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Linda A. Hall
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VIA EMAIL

Representative Tamara Grigsby
Wisconsin State Assembly
P.O. Box 8952
Madison, WI 53708

Senator Bob Jauch
Wisconsin State Senate
P.O. Box 7882
Madison, WI 53707-7882

RE: WAFCA Research and Recommendations for Action by Special Committee on Child Welfare Provider Rate Implementation

Dear Representative Grigsby and Senator Jauch:

In preparation for the Committee's December 17th meeting, WAFCA would like to offer information and proposed actions for Committee members' consideration. This letter and the attached documents address:

1. Analysis of Child Welfare Financing Models and Process Steps to Developing Performance-Based Contracting in Child Welfare (*Attachment 1*)
2. Proposed Outline for a Special Committee Report that would address:
   a. Principles for Child Welfare Rate Setting
   b. Child Welfare Rate-Setting Criteria/Statutory Clarifications
   c. Additional Issues for Future Legislative Study and Action (*Attachment 2*)
3. Proposed Wisconsin Child Welfare Finance Reform Four Year Transition Vision (*Attachment 3*)

An introduction to each of these documents is offered below.

1. Analysis of Child Welfare Financing Models and Process Steps to Developing Performance-Based Contracting in Child Welfare

Over the last few months, in addition to participating in the Special Committee on Child Welfare Provider Rate Implementation, we have been consulting with a national expert on child welfare and behavioral health financing and service delivery. Monica Oss who is the founder and CEO of OPEN MINDS-- a firm that consults with purchasers and providers to

generate information leading to better payer decisions and better delivery systems--worked with us to analyze a range of child welfare financing models and consider alternatives as Wisconsin steps away from our current, market-based rate setting system.

The attached presentation prepared by Ms. Oss addresses:

- eight child welfare financing models in use throughout the country, and for each:
  - a description of the model,
  - an example of its use, and
  - the advantages and disadvantages to children/consumers, providers and payers;
- advantages of a multi-year process of moving to a performance-based system; and
- eleven steps to developing performance-based contracting in child welfare.

After examining the eight models, Oss notes that four of the models require data supports that are not currently available in Wisconsin. She then concludes that performance-based contracting holds the greatest promise for Wisconsin to align financial incentives and desired outcomes for both payers and providers. This recommendation is followed by eleven steps for moving to performance-based contracting that are essential to ensuring continuity of quality and care during the transition .

We found Oss' command of child welfare financing systems impressive and the information very helpful in thinking through some of what would be required of Wisconsin to move to a performance-based financing system. As detailed as this analysis is, there are additional considerations that require attention including all the steps necessary for shifting from a county purchaser system to a state-directed payment formula and consideration of what the elimination of county/provider negotiations over placement and price, especially for treatment foster care, will mean.

2. Proposed Outline for Committee Report

While most Legislative Council study committees look at the status quo and determine changes that may be needed, this study committee has been directed to address a change that is on the verge of implementation. This assignment presents some challenges to designing a Committee report.

As I noted in my comments at the November meeting, since the Governor's budget was first introduced, WAFCA has taken issue with some of the assertions made by the administration whether rate-setting is the correct response to the quality and cost concerns raised. However, we recognize that the new rate-setting system has been enacted and that, even if there is general agreement that the new system was crafted without consultation and without sufficient study with regard to alternative mechanisms for better managing child welfare system costs and quality, there is little political will for returning to the previous rate setting system in these economic times.

In light of the political realities, Committee discussions, and our research described above, we recommend that the Committee's report focus on three areas:

1) Articulating "Principles for Child Welfare Rate Setting." (as discussed at the November meeting.)
2) Proposing additional rate-setting criteria that must be considered as a part of the DCF rule-making process.
3) Proposing statutory language that modifies/clarifies the new rate-setting system enacted in the budget and identifying additional, related issues for future legislative study/action.

The attached *Proposed Outline for Special Committee Report* describes these three components in detail.

