care written with particular reference to the foster care providing organization. The paper defines performance-based contracting and places it within the larger context of trends toward the privatization of functions that until recently were performed by public entities.

The author divides all performance-based contracting in foster care into three general groups. In the first group are contracts within a managed care service delivery system, and the author explores the division of labor between lead agencies and direct service providers. The second group consists of contracts that require specific activities to be undertaken. Various jurisdictions have mandated a wide range of activities, and the levels of planning and provider participation in that planning are just as varied. As a result, provider satisfaction with and evaluation of these systems are also quite varied. The third group comprises the systems established in Illinois and Philadelphia that specifically reward foster care providers for achieving permanency outcomes and penalize providers who fail to achieve those outcomes.

PREFACE

As an active member of the FFTA Public Policy Committee, I had participated in conference calls that, over several months, contemplated commissioning a white paper on performance-based contracting (PBC) in publicly funded but privately operated foster care systems, written from the provider's point of view. Ever rushing into the breach where wiser angels fear to tread, I volunteered to give the paper a shot. How hard could it be to survey several of the current manifestations of PBC in foster care, compare claims with results, and relate the findings to published articles about PBC and privatized child welfare? The Greeks had a word for this. They called it *hubris*. My commission was to write a scholarly, well-researched, and carefully cited paper. A couple of months and many long distance calls into the project, it became clear to me that any pretensions I might have had about attaining such comprehensiveness, much less scholarship, were hopelessly beyond my logistical means if I wanted to keep my day job. I adore my day job.

What I offer here instead, then, are more informal and somewhat more subjective observations about performance-based contracting based on many conversations with private foster care agency executives around the country. It is my hope this paper, more akin to journalism than serious scholarship, might prove at least somewhat useful to those of my colleagues who may be required to adapt the design, administration, and operation of foster care programs for our country's most vulnerable children and youth to a PBC environment. Although it is my intention to stay balanced and hold as close to the facts as I can, you should know that this paper was written by a foster care provider, based on conversations with foster care providers, for the benefit of other foster care providers. I owe many thanks to all those who provided information, wisdom, and guidance. The views expressed here as well as any factual errors that may have inadvertently crept in are entirely my own.

INTRODUCTION: PERFORMANCE-BASED CONTRACTING AND PRIVATIZATION

Over the past decade there has been a growing trend throughout the United States on the part of states and counties to require their private foster care providers to work under contracts that mandate deliverables in much greater specificity than ever before. In some locales this drive toward PBC has been a feature of a larger movement toward the privatization of child welfare services. Often spoken or written about together, almost interchangeably, performance-based contracting and privatization are technically not the same thing. Private operation of publicly funded foster care programs, often by nonprofit entities, has been a feature of the American foster care system since its inception. The most recent references to the privatization of child welfare services concern a newer trend of transferring to the private sector certain child welfare activities that heretofore were the exclusive province of government, such as case planning, purchasing of services, and court reporting. Sometimes under privatization, legal custody of children, which previously reposed with the county or state social services system, is now delegated to the private sector, with the newly empowered entity (often a lead agency that, in turn, contracts with service providers) reporting directly to the court. In other instances, privatization stops short of the reassignment of legal custody, retaining public agency involvement, but only minimally so. Here the public agency oversees lead agencies but still answers to the court.

There are many instances in which performance-based contracting has been introduced into child welfare services outside any larger privatization design. For the purposes of this discussion, I define performance-based contracting as a regime that imposes certain specific contractual obligations upon the provider of foster care services above and beyond the basic delivery of foster care services. Some jurisdictions have conceptually redefined this contract such that government is no longer buying a service (i.e., foster care) but instead has contracted with the private sector to purchase certain outcomes. Based on my conversations

with Treatment Foster Care (TFC) directors around the country, I would classify the current varieties of PBC as falling into three groups: (1) contracting within a managed care environment, (2) contracting for specific activities, and (3) contracting for outcomes. As is often the case, there are many instances of overlap among these typologies, creating a variety of hybrids.

