Washington State
Child Welfare Private Nonprofit Agency
Cost Study

Prepared by MCPP Healthcare Consulting, Inc.

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Study Abstract

Washington State's child welfare system is in the midst of profound changes in how services are delivered and funded. Key components of these changes include converting all contracts for child welfare services to performance-based contracts, increasing the use of evidence-based services, reinvesting savings in order to sustain and expand prevention and early intervention programs, and carefully monitoring the effectiveness of reforms in order to ensure that change results in improvement.

This study, funded by the Stuart Foundation and the Washington State Coalition for Children in Care, has determined that the Washington State Child Welfare system significantly underpays private agencies for child welfare services. Study findings include:

- **Current DSHS payment rates are 15% to 51% below the nonprofit agency costs** for three types of child welfare services: Facility-Based Behavioral Rehabilitation Services (BRS) (17% gap), Treatment Foster Care BRS (15% gap), and Child Placing Agency services (51% gap). Under the reforms identified during the 2009 Legislative Session, funding will be shifting to the area with the largest shortfall (Child Placing Agency services).
- The majority of service areas in the study experienced an annual deficit; the ability to raise additional revenues to close funding shortfalls varied greatly by agency and service area. During the period studied, contributions, fees and grants covered only a portion of the shortfall, leaving **average deficits of 4% to 24% for the service areas studied.** Together these issues suggest that relying on nonprofit agency contributions and other revenues to cover DSHS funding shortfalls is an unreliable public policy approach to managing the child welfare system.
- An examination of private nonprofit agency wages and employee benefits compared with three sets of benchmark data determined that the service provider positions in the study are below market value. The largest disparity is with comparable positions at the Washington State Department of Social and Health Services where **DSHS salaries for comparable positions are 24% higher**. If wage and benefits gaps were narrowed, DSHS funding shortfalls would increase even further.

Continuation of the current practice of balancing the budget through heavily discounted rate structures has the potential to undermine the ability of reformers to achieve an outcome-based system. Prior to this study, *adequacy of private agency rates* had not been part of the dialogue; rate studies have not been commissioned or completed and DSHS leadership and the Legislature have not been provided cost data or informed about the seriousness of existing rate gaps. Although mechanisms described in recent reform legislation have the potential to address the serious rate gaps, this will not automatically occur unless the findings from this study are brought into the reform process.

Background

Washington State's child welfare system is in the midst of profound changes in how services are delivered and funded. Although the state's Children's Administration has outlined reform efforts in its Strategic Plan,[1] the Agency continues to have difficulty lowering social worker caseloads, providing monthly visits to all children in care, and delivering timely health and education screening of children in foster care, among other key services. These issues came to the fore in 2008 when the agency was brought back to court in connection with a case involving foster children who had three or more placements while in foster care,[2] at the same time finding it necessary to abandon its pursuit for accreditation through the Council on Accreditation.[3] As the Children's Administration attempts to reform its system of care, Washington is confronting an unprecedented budget crisis.

In an effort to address these and other challenges, during the 2009 Legislative Session, Washington enacted a law calling for conversion to performance-based contracting for all privatized child welfare services.[4] The expressed intent of this change is to promote child safety, child permanency (including reunification), and child well-being. Because Washington's child welfare system is already extensively privatized,[5] and the new legislation calls for further privatization, it is critical to have an understanding of the true costs and necessary rates for private agency child welfare services.

In 2009 the Washington State Coalition for Children in Care (WSCCC) engaged MCPP Healthcare Consulting to complete a comprehensive Cost Study of key services delivered by Washington's private agency child welfare providers in order to analyze the financial impact of funding cuts and new initiatives on the system.

This study, funded by the Stuart Foundation and the Washington State Coalition for Children in Care, analyzed three of the system's key services:

- Facility-Based Behavioral Rehabilitation Services (BRS)
- Treatment Foster Care BRS
- Child Placing Agency (CPA) Services

As the WSCCC stakeholder group worked with MCPP to define and oversee the project, the following objectives were identified:

- Determine the unit costs of the above private agency child welfare services
- Assess the gap between unit costs and current Children's Administration rates
- Analyze the implications of performance-based contracting for private agency child welfare services and unit costs

This report describes the approach MCPP used to complete the project, and provides a set of findings and recommendations.

Approach

MCPP completed several activities during the project, drawing on a number of Washington State and national resources.

Unit Cost Study

MCPP consultants completed the following work:

- Cost Study Preparation: Prepared a set of data requests, cost study templates, and training materials; provided training and ongoing support to participating provider agencies as they completed their cost studies.
- Data Collection: Collected 26 completed agency cost studies from 14 organizations, reviewed each for reasonableness, conducted follow-up discussions with agencies to ensure accurate data submissions, and compiled the information into a Cost Study database.
- Data Analysis: Completed a detailed data analysis to arrive at a set of Unit Costs and Reimbursement Rates for each service area.

Analysis of Unit Costs, Reimbursement Rates and Future Contract Models

Concurrent to the Unit Cost Study efforts, MCPP consultants completed the following activities to project the effect of current and proposed Washington child welfare system funding mechanisms on private agency child welfare system Unit Costs.

- Wage Study: Completed a wage study, comparing data from the participating agencies, the *United Way 2009-10 Nonprofit Wage and Benefit Survey, 2008 State of Washington Department of Personnel Total Compensation Survey Results*, and the *March 2008 Washington State Employment Security Department Occupational Employment and Wage Estimates*.
- Benefits Study: Completed a benefits study to compare current provider agency benefit rates with local, state, and national benchmarks, drawing on analysis of U.S. Bureau of Labor Statistics (BLS) data and a Milliman USA study commissioned for the State of Washington.
- Scenario Development: Developed a set of Unit Cost Models with stakeholders from participating agencies to evaluate the impact of historical funding levels.
- Performance-Based Contracting Research: Collected national and state information on child welfare reform and performance-based contracting.
- Study Report: Compiled the results of the above activities into this Report.