3. Proposed Wisconsin Child Welfare Finance Reform Four Year Transition Vision

Assuming that in order to link payment to outcomes Wisconsin should move to a new rate-setting formula that incorporates performance-based measures, it is important to consider our state's readiness for this type of child welfare financing system. Transitioning to a new child welfare financing system that incorporates performance-based indicators to improve outcomes should be accomplished through a thoughtful process that will ensure the continuity and the quality of care during the transition process. To that end the Wisconsin Association of Family and Children's Agencies proposes for consideration a four-year process that would provide:

- time for state, counties, and providers to gear up to meet the data and operational 'know-how' requirements of a new system;
- experimentation with performance-based indicators;
- monitoring of adopted measures and policy changes; and
- Legislative review of the new methodology in year four with DCF, counties, providers, and stakeholders working together to make necessary revisions.

Including the vision statement in the Committee report would establish the legislative intent as to how the transition to performance-based contracting should proceed and would reinforce the Committee's desire to protect quality outcomes and quality services that currently exist.

We hope you will find the information presented here to be thought provoking and helpful as the Committee progresses into the next phase of our work.

Sincerely,

Linda A. Hall
Executive Director

Attachments (3)

cc: Wisconsin Legislative Council

Attachment 1

Analysis of Child Welfare Financing Models and Process Steps to Developing Performance-Based Contracting in Child Welfare

Child Welfare Financing Issues:

Discussion Guide Prepared for the Wisconsin Association of Family & Children's Agencies

Monica E. Oss, Chief Executive Officer, *OPEN MINDS*

Child Welfare Delivery System Emerging Market Model

Tech-Enabled Medical Home For Children	• Facilitated by PHR, RHIO, or specialty primary care practice
Tech-Enabled Supports To Foster Family, Biological Family, & Kinship Arrangements	• On-line and in-home services and supports for foster families and kinship arrangements • On-line and in-home services and supports for biological families to support family reunification • Mobile supports for case workers
Shift in Residential Arrangements For Children	• Increased kinship care and family preservation • Foster care increasingly intensive • Reduced use of residential and group home services

Eight System Financing Options Available to State/County Payers for Children's Services

1. Fee-for-service (FFS) reimbursement model
2. Market rate reimbursement model
3. Per diem with performance-based contracting (PBC) model
4. Case rate reimbursement model
5. Case rate reimbursement with PBC financing model
6. Capped allocation reimbursement model
7. Capitated or Capped allocation reimbursement with PBC financing model
8. Global budget transfer with PBC financing model

Model #1. FFS Reimbursement: Description

- Payments to provider organizations for each specific services rendered
- Basic risk to the provider is the cost of producing each unit of service
- Few incentives for service providers to control utilization, to build a more suitable array of services as an alternative to placement, or to more quickly return children to their families
- Typically, no bundling of billing allowed (e.g. for case management services) – each service billed separately

Model #1. FFS With Standardized Fee Schedule: Example - Colorado

Lincoln County rate negotiation (2008 methodology)

- For Residential Child Care Facility (RCCF), Therapeutic Residential Child Care (TRCCF), Psychiatric Residential Treatment Facility (PRTF): use state-approved rates posted in Colorado's Child Welfare automated case management system (called Trails)
- Any FFS additionally negotiated by number of services and units of service are paid at the state-established rate
  - ✓ Initial provider rate is set at time of placement and is then monitored closely for the first 90 days of placement to assure that appropriate FFS to meet the needs of the child are put in place and that appropriate outcomes are achieved.
  - ✓ After a child has been in placement for over 90 days, the provided contract is reviewed for determination of FFS after stabilization in placement has occurred. Current provider information is then used to assess the needs of the child and outcomes that have been achieved to determine the next 90 day provider rate based on Needs Based Care Assessment document.

Model #1. FFS Reimbursement: Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer/Child Perspective	Ideally should ensure best service package	• May be insufficient capacity to support choice of providers willing/able to provide needed services • Fragmented service system
Provider Organization Perspective	• Not at financial risk • Paid for every unit of service delivered	• Rates may be inadequate to attract and retain providers • Documentation required by increments of service • No incentive for communication and care coordination with other providers
Payer Perspective	Can standardize service rates across system, if desired	• Financial risk for performance failure is borne by payer • No link between delivery of services and outcomes • No bundling of services allowed, with each service build individually

Model #2. Market Rate Reimbursement: Description

- Payment schedules based on the rate offered by service delivery organizations for specific services and/or maintenance of specific service capacity

Model #2. Market Rate Reimbursement For FFS: Example - Virginia

- In Virginia, service providers set their price and referral sources decide whether the service is good value
- Current State reform efforts center on changing local funding match obligations (local match rates) to discourage overuse of congregate care