PERFORMANCE-BASED CONTRACTING IN THE MANAGED CARE ENVIRONMENT

The first of these species to evolve was managed care. Like other trends in management, managed care developed first in one industry (private health care) and then moved progressively to adjacent industries to meet buyer demands for cost containment. During the 1980s and 1990s, managed care spread sequentially from private health care to public health care, then to public mental health care (a subcategory of public health), and, finally, in some locations, to child welfare.

Early Managed Child Welfare, Kansas Style

One of the earliest and boldest forays into managed child welfare was undertaken by the Kansas Department of Social and Rehabilitation Services. The original Kansas design followed traditional managed care lines, largely based on insurance principles. Several regional lead agencies were paid flat amounts (case rates) to meet defined child welfare needs of a large, fixed population of children. Lead agencies were contractually obligated to provide or purchase a variety of services, including foster care, treatment foster care, family preservation, independent living skills training for emancipating foster youth, and mental health services, among others.

Lead agencies, in turn, contracted with direct service providers for these services. Although the lead agency–service provider contracts may not have been performance-based per se, lead agencies generally imposed strict

authorization and review procedures to keep very close tabs on both services and costs. Lead agencies might, for example, have required periodic formal service reviews to adjust (up or down) the level of care for the child. Generally, service providers had the right to appeal these decisions, but the lead agency clinical staff got to make the final call. Having only one purchaser of services in the region (the lead agency) but many vendors of services (providers) created a buyer’s market that put lead agencies into a strong bargaining position relative to the service providers. Lead agencies also probably enjoyed considerable economies of scale not available to smaller service providers.

To make matters more interesting, in addition to having lead agencies contract with service providers, Kansas allowed lead agencies to provide direct care or services. That is, the same agency could serve both as lead agency and as service provider. From the lead agency’s point of view, it is generally more economical to provide the service itself than to buy it from an outside provider. This also allows better control and continuity of care. This practice, however, put smaller foster care provider agencies into the difficult position of having to compete with their own customers. Under such a system, the smaller service provider’s best strategy might have been to develop a niche market—that is, a program with a special client population—in which the smaller provider was particularly skilled, effective, and/or economical. Other jurisdictions

insisted on a division of labor between lead agencies and providers. There, lead agencies could not provide direct service, and role definitions seemed less muddled.

Lead agencies under the Kansas arrangement inherited considerable risk. If the lead agency could meet client needs at a cost lower than the state’s payment, that agency was allowed to retain the difference as profit. Conversely, if services cost more than the state payment, the lead agency was obligated to cover the costs and sustain the loss.

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Unintended Consequences: The Law of Adverse Selection

Unfortunately, the initial Kansas experiment ran into serious difficulties that would have been very predictable to members of the insurance industry but were unfamiliar to the state and its lead agencies. In introducing managed care, Kansas hoped to shorten stays and decrease the number of children in the foster care system, among other goals. In the first two goals, it was very successful. The numbers of foster children in care decreased, just as the state had hoped. But the remaining children were proportionately more difficult and more expensive to care for, causing the per-child costs to skyrocket. My spies in the insurance business tell me this phenomenon is known as *adverse selection*. Lead agency contracts failed to accommodate this consequence of adverse selection, holding the per-child reimbursement constant over time. At an FFTA pre-conference institute dealing with managed care, I recall an executive from Kansas remarking, “In the first year everyone made money, the second year everyone broke even and in the third year everyone went broke.” It would seem that contracting systems that don’t take what I call the Law of Adverse Selection into consideration will have difficulty succeeding.

It would follow, then, that both lead agencies and providers have a common interest in advocating for strong reinvestment features in the state plan.

Reinvestment means that the state agrees to reinvest, or retain, managed care–created savings back into the child welfare services system so that sufficient funds remain available to meet the needs of the more intractable children and youth who stay in care. Reinvestment might be viewed as a shift of the system’s ultimate goal from pure cost containment to one in which both cost containment and better outcomes are goals.