Note that for purposes of this study, the costs incurred by foster care parents and related revenues were not examined and thus not included in the revenue and expense figures in this study. Although this is an important component of the child welfare system, it was considered a separate study requiring a separate workplan and outside the scope of this project.

Study Findings

This section contains three major findings related to the gap between Children's Administration Rates and Agency Unit Costs (Finding 1); problems with relying on Agency Contributions and Other Revenues to close the gaps (Finding 2); and an analysis of how Agency Wages and Employee Benefits are below market for the service provider positions identified in the study (Finding 3).

Finding 1: Current Children's Administration Rates Do Not Cover Costs

Current DSHS payment rates are 15% to 51% below the nonprofit agency costs for three types of child welfare services: Facility-Based Behavioral Rehabilitation Services (BRS) (17% gap), Treatment Foster Care BRS (15% gap), and Child Placing Agency services (51% gap). This finding, which was based on a detailed analysis of 26 service areas at 14 private non-profit agencies, is consistent with stakeholder feedback that Washington State has a long history of inadequately funding private agency child welfare services. The current payment gap represents a $5.5 million annual shortfall from the $20.2 million service costs included in the study.

Table 1 and Figure 1 examine the shortfall for each of the three service areas. Table 1 states the cost components for the services and compares the total cost to the Department of Social and Health Services (DSHS) Children's Administration average rates for the agencies in the study. DSHS rates include all Children's Administration receipts, including foster care parent pass-through funds, minus foster care parent payments.

Table 1: DSHS Rates and Agency Costs

	Facility-Based BRS	Treatment Foster Care BRS	Child Placing Agency
DSHS Average Payment Rate	**$6,605**	**$3,314**	**$529**
Agency Expenses			
Provider Salaries-Contract Fees	$3,694	$1,309	$457
Other Staff Salaries	$1,145	$650	$106
Payroll Benefits/Taxes	$1,093	$495	$114
Other Expenses	$2,040	$1,447	$410
Total Cost per Child per Month	**$7,972**	**$3,902**	**$1,087**
DSHS Rates Shortfall $	**-$1,367**	**-$588**	**-$558**
DSHS Rates Shortfall %	**-17%**	**-15%**	**-51%**
Number of Agencies	7	7	12
Number of Slots	125	82	425

Figure 1 illustrates the shortfalls, displaying the total unit cost and the DSHS rates shortfall for each service area. Note that under the reforms identified during the 2009 Legislative Session, funding will be shifting to the area with the largest shortfall (Child Placing Agency services). Efforts to further privatize the Child Welfare system will need

to address the fact that current payments cover less than half of current Child Placing Agency service costs.

Figure 1: DSHS Rates and Agency Costs

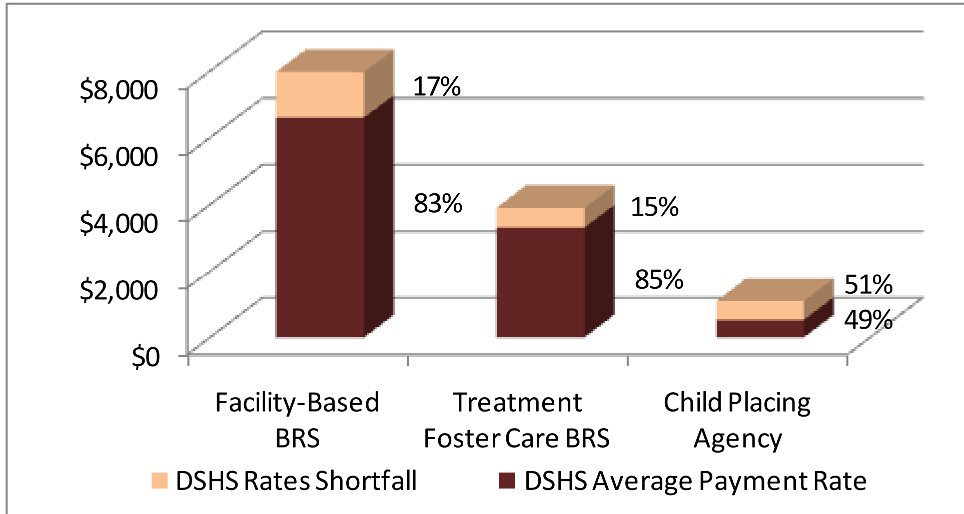
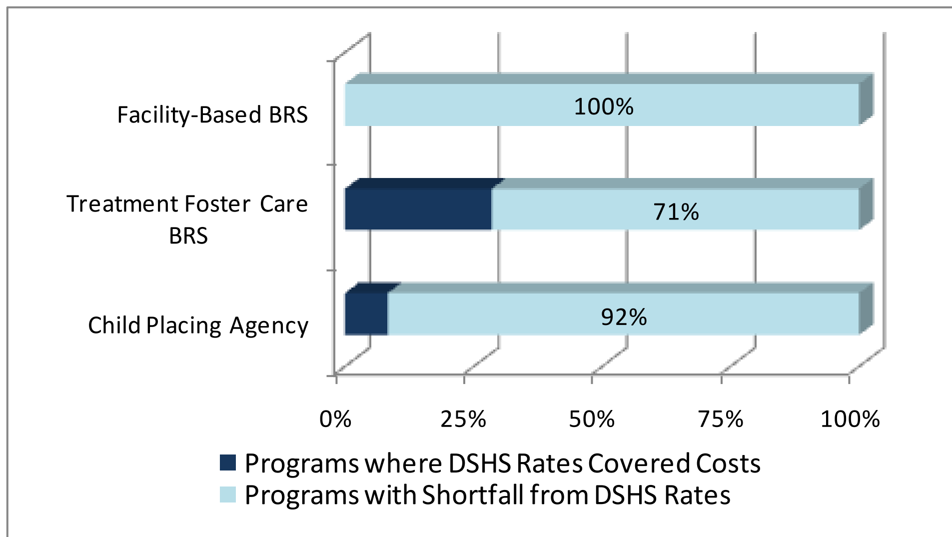


Figure 2 illustrates the service area-level variation in the ability of DSHS rates to cover costs. None of the Facility-Based BRS programs were able to cover costs with their DSHS payments; two Treatment Foster Care programs (29%) were able to cover costs; and one Child Placing Agency that received an unusually high number of add-on payments for special needs was able to cover program costs.