✓ Amount localities must match for community-based services reduced by 50% from each locality's 2007 rate

✓ Amount localities must match for residential services increased by 15% above each locality's base rate after incurring $100K and by 25% after incurring $200K during the year

Model #2. Market Rate Reimbursement: Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer/Child Perspective	Ideally should ensure best service package	• Emphasis on service delivery components and not outcomes • Fragmented service system in FFS model
Service Provider Organization Perspective	• Providers usually reimbursed without regard to issues of performance • Providers set prices for service delivery	• No guaranteed referrals • No incentive for communication and care coordination with other providers
Payer Perspective	• Cost control primarily through utilization review and selection of providers • Market pressures on providers for cost efficiencies • Allows for competitive bidding and specific accountability for deliverables	• Financial risk for performance failure is borne by payer • No direct link with the desired outcomes for the payer

Model #3. Per Diem With Performance-Based Contracting (PBC): Description

- Combines per diem (bundled per day payment) with performance-based contract that targets specific desired outcomes
- Possible models include:
  - ✓ Shared risk arrangement
  - ✓ Rewarding performance improvements that contribute to provision of a more suitable array of services as an alternative to placement or to more quickly return children to their families
  - ✓ Penalties or declining per diem amount for more intensive or longer lengths of stay

Model #3. Per Diem With Performance-Based Contracting (PBC): Example - Tennessee

- Financing Model: Per-diem payment, performance-based contracting (PBC) with provider organizations paid on a per diem basis by level of service
- Key Performance Measures: Each provider organization is asked to improve from its current level of performance in three main areas:
  - ✓ Permanent exits — 10% increase in number of children achieving a permanent exit
  - ✓ Fewer care-days — 10% decrease in number of care days used getting children to permanence
  - ✓ Lower re-entry rates — staying within a specified corridor — up to 12 months post discharge — for number of re-entries
- Provider organizations showing improved performance receive a financial reward on top of per diem based on the amount of state dollars "saved" due to program improvements and extent of improvement from their baseline
  - ✓ To "save" state dollars, the number of care-days used must be reduced
  - ✓ Providers are not restricted in how they spend their reinvestment incentive payment
  - ✓ Providers failing to meet their performance baseline receive no incentive payment (in Tennessee, the state prepaid the incentive payment, so providers failing to achieve the performance baseline must repay the reinvestment)

Model #3. Per Diem With Performance-Based Contracting (PBC): Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer/Child Perspective	Incentivizes outcomes important to children and families	Regional variation in service availability possible
Provider Organization Perspective	•Financial sustainability •Opportunity to receive incentive payments above base payment rates for improved performance • Increased flexibility to use clinical judgment and provide services deemed most effective for each consumer	• Will not receive the incentive payment unless outcomes achieved • Increases data collection and reporting requirements
Payer Perspective	• Increases risk sharing without major system changes • Creates a link between delivery of services and outcomes • Allows for competitive bidding and specific accountability for deliverables	• Increased administrative overhead and contract monitoring • Need accurate and timely information on services and outcomes

Model #4. Case Rate Reimbursement: Description

- Case rates are fixed, per-child rates paid to an organization to provide a group of services for each child
  - ✓ Provider organization has flexibility in how it uses the fixed amount of funds per child or family
- Rates are based on the expected costs of providing services for children with a given set of characteristics
  - ✓ Provider organizations accept some level of risk: the case rate will only be adequate if the number and intensity of services used by a particular child is equal to or less than the projected cost
  - ✓ Risk is offset by the potential for the organization to retain savings to invest in expanded services for children

Model #4. Case Rate Reimbursement: Description

- Two payment types: episodic vs. annual
  - ✓ Episodic case rate is based on the estimated costs of proposed services for children in the target population from referral to end of 'episode' (however defined)
  - ✓ Annual case rate is based on an estimated cost of proposed services of the target population from referral until a particular outcome or milestone
- Either episodic or annual case rates can be for all out-of-home services, for just foster care, or for congregate placements (group home or residential)

Model #4. Case Rate Reimbursement: Example - Missouri

Missouri Interdepartmental Initiative for Special Needs Children (1998-2005)