Under managed care, fiscal efficiency takes on new significance.

The Evolution of Managed Child Welfare in Kansas

Over time, Kansas updated many features of its system in light of experience, but the system still operates on the managed care–lead agency model. Now, lead agencies bid for multiyear contracts that pay a monthly per-child care rate. This rate steps down mandatorily over time. Once the rate is established, the lead agency will receive that rate for the first 6 months of care. During the second 6 months of care, lead agencies are paid 67% of the initial rate, then 29% thereafter. This creates a powerful incentive to have children exit care quickly or at least move briskly into more inexpensive care settings. Another safeguard against excessive state expenditure is that the state–lead agency contract stipulates a maximum billing amount (with certain built-in exceptions in the event of a population spike) beyond which the lead agency may not collect. Finally, if a child is reunified with her family or is adopted but returns into care within one year, the lead agency must admit her back into care and *assume all the costs of that care*, as lead agencies are not reimbursed for children returning to care within 12 months. Although the lead agency’s contract stipulates what it is *obligated* to do for reunified or adopted clients during the first 12 months postdischarge, it behooves the agency to maintain contact and provide a level of service that will guard against readmission.

Youthville, a lead agency, suffered during the early years of the Kansas managed care system. It was forced to file for Chapter 11 bankruptcy in 2001, though it subsequently emerged. Successfully navigating the managed care model requires the development of practices that bridge the former division between clinical and administrative functions. Program executives at Youthville cite these practice changes as a major factor contributing to the agency’s successful recovery. Now all managerial staff members are very involved with budgeting issues. Under managed care, fiscal efficiency takes on new significance. Agencies have found it prudent to beef up their Total Quality Improvement practices. At Youthville, a number of ongoing Quality Committees comprised of

managers, frontline clinical staff, and training staff meet on a regular basis to discuss policies and practices regarding recruitment, training, satisfaction surveys, and Treatment Foster Care. The consensus recommendations of these groups are rolled into the agency's ongoing training program. To stay on track, every department within the agency develops and follows a monthly work plan containing quantitative objectives in the department's area of activity, such as the number of foster care beds to be recruited, number of placements at various levels (kinship, adoptive, etc.), timeliness of reports, or the percentage of children placed at each level of care. An important function of the Quality Committees is to review the monthly work plan report of each unit.

Notwithstanding the new administrative and clinical difficulties this system imposed on lead agencies and care providers, those I spoke with in Kansas believe that the change has generally been positive for the kids in the system. Services reach children and families much quicker than before, and community, family-based placements have replaced formerly high numbers of placements in congregate care.

CONTRACTING FOR DEFINED ACTIVITIES

It may be that the most common form of performance-based contracting in publicly funded foster care takes the form of government requiring private providers to undertake specific activities or simply to report on a list of specific benchmarks. The sheer diversity of activities that have been contracted for, the myriad of application methodologies, and the spectrum of results from shining successes to abject failures make it difficult to say anything here that is meaningful or helpful. Agencies have been required to track the time it takes them to engage families, identify family members, increase collaborations, commit to permanency timelines, reconfigure staffing, provide foster home training and recertification within a strict timeline, and monitor the time from placement to permanency—just a taste of a nearly endless list. In many cases, the consequences for not meeting these

objectives are vague. Although states retain the right to limit referrals or cancel contracts, it seems that many jurisdictions rely solely on publishing the results of their various report cards, apparently in the belief that the public relations consequences to the private agencies are sufficient to motivate performance.