Figure 2: Adequacy of DSHS Rates by Agency and Program



Finding 2: Relying on Private Nonprofit Agency Contributions and Other Revenues is Not a Reliable Public Policy Strategy for Covering DSHS Funding Shortfalls

The majority of service areas in the study experienced an annual deficit. The ability to raise additional revenues to close funding shortfalls varied greatly by agency and service area; together these issues suggest that relying on nonprofit agency contributions and other revenues to cover DSHS funding shortfalls is an ***unreliable public policy approach*** to managing the child welfare system. The following sub-findings help explain these issues.

Finding 2a: Contributions and Other Revenues Do Not Close the DSHS Funding Gaps

During the period studied, contributions, fees and grants covered only a portion of the shortfall, leaving **average deficits of 4% to 24% for the service areas**. The Total Shortfall amounts listed in Table 2 below illustrate the gaps between total per-child-per-month revenue and agency costs.

Table 2: Per-Child-Per-Month Average Shortfall after Addition of Contributions Fees and Grants

	Facility-Based BRS	Treatment Foster Care BRS	Child Placing Agency
DSHS Average Payment Rate	$6,605	$3,314	$529
Total Cost per Child per Month	$7,972	$3,902	$1,087
DSHS Rates Shortfall $	-$1,367	-$588	-$558
Other Sources of Funds			
Contributions, Fees, and Grants	$1,082	$124	$301
Excess (Deficit) $	-$285	-$464	-$257
Excess (Deficit) %	-4%	-12%	-24%

Finding 2b: There are Large Variations in Nonprofit Agency Fundraising Abilities

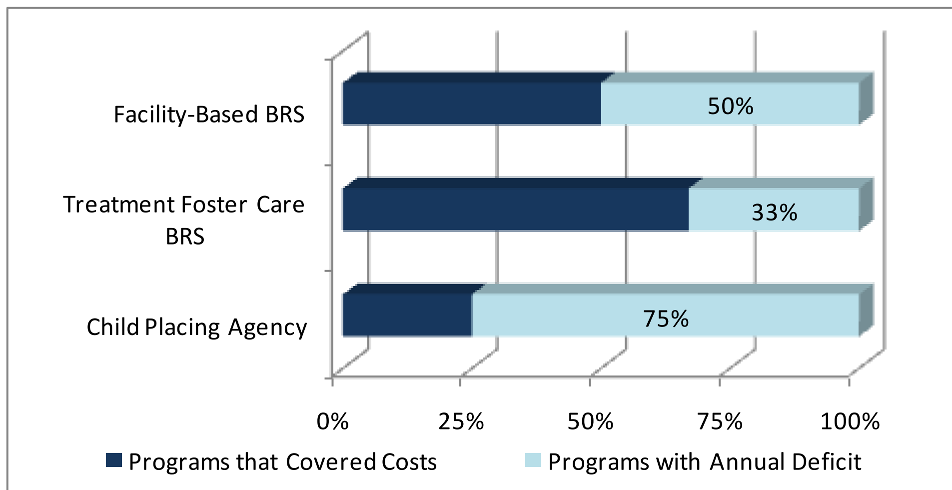
There is a great deal of variation in the ability of the nonprofit agencies to cover the shortfalls in DSHS Rates. Contributions, fees and grants ranged from $7 to $2,482 per-child-per-month for the various agencies. Table 3 illustrates this variation by comparing outside funding of low, midpoint and high agencies in each of the three service areas.

Table 3: Range of Agency Contributions, Fees and Grants

	Facility-Based BRS	Treatment Foster Care BRS	Child Placing Agency
Agency with Lowest Level of Other Revenue			
Total Agency Costs	$1,068,869	$543,607	$243,002
Contributions, Fees, and Grants	$36,020	$4,876	$3,275
Other Funding % of Agency Costs	3%	1%	1%
Other Funding - Per Child per Month	$254	$30	$7
Midpoint Agency			
Total Agency Costs	$314,247	$567,520	$39,984
Contributions, Fees, and Grants	$39,918	$25,383	$8,388
Other Funding % of Agency Costs	13%	4%	21%
Other Funding - Per Child per Month	$860	$182	$175
Agency with Highest Level of Other Revenue			
Total Agency Costs	$364,572	$350,325	$429,202
Contributions, Fees, and Grants	$110,193	$16,681	$232,370
Other Funding % of Agency Costs	30%	5%	54%
Other Funding - Per Child per Month	$2,482	$221	$745

Figure 3 illustrates the service area-level variation in ability to cover costs. One-half of Facility-Based BRS, one-third of the Treatment Foster Care, and three-quarters of the Child Placing Agency service areas showed ***annual losses*** for the study period.