- Pooled funding streams from multiple state departments to support diversion of children with multiple behavioral and mental health problems from most restrictive (and expensive) treatment settings
- State contracted with a private agency to assume total case management responsibility for the children referred
  - ✓ State paid the private agency a fixed monthly case rate per child
  - ✓ Case rate was established based on the average monthly cost for intensive needs children
- Key features:
  - ✓ Single source of funding
  - ✓ Single referral process across agencies
  - ✓ Flexibility in private agency's use of funds
  - ✓ No reject/No eject philosophy
  - Contract rebid as Specialized Case Management in 2005
  - ✓ Contracts now performance-based — outcomes focus on stability, permanency, and well-being

Model #4. Case Rate Reimbursement: Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer/Child Perspective	Continuum of care more seamless as children and families move between levels of care	Potential for under-service — depends on adequacy of provider network
Provider Organization Perspective	•Contractor is not at risk for the number of children who will use services •More financial predictability and stability •Increased flexibility to use clinical judgment and provide services deemed most effective for each consumer	•More responsibility/risk •May lack the operational resources, infrastructure, or knowledge to achieve financial and performance outcomes •Increased data collection and reporting requirements •Some costs remain outside control of providers (judicial/court requirements)
Payer Perspective	•Fewer children in bed-based services •Flexibility in how it uses fixed level of funds to provide services not otherwise covered in a cost reimbursement system	•Change in role for caseworkers •New contract management requirements

Model #5. Case Rate Reimbursement With PBC: Description

- Case rates are paired with incentive payments for completion of required processes and achievement of desired outcomes, such as:
  - ✓ Movement of a child to a lower level of care
  - ✓ Placement of a child in a permanent setting
  - ✓ Achievement of permanency for a child for a defined period of time

Model #5. Case Rate Reimbursement With PBC: Example - Kansas

- Current system — a tiered payment system paid as a monthly case rate
- Case rate is negotiated with providers who receive a proportion of that case rate (known as a progress payment) when they accomplish any of 4 major milestones
  - ✓ Child referred to contractor — 25% of case rate
  - ✓ 60-day report provided to state — 25% of case rate
  - ✓ 180-day report provided to state — 25% of case rate
  - ✓ Child achieves permanent placement — 25% of case rate
- Contractors may incur loss if they do not meet milestones
- Agency performance on these measures determines whether or not contracts are renewed
  - Payment does not include services during the year after achieving permanency when contractor must provide services with no additional payment

Model #5. Case Rate Reimbursement With PBC: Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer & Child Perspective	• Emphasis on outcomes important to children and families • More individualized care for families	Potential for under-service — depends on adequacy of service controls and reporting
Provider Organization Perspective	• Provides a financial incentive to providers to reduce costs and improve outcomes • Increased flexibility in providing array of services • Maintains a level of predictability in cash flow	• More responsibility/financial risk • May lack the operational resources, infrastructure, or knowledge to achieve financial and performance outcomes • Increased data collection and reporting requirements
Payer Perspective	• Fewer children in bed-based services • Payers can tie program goals and expectations to provider compensation • Allows for competitive bidding and specific accountability for deliverables •Provider base rates standardized and increased cost outlays directly tied to established outcomes	•If rewards heavily weighted toward process or methods, it can weaken tie to improved outcomes •Outcomes and deliverables need specific definition and mutual agreement •Need accurate and timely information on services and outcomes

Model #6. Capped Allocation Payment: Description

- A fixed pool of dollars to provide a defined set of services to a defined entitled population
- Similar to capitation contracting with respect to risk, but without an actuarial basis (in terms of population, users, and demand) for the contract amount
- State provides contractor (i.e., county or provider organization) with an allocation (block grant) – contractor assumes responsibility for provision of all defined services to entitled population
  - ✓ Contractor typically has flexibility and control over resources and the ability to retain savings
  - ✓ Contractor can decide to share financial risk and management responsibilities with lead agencies or individual provider organizations

Model #6. Capped Allocation Reimbursement: Example - New York

- In June 2002, New York State sought to reduce use of foster care placements by combining capped funding for foster care with uncapped funding for preventive services
  - ✓ State reimbursement to social services districts for foster care services is capped at the annual amounts appropriated
  - ✓ State reimburses 65% of every dollar spent by districts on preventive services (after first applying available federal funds)
  - ✓ State provides additional funding via the Quality Enhancement Fund to increase the availability and quality of children and family services programs
- If a district claims less than its capped allocation for foster care, unexpended funds may be used by the district in the next fiscal year for the district's expenditures on preventive services (including reunification services), independent living services, and aftercare services
- If a district exceeds its allocation, there is no additional funding