It is not surprising, then, that those with whom I spoke expressed the full range of satisfaction—from very high to very low—with the contracting models imposed on them. A consistent complaint was that though the required activities seemed generally positive for children, the documentation required was often excessive and duplicative. In other instances, scoring systems did not properly weight the relative values of the activities being scored. In New York City, for example, one agency felt it unfair that the city scored the recruitment of adoptive parents for healthy babies equally to the recruitment of adoptive parents for children with serious medical conditions, clearly a much more difficult task. On the other side of the ledger, an agency executive from Indiana spoke of a PBC model that providers thought was exemplary, great for kids, and truly rewarding of excellence, but it was costly. When the county ran into money trouble, a new county administrator scuttled the program. Providers in Washington, D.C. expressed their frustration with a system they view as highly dysfunctional.

Fortunately, there are others in the world better situated, resourced, and prepared than I am to make more sense of this confusing array. In my brief foray into the tangled world of PBC, I found the website of the University of Kentucky's Quality Improvement Center on the Privatization of Child Welfare Services (<http://www.uky.edu/SocialWork/qicpcw/assessment.htm>) particularly impressive. There you can find a literature review on performance-based contracting and quality assurance, and another on the privatization of child welfare services.

The same website offers an annotated bibliography of literature and materials regarding privatization. Among the resources listed there, one in particular

caught my eye as being especially appropriate for our topic at hand. McCullough & Associates (2005) provides an excellent overview and case studies in both privatization models and PBC. Of the wide range of success and failure, McCullough states:

There appear to be many reasons why some initiatives succeeded and were later expanded and others failed to achieve fiscal and programmatic goals and were dismantled. At times, plans failed because they had design flaws from the outset or because there was not a balance between expectations, authority for decisions, and resources. It is encouraging that many initiatives appear to focus on increasing family involvement, cultural competency, and wrap-around approaches to service planning and delivery. Less promising is the fact that many states and private agencies still struggle to track basic utilization, cost, and outcome data within child welfare and across other child-serving systems to analyze the effect of various privatization initiatives. (p. 17)

McCullough is good enough to summarize the best practices emerging from the PBC movement as well as the challenges that PBC regimes have faced. I encourage you to obtain the original document for a readable, thorough treatment, but here are the bullet points.

Best practices emerging from privatization and PBC include the following:

- Wraparound values/principles
- Family team conferencing
- Evidence-based practices and decision support tools
- Continuity in case managers
- National accreditation standards
- Expanded services through community service networks
- Improved use of technology
- Added training and supports for caregivers
- Promising contract monitoring practices
- Utilization review

The major challenges are these:

- Inadequate data collection and analysis capability
- Lack of role clarity between private agency case managers and public agency staff
- Inadequate service capacity

- Poorly defined or wrong outcomes
- Resources that are not aligned with expectations
- Problems with financing
- Lack of private agency expertise in family-centered practices, evidence-based innovations, or new business processes
- No magic bullet for staffing
- Lack of understanding of legal issues and experience engaging the courts
- Failure of limited funding sources to meet complex needs
- Adherence to rigid procedures
- Flawed contracts
- Overdone or underdone monitoring
- Lack of attention to cultural and linguistic competence

CONTRACTING FOR OUTCOMES

The performance-based contracting regime that has shown the most dramatic results and accordingly drawn the most attention began a decade ago in the state of Illinois. The model was replicated with certain modifications in Philadelphia, Pennsylvania. These systems are not within a privatization model. Here, government has retained many of its traditional roles of referring children for care, holding legal custody, and reporting to the court. On the other hand, state (or county) workers under this system are less concerned with the actual delivery of services than they were before system reform and have taken on a more formal oversight capacity.

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Illinois' performance-based contracting ties payments to foster care agencies directly to the outcomes they produce. This system of rewarding (or punishing) outcomes is in contrast to those performance-based contracting systems that regulate around process

objectives. In the following discussion of the Illinois/Philadelphia models, I have substantially oversimplified their complexity, as my objectives are to outline the basic structure of these systems and to point to some of the related practice implications, rather than describe the systems in detail.