Figure 3: Variations in Ability to Cover Costs after Addition of Contributions Fees and Grants



The average agency in a metropolitan area (e.g., King and Spokane Counties) was able to raise more contributions, fees and grants than agencies in mostly rural areas (e.g. Kitsap and Skagit Counties). Contributions, fees and grants in rural areas were 40% of the median for all agencies. ***This geographic disproportionate ability to cover shortfalls underscores the problem of relying on nonprofit agency contributions and other revenues to cover DSHS funding shortfalls.***

Finding 3: Wages and Benefits at Private Nonprofit Agencies are Below Market; Narrowing the Gaps will Increase the DSHS Funding Shortfalls

In the study, *Help Wanted: Turnover and Vacancy in Nonprofits*, San Francisco-based CompassPoint Nonprofit Services found that nonprofit employees in the Bay Area cited money as a major reason for leaving their jobs, with large numbers moving to government positions (26%) and for-profit businesses (20%).[6] This report, along with several other studies, supports the concern that nonprofits often find it difficult to compete due to low salary and benefit levels.[7] Benchmarking salaries and working with funders to keep wages competitive is an important part of retaining qualified staff.

A comparison of the private nonprofit agency wages and employee benefits with three sets of benchmark data determined that the four service provider positions in the study are below market. The largest disparity is with comparable positions at the Washington State Department of Social and Health Services. If these wage and benefits gaps were narrowed, the DSHS funding shortfalls identified in Finding 1 would increase even further. The three sub-findings in this section examine Wages (Finding 3a), Employee Benefits (Finding 3b), and the costs of narrowing the Wage and Benefits gaps (Finding 3c).

Finding 3a: Agency Wages for Key Positions are Below Market

There were four positions that provided direct service for the service areas in the study: Direct Care Worker not requiring a Bachelor Degree, Bachelor's Level Clinician, Master's Level Clinician, and Psychiatrist. **Average wages for these four positions were 24% below median wages for employees of the Washington State Department of Social and Health Services** (DSHS). The positions in the study were 16% below statewide median wages from the *Washington State Occupational Employment and Wage Estimates Study*, and 3% below the *United Way 2009-10 Nonprofit Wage and Benefit Survey*. Tables 4 and 5 translate these figures into salary dollars for the 263 Full Time Equivalent (FTE) direct service providers in the study.

Table 4: Wage Comparison Analysis

	Below Bachelor's	Bachelor's Level	Master's Level	Psychiatrist	Total/ Average
Nonprofit Agencies in Study					
Provider FTEs	115.2	110.6	36.5	0.3	262.5
Provider Mix	43.9%	42.1%	13.9%	0.1%	100.0%
Average Hourly Wage	$11.55	$14.49	$20.51	$94.58	$14.12
Benchmark Wage Data					
Washington DSHS	$16.09	$19.00	$25.55	$75.76	$18.69
Washington Statewide	$13.70	$18.27	$21.53	$73.07	$16.77
United Way Survey	$11.83	$16.02	$17.70	$83.20	$14.49
Study Agencies Above (Below) Benchmarks					
Washington DSHS	-28%	-24%	-20%	25%	-24%
Washington Statewide	-16%	-21%	-5%	29%	-16%
United Way Survey	-2%	-10%	16%	14%	-3%

Table 5: Wage Comparison Impact

	Below Bachelor's	Bachelor's Level	Master's Level	Psychiatrist	Total/ Average
Annual Cost of Adjusting Up (Down) to Benchmarks					
Washington DSHS	$1,085,887	$1,036,349	$382,303	-$10,374	$2,494,164
Washington Statewide	$513,693	$869,335	$77,773	-$11,856	$1,448,945
United Way Survey	$66,589	$352,838	-$212,827	-$6,273	$200,327

Note that Psychiatrist is the only position where agency wages were above benchmarks. This is due to the fact that only 0.3 FTEs are employed across the 14 organizations in the study, all positions are contracted, and the agencies have to pay a premium to hire and retain psychiatrists for one day per week or less.

Finding 3b: Agency Employee Benefits are Below Market

Analysis of U.S. Bureau of Labor Statistics (BLS) data and a Milliman USA study commissioned for the State of Washington shows that average employee benefits of the nonprofit agencies in the study are *below* comparative benchmarks. As illustrated in Table 6, the private nonprofit agency employee benefit rates are 1% below the U.S. Civilian Workforce for the Pacific Coast (BLS), 3.3% below the rates for government and non-government workers in Washington State (Milliman), and 9.8% below the rate of Service Sector of Government Workers, which includes health and education services in the state and local government workforce (BLS).

Table 6: Employee Benefits Analysis

	Study Employee Benefits Rate	Benchmark Employee Benefits Rate	Study Agencies Above (Below) Benchmarks	Annual Cost of Adjusting to Benchmarks
Nonprofit Agencies in Study	23.8%			
Benchmark Employee Benefits Data				
US Civilian Workforce Pacific Region		24.8%	-1.0%	$74,632
Milliman Washington State Survey		27.1%	-3.3%	$254,414
US Gov't Workforce Service Providers		33.6%	-9.8%	$759,284

When wages and benefits are combined, the average private nonprofit agency compensation rate of $17.48 per hour is 43% below the average DSHS compensation rate of $24.97 per hour.

Finding 3c: Narrowing Wage and Benefit Gaps Further Increases Funding Shortfalls

MCPP examined the impact of the DSHS funding gaps on the private nonprofit child welfare providers by developing a set of scenarios that project how Unit Cost and Total Shortfall would change if the gaps noted in Findings 3a and 3b were reduced.

- ***Scenario 1: Market Adjustment A***, brings average wages to the United Way level (3% adjustment) and employee benefits to the Civilian Workforce Pacific Region level (1.0% adjustment).
- ***Scenario 2: Market Adjustment B***, brings average wages to the Washington Statewide level (16% adjustment) and employee benefits to the Milliman Washington State level (3.3% adjustment).
- ***Scenario 3: Market Adjustment C***, brings average wages to the Washington DSHS level (24% adjustment) and employee benefits to the Government Workforce level (9.8% adjustment).