Model #6. Capped Allocation Reimbursement: Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer/Child Perspective	Opportunity for increased service delivery options	Regional variations possible
Provider Organization Perspective	• Defined level of financial predictability and stability • Ability to retain/reinvest savings	• At risk if number or acuity level of eligible population exceeds anticipated levels • Savings may not be returned to the system
Payer Perspective	• Fewer children in bed-based services • Increased flexibility in service offerings, but retain controls over resources • Reinvestment of savings can be made in capacity building	• Lack of accurate data to project what percent of population will require services, at what level, for how long, and at what cost • Data collection requirements to establish rate sufficient to retain financial viability of providers and build needed capacity

Model # 7. Capitated or Capped Allocation Reimbursement With PBC: Description

- A fixed pool of dollars to provide a defined set of services to a defined entitled population on a monthly basis
  - ✓ Fixed rate per *eligible* user in comparison to a case rate which pays care organizations a fixed rate per *actual* user
  - ✓ Payment typically expressed as "per member per month"
  - ✓ Contractor is at risk both for the number of children who use services and for the level or amount of services used
- Contract between State and provider agencies (i.e., county or provider organization) involves an allocation (block grant) that ties compensation and/or contract extensions to performance measures that establish set levels of accomplishment

Model # 7. Capitated or Capped Allocation Reimbursement With PBC: Example - Massachusetts

Massachusetts Commonworks

- Risk-shared privatized case management for children who entered the child welfare system with complex needs and required placement in therapeutic levels of care
- State established capitated agreement with lead agencies that combined intensive case management with funding strategies that rewarded positive outcomes
  - ✓ Outcomes related to children's movement to less restrictive settings and reentry into residential care
  - Performance standards were not introduced into lead agency contracts until the third year of operation when sufficient information had been collected to establish a baseline for standards
  - Lead agency participates in financial risk model to manage volume and outcomes and received $1,000 per child payment of flexible funds at intake and another $1,000 at each key performance point

Model # 7. Capitated or Capped Allocation Reimbursement With PBC: Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer/Child Perspective	•Increases potential for individualized service delivery •Incentivizes outcomes important to children and families	Regional variation in service availability
Provider Organization Perspective	•Contractors can specialize by service or by population •Can preserve smaller, community based providers •Incentive opportunities for lead agency	•Success may depend on factors outside of providers' control, such as judicial actions and the availability of services •Adverse selection possible if per-child reimbursements doesn't take into account case complexity •Increased data collection and reporting requirements
Payer Perspective	•Fewer children in bed-based services •Increased competition may lead to higher quality or less costly services	•Lack of accurate data to project what percent of population will require services, at what level, for how long, and at what cost •Additional administrative costs and challenges to effectively monitor contracts •Use of multiple providers increases likelihood of variability in performance across providers •Need accurate and timely information on services and outcomes

Model #8. Global Budget Transfer With PBC: Description

- State gives lead agencies a fixed percentage of the State's annual operating budget to provide all services covered in an entitlement program
  - ✓ Lead agency pays for all child welfare services provided through the network
  - ✓ Lead agency is also responsible for accessing services that fall outside their child welfare budget through various interagency agreements
- Similar in concept to capitation contracting with respect to risk – but without an actuarial basis for the contract amount
- Similar in concept to capped allocation payment with respect to role of contractor

Model #8. Global Budget Transfer With PBC: Example - Florida

- Florida the only state that uses a global budget transfer for child welfare
  - ✓ Florida used an Invitation to Negotiate process to select twenty lead agencies now operating across 22 geographically defined sites
  - ✓ Lead agencies (called community-based contractors or CBCs) differ in organizational and governance structures, as well as across specific child welfare practices such as case management, and levels of funding
  - ✓ State retains responsibility for child protective investigations, program oversight, and child welfare legal services
- Lead agencies given a predetermined % of the State's annual operating budget
  - ✓ Lead agencies responsible for providing or procuring all services needed by a child and family from the time of referral until the child achieves permanency
  - ✓ Allocation based on historical data of geographic area covered and on anticipated effects of privatization on utilization and outcomes