Between the mid-1980s and mid-1990s, Illinois experienced explosive growth in its foster care population. The number of children in the custody of the state of Illinois rose some 250% from 13,700 children in 1986 to 47,900 children in 1995 (Testa, Cohen, & Smith, 2003). During the same period, median lengths of stay increased 600% from 8 months to 56 months (Illinois DCFS, 2003).

A Contracting Regimen Based on Achieving Permanency

Of the many changes undertaken within the Illinois system reform, the most dramatic involved the creation of contractual obligations for foster care agencies providing basic-level care (not TFC) to move 24% of their caseload to permanency within the fiscal year. In general, the system worked like this: Each agency's contract stipulated the initial size of the agency's caseload based on historical experience. For example, an agency that averaged 100 children in care over the past several years would receive a contract for 100 children and would be paid the same as it would have been for 100 children in the old system. Let's assume that the agency's original per diem rate was \$40, creating total agency-wide revenue of \$4,000 per day (for 100 children), or \$1,460,000 per year. Under the new contract, the agency is expected to move 24 of these youngsters to permanency within the fiscal year. Over the course of the contract, the state plans to refer 24 new children, bringing the caseload back up to 100 children. If the agency is very successful and moves 6 *additional* children to permanency (that is, it sends a total of 30 children to permanency), it will again receive the promised 24 new referrals. But this will lower the agency's overall caseload to 94 (100 – 30 + 24), thereby raising the *per diem* rate to \$42.55

(\$1,460,000 divided by 94 kids divided by 365 days), a 6.4% increase in this example. Conversely, if the agency is not successful and moves only 18 children to permanency, 6 fewer than the target, it will still receive the same 24 new children. But now the agency must serve its caseload of 106 youngsters (100 – 18 + 24) on the same total payment, effectively lowering its rate to \$37.74 per day (\$1,460,000 divided by 106 kids divided by 365 days), a 5.7% rate cut.

You will quickly deduce that this type of system would produce deep inequalities among foster care providers if one agency is allowed to take all the “easy” children while another must cope only with more difficult ones. To avoid this problem, referrals are made on a strict no-decline, rotational basis, with every agency required to accept every referral or suffer serious financial consequences. The system allows certain considerations, such as keeping siblings together, to “trump” the strict rotation. For example, if an agency already has one sibling in placement when another comes into the system, that agency will receive the newly referred sib. Later, other trumps, such as same-neighborhood placements, were added. The Philadelphia system is similar except the expectation for permanency is linked to a substantially higher fraction of caseload. There, agencies are funded to handle “dynamic caseloads” of 13 children each. The expectation in Philadelphia is that 5 of the 13, or 38%, achieve permanency within a year. Finally, in both locations, if the permanency placement for a discharged child fails within a specified time postdischarge, the foster care agency is required to take the child back into care *at no charge* and must provide care with no additional payment. From the state's point of view, the agency has already been paid for that child. Remember, the state is not paying for foster care, it is paying for permanency.

Report Cards

Although one might think the outcome provisions of contracts in the Illinois/Philadelphia models would be sufficient to produce the desired results, these

contracts also contain a considerable number of process objectives for the foster care agency to meet. In addition to what we might call the structural outcome objectives, every agency is given a monthly “report card” that grades the agency on both outcome and process measures. Originally outside the outcome system, reference to the report card has now been incorporated in the agency contracts. Agencies are scored on process measures such as placement stability, providing appropriate access to education and educational services, providing required alcohol or substance abuse screenings, frequency of permanency family visitation, worker-child contact, frequency of family team meetings, and goals for planned and unplanned discharge rates. Each agency receives a monthly report card score that is published in a list that ranks all agencies from best to worst. In addition to the public exposure, the state has several enforcement tools at its disposal: The state reserves the right to close an agency’s intake, limit an agency’s growth, make no additional placements, or cancel the contract outright and shut down the agency.