Table 7 illustrates the results for the three scenarios. Wage and Benefit gaps are quantified and totaled for each scenario in order to compute a revised Shortfall between current DSHS Rates and projected Unit Costs. For example, the actual average shortfall for Facility-Based BRS services was $1,367 per-child-per-month. Factoring in a 3% wage and 1% benefits increase in Scenario 1 adds $149 to the per-child-per-month cost, increasing the shortfall to $1,516, which increases the gap from 17% to 19%. The Facility-Based BRS gap increases to 26% in Scenario 2 and 34% in Scenario 3.

Table 7: Impact of Market Adjustments on Unit Costs

	Facility-Based BRS	Treatment Foster Care BRS	Child Placing Agency
DSHS Average Payment Rate	$6,605	$3,314	$529
Total Cost per Child per Month	$7,972	$3,902	$1,087
DSHS Rates Shortfall $	-$1,367	-$588	-$558
DSHS Rates Shortfall %	-17%	-15%	-51%
Scenario 1 - Market Adjustment A			
Wage Adjustment 3%	$111	$39	$14
Benefits Adjustment 1%	$38	$13	$5
Total Adjustment	$149	$53	$18
Revised DSHS Shortfall	-$1,516	-$641	-$577
Shortfall %	-19%	-16%	-53%
Scenario 2 - Market Adjustment B			
Wage Adjustment 16%	$591	$210	$73
Benefits Adjustment 3.3%	$141	$50	$17
Total Adjustment	$732	$260	$91
Revised DSHS Shortfall	-$2,099	-$848	-$649
Shortfall %	-26%	-22%	-60%
Scenario 3 - Market Adjustment C			
Wage Adjustment 24%	$887	$314	$110
Benefits Adjustment 9.8%	$449	$159	$56
Total Adjustment	$1,335	$473	$165
Revised DSHS Shortfall	-$2,702	-$1,061	-$723
Shortfall %	-34%	-27%	-67%

Implications for Performance-Based Contracting

Overview

Washington State's child welfare system improvements have been designed to occur through the staged implementation of "strategic and proven reforms." Key components include converting all contracts for child welfare services to performance-based contracts, increasing the use of evidence-based services, reinvesting savings in order to sustain and expand prevention and early intervention programs, and carefully monitoring the effectiveness of reforms in order to ensure that change results in improvement.[4] These components are consistent with the body of knowledge that is emerging from numerous efforts to reform the child welfare system in other states.

Since the early 1990s, MCPP Healthcare Consulting has worked with a number of states, regional authorities and counties across the United States to implement similar reforms in the public mental health system. As noted in much of the literature on child welfare reform, public mental health reform has a number of lessons to offer.[8] In particular, both child welfare and mental health reformers will agree that success depends on several factors, perhaps most critically on defining and aligning the ***services*** to be provided, the desired ***outcomes***, and related ***payment mechanisms***. This section of the study examines the relationship between these reforms and the findings from the Cost Study.

Population-Based Planning

The Washington State Institute for Public Policy has been working closely with the Legislature to design the framework for child welfare reform and will continue to play an important role along with the Child Welfare Transformation Design Committee, and DSHS and legislative staff. It is anticipated that these groups will continue to draw on best practices from other states to increase the likelihood of success. We anticipate that the roadmaps found in reports such as ***Building Systems of Care: A Primer for Child Welfare***, prepared for the National Technical Assistance Center for Children's Mental Health at Georgetown University,[9] will be one tool used to guide the redesign process.

A key concept from the Child Welfare Primer, that has also been a cornerstone of reform in general healthcare and public mental health, is utilizing a ***Population-Based Approach*** to redesigning and managing services and programs. Using this approach, child welfare, mental health and healthcare systems project ***how many people will need services*** in a given year; ***how much of what types of services will be needed***, based on evidence-based and emerging best practices; and the ***cost of providing these services***. The results of this design work are compared to available revenues and, if shortfalls exist, the service delivery design is revised.

Population-based planning supports a thoughtful evaluation of service delivery need; financial feasibility testing to identify service and financial gaps; prioritization of the gaps; and development of short, medium, and long range efforts to address quality, access, utilization, and cost shortfalls. It is clearly a complex process, but one that is essential for establishing and maintaining a system that delivers the right service, to the right person, at the right time, in the right place, at the right cost.

It appears that the Children's Administration has not used this type of population-based planning in the past and efforts to balance its budget have been based on setting financial targets for specific program areas and underpaying private agencies. These approaches are not compatible with successful, performance-based reform. The attachment at the end of this report provides additional detail on best-practice population-based planning.

Performance-Based Contracting and Payment Methods

Once the population-based planning process has resulted in the identification of the array of services and supports and the types of providers that are needed, the groundwork is laid to determine which purchasing and contracting options to use.

Recent Washington legislation defines "performance-based contracting" as "the structuring of all aspects of the procurement of services around the purpose of the work to be performed and the desired results with the contract requirements set forth in clear, specific, and objective terms with measurable outcomes." The legislation goes on to require that "contracts shall also include provisions that link the performance of the contractor to the level and timing of reimbursement."[4]

This language is consistent with the notion that performance-based contracts, by definition, integrate outcome measures with payment mechanisms. It is also consistent with the fact that current Washington State child welfare contracting and payment methods have many of the same problems identified by reformers of the general health care system in the United States. As noted in a U.S. Senate Finance Committee April 2009 Policy Options Paper, *"It has become increasingly evident that the way health care is paid for in our system does not always encourage the right care, at the right time, for each and every patient. Today's payment systems more often reward providers for the quantity of care delivered, rather than the quality of care and discourage providers from working together to offer patients the best possible care."*[10]

Research on new reimbursement methods relevant to the Children's Administration are influencing general health reformers and new payment models are emerging. In a number of settings, capitation is giving way to a three-part payment model.[11]

- ✓ A **Fixed Budget** layer of funding is used for the prevention, education and care management services that don't lend themselves to fee-for-service-type payment mechanisms. Historically, these services are unfunded or, in some cases, funded with limited grant dollars.
- ✓ **Case Rate or Fee-for-Service** payments are made for services that are part of formal planned care, not included in the fixed budget. Hourly, per diem, and per month payments, like the current Private Agency fee for service payment system, keep the financial risk with DSHS. Semi-annual or annual case rates push risk and the potential for reward down to provider level and have the potential to reduce lengths of stay and achieve other desired outcomes.
- ✓ **Bonus-Type Gainsharing** mechanisms are used where providers who contribute to the reduction in total system expenditures for a given population

or achieve other important outcomes receive a share of the savings in the form of a bonus.