Model #8. Global Budget Transfer With PBC: Advantages & Disadvantages

Stakeholder Perspective	Advantages	Disadvantages
Consumer/Child Perspective	•Raises potential for increased access and individualized service delivery •Incentivizes outcomes important to children and families	Regional variability in service offerings and delivery
Provider Organization Perspective	•Lead agency can pay provider network in variety of innovative ways •Permits flexible funding to cover services categorical funding would not allow •Blends public and private funding streams because private agency can fundraise from the community	•Increased data and reporting requirements •At risk if number or acuity level of eligible population exceeds anticipated levels •Communication of connection between contract outcomes and practice must reach front-line staff
Payer Perspective	•Fewer children in bed-based services •Allows for greater coordination and service integration •Explicit and measurable performance standards in place as a quality check on service delivery •Closer to real-time data informs decision-making and strategy development	•Lack of accurate data to project what percent of population will require services, at what level, for how long, and at what cost •Oversight and accountability systems must be designed to monitor lead agency provider networks •Need accurate and timely information on services and outcomes

OPEN MINDS Recommendations for Child Welfare Finance Reform in Wisconsin

- Models #1 and #2 (market-share and FFS) are less compatible with cost and outcome goals
- Models #5 to #8 (capitation, capped allocation, and global budget transfer) require data supports that do not currently exist in the Wisconsin system on either the payer or provider side
- Performance-based contracting elements hold the greatest promise for aligning financial incentives and desired outcomes for both payer and provider

OPEN MINDS Recommendations for Child Welfare Finance Reform in Wisconsin

- Multi-year process of progressive introduction of reforms from a per diem to a PBC system
  - ✓ Recognizes the need to transform the system, but allows state, counties, and providers to gear up to meet the data and operational 'know-how' requirements
  - ✓ Aligns state investments in child welfare with desired outcomes for children
  - ✓ Phased introduction permits corrections in process to address issues as they arise
- Incorporate three financing levels to meet the unique needs of children in different settings
  - ✓ Monthly foster care/treatment foster care
  - ✓ Group home per diem
  - ✓ Residential per diem

Process for Development of Performance-Based Contracting

1. Identify and prioritize problematic system performance issues
2. Review current performance data generated within system – by system manager and by provider organizations
3. Identify which of the current performance measures can be proxy indicators of high-priority performance issues
4. Develop preliminary performance-based contracting model – high-priority issues with proxy performance measures for each (with definition and measurement specification)
5. Research and establish estimated 'baseline' and 'target' for each selected proxy performance measure
6. Establish 'incentive amount' or 'penalty amount' for each proxy performance measure – in total and by provider organization – and threshold for achieving incentive or being penalized

Process for Development of Performance Based Contracting

7. Develop a model of estimated provider performance under system with estimate of financial impact in total and by provider organization
8. Develop provider system contracts based on performance-based contracting system
9. Meetings with provider organizations and other system stakeholders to gain buy-in on the new system, the system measures, and operationalization of the system
10. Conduct beta test of the new performance-based contracting system
11. Based on beta test period, revise and refine the performance-based contracts for "go live" year

Bringing the Management of Behavioral Health & Social Services Into Focus

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Attachment 2

Proposed Outline for Special Committee Report

Principles for Child Welfare Rate Setting

Provide for quality, individualized services for children and families**.**

- support for individualized responses to the unique situations and cultures of children in the system (Hall)
- support recruitment and retention of experienced, quality staff (Hall)
- assessment of child's needs – need organized, consistent assessment (Orth)

Provide a full continuum of services from in-home family supports to inpatient hospitalization for children in need of protection and services**.**

- support success with the most challenging children by creating incentives for providers to work with them (Whelan testimony)
- robust, quality data on children's needs, system capacity and service/agency cost drivers (Hall)

Support quality by financially incentivizing agency efforts to integrate best practice and evidence-based standards.

- recognize and pay for measures that contribute to quality, incl. accreditation by a national accrediting body (Hall)
- focus on evidence-based practice such as trauma-informed care (Orth)
- incorporate aftercare in the rate payment to recognize the importance of managing transitions (Maro testimony)

Encourage development of new services and new providers.