Process objectives in agency contracts allow the state to enforce quality of care measures for children who might never find permanency. One Illinois agency executive speculated that once the state realized that some fixed number of children will not achieve permanency, it understood that the report card afforded a means to guarantee quality services to these remaining children who were relatively ignored under the structural outcome provisions of the contract. The state found other ways to refine system outcomes with the use of process objectives. For example, the state found it could demand and obtain higher levels of placement stability from care providers. An agency that moves a child through several different foster homes along the road to permanency will receive a report card score lower than that of an agency that achieved permanency in the same time period but needed only one placement to do it. In another example of fine-tuning, family reuni-

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fications are now worth more report card points than are other forms of permanency. Similarly, foster care agencies can get report card credit for helping foster youth go to college or join the armed forces.

To some degree, these new and increasingly demanding process objectives are a result of the success of the structural outcome system. In Illinois, so many agencies achieved their contractual permanency objectives that the state needed additional measures to distinguish low performers from high ones. From the state’s point of view, it is desirable to create a system that pits providers against one another. It is a primary tenet of capitalism that competition lowers cost and improves quality. But beyond that, the reduced number of children in the foster care system meant that the state could no longer promise each provider the same number of children for whom services were originally contracted. Some agencies felt they were treated unfairly when they found that even

though they met all the required permanency goals in their contracts, they still lost funding or lost contracts in subsequent years because they had not done as well as their colleagues on the process measures. One Illinois agency director said, “The state’s philosophy is to try to help the agency fix what needs to get fixed, but it reserves the right to pull the contract or not make placements.” It

would seem to me that it became an implicit if not explicit objective of the state’s public policy to drive more poorly performing agencies out of business so that the reduced number of children left in the system would derive the benefits of being cared for by only the most qualified programs.

Cries, Whispers, Brickbats, and Kudos

The effect of Illinois’ reforms on the number of children in the system was dramatic. According to the state’s website (<http://www.state.il.us/dcf/docs/subguard.shtml>), there were 50,735 cases of substitute care in 1997 but only 24,130 in 2002, a reduction of

52.4% in only 5 years. During the same period, adoption and guardian cases rose from 11,539 to 41,415, a 260% increase. One reason for these large foster care caseload reductions was the availability of a well-funded subsidized guardianship option made possible by a federal Title IV-E waiver. Under the terms of the waiver, funding previously restricted to foster care could be redirected to the child's legal guardian in roughly the same amount that foster parents would have received. Even though the state was not saving much on the maintenance costs of the discharged children, it was able to save significant sums on the dependency-related and public child welfare oversight costs. It may be, then, that caseload reductions in jurisdictions imposing this kind of system without subsidized guardianship programs won't be as dramatic as those seen here.

Rapid change of this nature is always controversial. The financial consequences of this system forced poorly producing agencies out of business. Some of the successful providers disclosed to me privately that they believe that getting rid of substandard agencies was one of the state's original objectives and, perhaps, not a bad one. In any event, it appears as if the state felt it needed to whittle down the number of contract agencies consistent with the lowered numbers of children in the system. Implementation of the system created divisions among providers and their advocates. Those agencies that felt threatened by the changes also felt betrayed by the trade associations that embraced the changes as being good for children.

In Illinois, the new system created a very strong demand by the state for foster parents to adopt their foster children or risk losing contact with children they loved. Press reports revealed that long-standing foster parents who had loved their foster children through the tough years and who were willing to adopt the children felt wronged upon learning that funding for services their kids needed would cease upon adoption, services the foster parents could not hope to afford (Karp, 1999). Moreover, other system observers felt that the adoption process was far too

rushed, resulting in substantial numbers of disrupted adoptions, traumatizing both adoptive parents and children. These children then reentered the system with substantially lowered permanency prospects. According to one foster care executive, "The state keeps those numbers quiet." Others dispute this claim, saying that in the last few years only about 5% or less per year of system adoptions were disrupted to the point that the child had to reenter care.