Over the next few years this three-layer approach is likely to become widely used in primary medical care settings: variations of this approach hold promise for child welfare systems.

Performance-Based Contracting and Payment Adequacy

As this study has identified, the Washington State Child Welfare system systematically underpays private agencies for Behavioral Rehabilitation and Child Placing Agency Services. Continuation of the practice of balancing the budget through heavily discounted rate structures has the potential to undermine the ability of reformers to achieve an outcome-based system. This practice hinders the ability of private agencies to hire and retain quality service delivery staff and provide sufficient support for their work (e.g., facilities, supplies and support staff). Increasing reliance on an underfunded nonprofit private agency system poses a threat to the child welfare system and the children it is intended to protect.

Addressing problems with current *payment methods* has been identified as a goal by DSHS and the Legislature, and recently enacted legislation includes strategies for addressing these issues. **Prior to this study, *adequacy of private agency rates* has not been part of the dialogue; rate studies have not been commissioned or completed and DSHS leadership and the Legislature have not been provided cost data or informed about the seriousness of existing rate gaps.** Although mechanisms described in Washington's recent legislation (2SHB 2106) have the potential to address the serious rate gaps, this will not automatically occur unless the findings from this study are brought into the reform process.

Recommendations

This report presents three recommendations that MCPP Healthcare Consulting considers baseline requirements for preparing Washington's child welfare system for upcoming reforms and promoting the stability and long term viability of Private Agency Child Welfare services.

Recommendation 1: Implement a Population-Based Planning Process for Washington State's Child Welfare Services

As part of the redesign process, DSHS and the Child Welfare Transformation Design Committee should implement a population-based planning process that addresses the nine questions posed on pages 17 and 18 of this report. This is an essential framework for aligning service need with outcomes and payment mechanisms. The work should include the development and use of a multi-year financial planning model that translates desired outcomes into demand forecasts and balances demand with capacity, and revenues with expenses.

Recommendation 2: Integrate Payment Mechanisms with Performance-Based Contracts

As part of the redesign process, DSHS and the Child Welfare Transformation Design Committee should look to payment reform methods under consideration by national healthcare reformers and design a performance-based contracting system that appropriately aligns risk, payment and outcomes. The designers should consider the three layer approach that is being piloted in primary medical care as a potential best-practice model for child welfare systems.

Recommendation 3: Develop a Plan to Close Existing Funding Gaps in Private Agency Child Welfare Services Payment Rates

This study demonstrates that Facility-Based BRS, Treatment Foster Care BRS, and Child Placing Agency Services are not adequately funded. As DSHS and the Child Welfare Transformation Design Committee redesign the system and develop performance-based contracts, the findings from this study and subsequent cost studies should be used to set rates for these contracts.

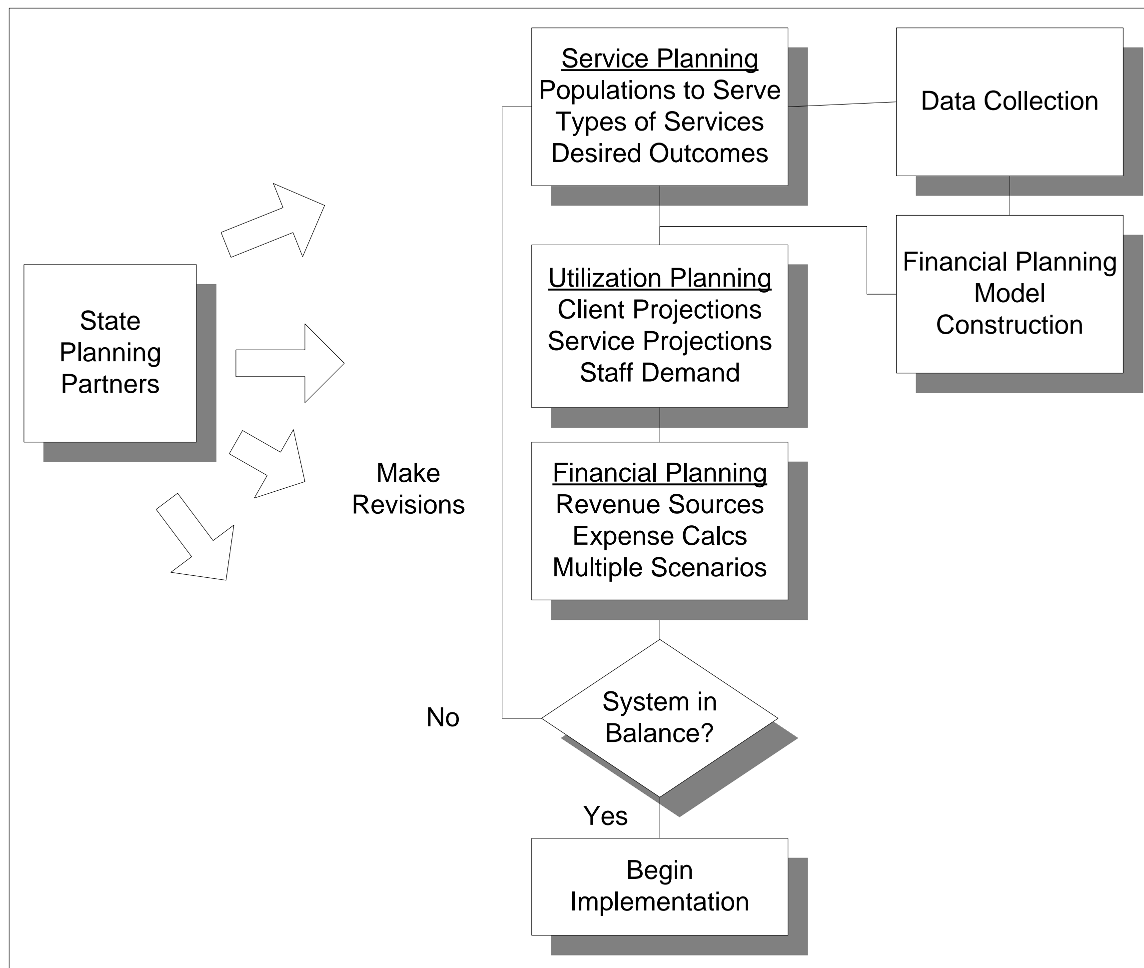
We recommend, at a minimum, that the current costs identified in Table 1 – adjusted for inflation – be used to set rates during the first round of performance-based contracting. These adjustments should then be factored into the demand/capacity, revenue/expense balancing process described above. In subsequent cycles, DSHS should use the data from the market rate adjustments in Finding 3c to set rates in order to ensure that quality staff are able to be hired and retained at private agencies.