Notwithstanding these problems and criticisms, it is impressive how much Illinois got right. To begin with, Illinois made a very public commitment to quality. Not only did it require all agencies to become accredited as a condition of contract, but the state system *itself* applied for and won accreditation by the Council on Accreditation. Illinois also met its moral obligation to its children by fully funding the subsidized guardianship program. Both Illinois and Philadelphia applied these system changes to the basic level of privately delivered foster care, but neither imposed the system on the higher levels of Treatment Foster Care. In Illinois, specialized or treatment foster care agencies may be called upon to explain low levels of permanency achievement, but they are not subject to the same financial consequences as providers of basic or relative care are. Strict rotational referral is not used in treatment or specialized care. In these cases, the state sometimes makes referrals to up to five agencies concurrently, with the most responsive agency getting the placement. In other instances, there may be a single referral to the agency considered most qualified to meet the particular child's needs.

For a variety of reasons it makes sense for this kind of regime to begin with kids in basic care because it brings the largest number of children to permanency and saves the most money. I received conflicting accounts on why this is so. Some believe that the resistance of the providers accounts for why these principles were not applied to TFC. Others cited the fact that with more difficult children, it is clinically desirable to match the child's needs with particular

agency capabilities, which destroys the rotational, no-decline referral process necessary to maintain this contract model. Some observers point to the high degree to which federal Medicaid funding supports TFC programs. According to this view, the difficulty of reconciling federal Medicaid funding guidelines to the Illinois contract model accounts for why this variant of PBC has not been applied to Treatment Foster Care. Others have countered that there is really little Medicaid in treatment or specialized care and that given the administrative burdens attached to this funding, most have chosen to forgo it. It may be that some portion of all these possibilities is true. But for whatever reason, it is a comfort to know that the system performs in the best interest of the most problematic children by continuing to allow their placement with programs that have the expertise to meet their needs.

Now that the number of children is relatively stable, some observers feel that Illinois has achieved its initial goals and is moving on to find new ways to track performance. The state is beginning to recognize it has a large cohort of adolescents who will likely not be adopted or be taken into guardianship. There is new emphasis on the achievement of educational goals, methods of dealing with runaways, and the development of “front end” services to help children avoid entering the foster care system.

To my thinking, the best thing about the Illinois model is that it is inherently a reinvestment model. By holding the pot of money constant as the caseload dwindles, savings are automatically reinvested in the remaining group of children. In Illinois this has allowed agencies to reduce individual caseworker caseloads, which had been between 22 and 25 children per worker prior to system reform, to current levels of about 15 children per worker, approximating TFC caseload sizes in regular foster care.

A Troubling Philadelphia Story

Unfortunately, the Philadelphia story isn't quite as sanguine. In Philadelphia the report card system was imposed on agencies midcontract, without consultation. Agencies felt that the rules had been changed midgame without their consent or input. In neither Illinois nor Philadelphia did government surrender legal custody (i.e., case planning authority) to the private providers. However, according to those with whom I spoke, Illinois was much more willing to delegate authority. Philadelphia providers claim that the county was not very effective in obtaining the widespread buy-in from either county line social work staff or the courts that was necessary to make system reforms successful. Maybe Illinois drilled that message down to the line level and the bench in the act of acquiring COA accreditation.

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The entire thrust of both these systems, indeed the whole point of the financial incentives/disincentives of this model, is to get kids out of care and into a permanent family. In Philadelphia the foster care providers were

given the authority to determine which particular form of permanency (reunification, adoption, or legal guardianship) would be pursued in any given case, provided the choice conformed to law and regulation. But repeatedly, when Philadelphia providers prepared youngsters for reunification, they found their decisions vetoed by county line staff at the last minute. Though it was the county worker who would not allow the reunifications to take place, the foster care providers were nonetheless penalized for not achieving their permanency goals.

According to one provider with whom I spoke, an even more fundamental difference between Illinois and Philadelphia is that “the county did not have the political will to shut down the poorly performing providers.” In Illinois, the state moved aggressively against poorly performing providers and concentrated

the children remaining in the system into the caseloads of the better performing agencies. But as the total number of children in care in Philadelphia decreased, the county simply drew down caseload sizes across the board, effectively deciding to starve all agencies instead of feeding just a few good ones. Provider opinion of the county's conduct runs from moderately critical to outright condemnation. Moderates believe that it was the original intention of the system reforms to help *every* agency improve its practice. They point out that the providers' own advocacy efforts resulted in giving poorly performing agencies more time to become better at doing the job. They assert that county flexibility is only short term and that the requirements are tightening, performance is improving, and there is value in maintaining the presence of community-based agencies. Those with this viewpoint argue that work in highly impacted urban communities is slow going. Agencies struggle to get biological parent cooperation and often have to resort to using the courts to get biological parents to give up custody of their children. Adherents of this view point to the county's new emphasis on preventing kids from entering the system through funding family engaging programs, such as after-school programs, truancy prevention programs, and in-school counseling.

The more critical view is that the county fundamentally misunderstands how its own system is supposed to work. It seems to these critics that Philadelphia is pursuing an intentional *disinvestment* system. It has not held aggregate system spending constant, redistributing its resources among the remaining youngsters who are more difficult and more expensive to care for. Instead, it has held *per-child* spending constant, decreasing the *total* investment with every child who leaves care. The result is that poorly performing agencies stay in business, and kids don't get what they need. Critics feel that the system is staggering without clear goals or clear leadership, with the public agency unable or unwilling to clarify policy. For example, critics say more children are achieving permanency via permanent legal custody (subsidized guardianship)

simply because it is easier to accomplish, not because it is the best choice. Care agencies are required to provide aftercare in permanent legal custody and reunification cases, but not for adoptions. Agencies are paid \$4,000 to provide reunification aftercare, but only \$1,000 for aftercare in permanent legal custody cases. Critics also lament that the county has allowed many children on the permanency track to go to an "alternative permanent planned living arrangement" (the local term for supported independent living) and call it permanency.

In addition to these complaints, there has been a constant drumbeat of press stories critical of the performance of the foster care system over the past decade; the current mayor will soon be replaced because of term limits; and both social services and mental health services are now directed by a common, temporary administrator—a pretty good recipe for system malaise if not dysfunction. No one is sure whether the county will stay committed to its current approach after a new mayor takes office. But both the moderates and the critics agree that what they had hoped would be an innovative system that promised both rewards and punishments to providers based on their performance has devolved into one that relies mainly on punishments. Clearly such a system can't be much fun to work with, and it begs the question whether the children are any better off.

HOW IS PERFORMANCE-BASED CONTRACTING WORKING ELSEWHERE?

This article highlights some of the successes and challenges associated with performance-based contracting in foster care in several states and counties around the country. FFTA would like to know how performance-based contracting works in other states that have instituted it. Please send information to mcole@ffta.org. It is our hope that in the coming months, the FFTA Public Policy Committee can gather additional information from FFTA members around the country and publish other accounts of performance-based contracting.

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SOURCES

Illinois Department of Children and Family Services. (2003). *Performance contracting in Illinois' child welfare system*. http://www.state.il.us/dcf/library/com_communications_performance.shtml

Karp, Sara. (1999, October). DCFS policy spells pressure for black families. *Chicago Reporter*.

McCullough & Associates, Inc. (2005, December). *Child welfare privatization: Synthesis of research and framework for decision makers*. Retrieved January 27, 2007, from http://www.cfsa.dc.gov/cfsa/lib/cfsa/frames/pdf/Privatization_Framework.pdf

Testa, Mark, Cohen, Leslie, & Smith, Grace. (2003). *Illinois subsidized guardianship waiver demonstration final evaluation report*. State of Illinois Department of Children and Family Services. <http://cfcwww.social.uiuc.edu/pubs/pdf.files/sgfinalreport.pdf>

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