DSHS should also develop an ongoing process to update the population-based planning model that includes a three-year cycle of cost studies in order to evaluate and update gaps that may exist between reimbursement rates and *reasonable and necessary* costs.

Appendix – Population Based Planning

Population-Based Planning is an approach used by child welfare, mental health and healthcare systems to project ***how many people will need services*** in a given year; ***how much of what types of services will be needed***, based on evidence-based and emerging best practices; and the ***cost of providing these services***. The results of this design work are compared to available revenues and if shortfalls exist the service delivery design is revised. This approach is illustrated in Figure 4 below.

Figure 4: Population-Based Planning Process



A number of successful reform efforts have built on this process to create a blueprint for improvement that involves examining and answering the following questions.

1. **Target Population:** What is the target population and what are its demographic characteristics (e.g., infants and toddlers, transition-age youth, racially and ethnically diverse children over-represented in child welfare)?
2. **Outcomes Definition:** What are the desired outcomes for the population in general and for targeted sub-populations (e.g., safety, permanency and well-being)?

3. **Utilization Projections:** Based on the needs of the population and desired outcomes, how much of what types of evidence-based services, through which service areas, ought to be provided to achieve these outcomes? What is the right mix of prevention and early intervention, wraparound and other ongoing services, and post-permanency services?
4. **Capacity Analysis:** How do utilization projections translate into how many of what types of providers are needed? How does current capacity align with projected demand? Are there areas of surplus capacity and shortfalls?
5. **Cost Projections:** What is the cost of providing these evidence-based services in the desired proportions?
6. **Contracting and Payment Mechanisms:** What contracting and payment mechanisms should be utilized to align the provider network with identified outcomes, reward high performance and move toward eliminating non-value adding services and utilization?
7. **Administrative Alignment:** What changes can be made in how the system is administered to better align with system reform, reduce non-value added administrative work and reduce overhead costs?
8. **System Financing:** What changes in financing within the target system and across related systems can be implemented to better leverage existing funds and tap into potential new sources of funds?
9. **Balancing Revenues and Expenses:** If revenues are insufficient to fully fund the population-based design, what changes should be made to the design to maximize the ability to achieve outcomes while balancing the budget?

Figure 5 illustrates how the process involves two balancing acts – balancing demand with capacity and revenue with expense.

Figure 5: Two Sets of Balancing Requirements

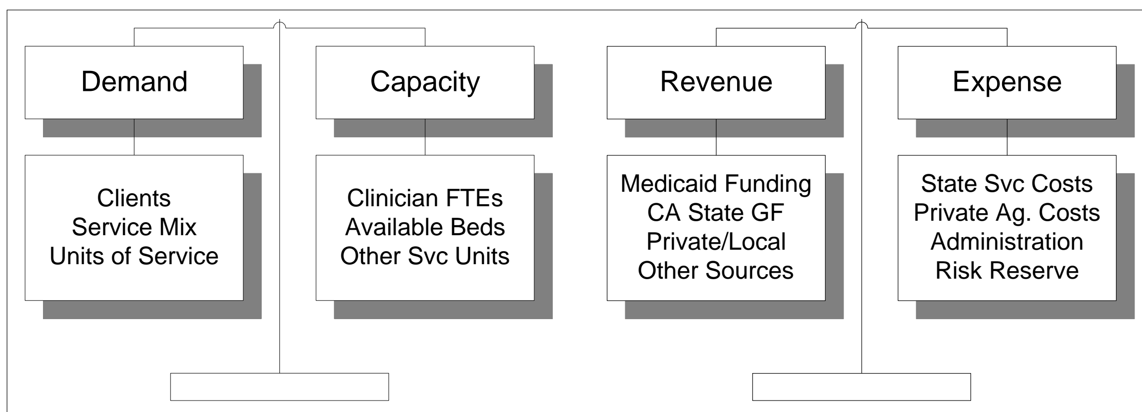


Figure 6, taken from the Child Welfare Primer, is an example of how this process is used to estimate how many youth require out of home placement, early intervention and family preservation, and primary prevention services during a given year.

Figure 6: Population–Based Demand Projections Example[9]

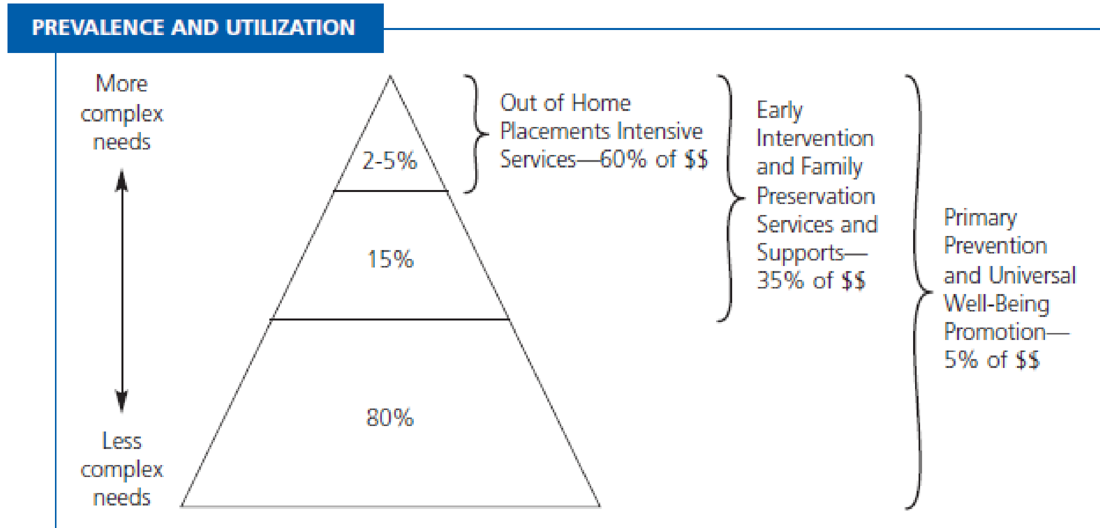
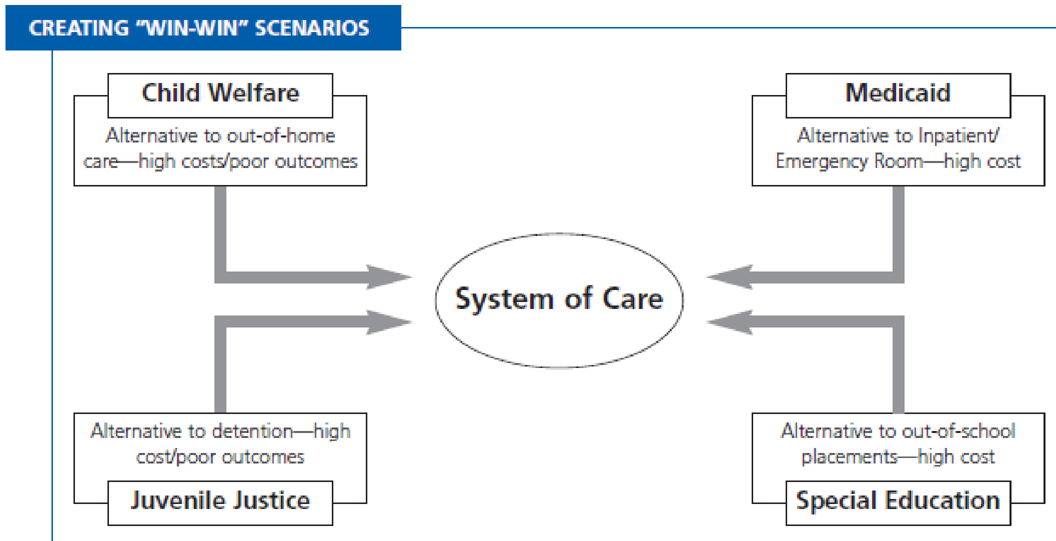


Figure 7, also from the Child Welfare Primer, illustrates how reform efforts often blend funding from multiple state departments to fund an integrated system of care for youth requiring child welfare services.

Figure 7: Braided and Blended Financing Example[9]



Population-based planning supports a thoughtful evaluation of service delivery need; financial feasibility testing to identify service and financial gaps; prioritization of the gaps; and development of short, medium, and long range efforts to address quality, access, utilization, and cost shortfalls. It is clearly a complex process, but one that is essential for establishing and maintaining a system that delivers the right service, to the right person, at the right time, in the right place, at the right cost.

End Notes

[1] DSHS Children's Administration Strategic Plan 2007-2011, http://www1.dshs.wa.gov/pdf/ca/strategy.pdf

[2] DSHS Children's Administration Braam Settlement Agreement webpage, http://www1.dshs.wa.gov/ca/about/imp_settlement.asp

[3] DSHS Children's Administration Accreditation webpage, http://www1.dshs.wa.gov/ca/about/imp_Accred.asp

[4] 2SHB 2106 Second Substitute Bill Summary, 2009, http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202009/2106-S2.SL.pdf

[5] DSHS Research and Data Analysis Division Children's Administration Clients, http://www.dshs.wa.gov/pdf/ms/rda/research/11/136.010.pdf

[6] The Nonprofit Quarterly; Help Wanted: Turnover and Vacancy in Nonprofits, CompassPoint Nonprofit Services (Fall 2002).

[7] Preston, Anne E. "The Nonprofit Worker in a For-Profit World", Journal of Labor Economics 7(4), 1989, 438-463.

[8] Including, Effective Financing Strategies for Systems of Care: Examples from the Field, The Research and Training Center for Children's Mental Health, March 2008.

[9] Building Systems of Care: A Primer for Child Welfare, The National Technical Assistance Center for Children's Mental Health, Georgetown University, Spring 2008.

[10] Senate Finance Committee, Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs, April 29, 2009.

[11] Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Healthcare System?, National Council for Community Behavioral Healthcare, April 2009.