- acknowledge start-up costs for new organizations (Orth)
- invest in technical assistance for new organizations or organizations with unique contributions to caring for child welfare children (Orth)

Promote accountability for agency performance by developing thoughtful measures that ultimately connect outcomes to agency compensation.

- develop a standardized set of performance measures (Orth)
- identify factors necessary to achieve goals that are within the control of providers (Hall)
- allow flexibility for agencies to spend dollars in ways that work for them (Hall)

Outline clear roles for the state, counties, and providers in developing reimbursement methodologies and determining accountability for outcomes.

- establish clearly defined roles for the state, counties and providers in setting reimbursement(Hall)
- establish clearly defined roles for the state, counties and providers in achieving quality goals(Hall)

Maximize alternate revenue streams, while preserving state and county financial commitment to support reinvestment in prevention and early intervention.

- maximize alternate revenue streams like Medical Assistance, Public Health, and W-2 (Hall); education/special education funding for RCC (Balestrieri testimony)
- value reinvestment strategy so that hoped for savings on out-of-home care are translated into funding for prevention and early intervention services with children and their families so that out-of-home care costs remain lower over the long term (Hall)

Promote financing and rate-setting system integrity by ensuring sufficient administrative support for DCF and for agencies to comply with expectations for rate setting process.

- funding that fully supports the rate methodology (Hall)

- funding reflects state and provider cost to collect and manage data needed to support quality child welfare funding decisions (Hall)
- funding reflects DCF and agency costs to implement the new methodology (Hall)
- funding reflects historical accounting of providers' cost and agency cost drivers with limits on administration and profit (Orth)

Child Welfare Rate-Setting Criteria/Statutory Clarifications

- *Performance-based Contracting* – establish timeframes for introduction of performance-based measures and related payments
- *Negotiation, Mediation and Appeal Process* - define negotiation and mediation process in rules and connect the appeal process to the standard hearings and appeals statutes
- *Provider Representation in Rate Setting* Process - establish a formal role for providers (with a specific inclusion of WAFCA) and other designated stakeholders in the rate setting process
- *Level of Care Determinations* - require DCF to contract with a third party to assess levels of care for children or to develop a process that ensures a joint effort by purchasers and providers
- *Other statutory factors* – enact additional factors to be recognized in the formula, like accreditation and health care CPI, that the department must consider.
- *Accreditation* – incentivize agencies for accreditation by a national accrediting body.
- *Allowable reserves* – current language conflicts with principles of performance-based contracting and should be removed if performance-based contracting is adopted for child welfare.
- *Protecting out-of-home care resources through the transition* –during the rate freeze, recognize employee health insurance increases as a factor that should not result in agency closure or an agency's elimination of an out-of-home care service category (Anderson testimony)

Additional Issues for Future Legislative Study and Action

- *Education Funding* – modify source of funding for education in residential care by taking dollars off the top of the school aids formula to fund residential care educational funding and IDEA education for youth ages 4 to 21; and require Medical Assistance to fund speech and occupational therapy especially as related to IDEA education.
- *Role of Group Homes*- clarify and possibly modify the role of group homes in the care continuum.
- *Stabilization* – modify statutes and administrative rules to allow for improved and more diverse crisis services due to change in funding for the mental health institutes
- *Certificate of Need* – modify to increase flexibility in the ratio of in-state to out-of-state children to more readily accommodate requests for care that are cost neutral to the state or allow for increased state revenue.

Attachment 3

Wisconsin Child Welfare Finance Reform Four-Year Transition Vision

Transitioning to a new child welfare financing system that incorporates performance-based indicators to improve outcomes should be accomplished through a thoughtful process that will ensure the continuity and quality of care during the transition process. To that end the Wisconsin Association of Family and Children's Agencies proposes a four-year process that would provide:

- *time for state, counties, and providers to gear up to meet the data and operational 'know-how' requirements of a new system;*
- *experimentation with performance-based indicators;*
- *monitoring of adopted measures and policy changes; and*
- *Legislative review of the new methodology in year four with DCF, counties, providers, and stakeholders working together to make necessary revisions.*

CY 2010

Rate System – Provider rates are frozen at 2009 levels.

New Rate System Methodology Activities – State, counties, and providers engage in a process to: 1) select payment tiers based on child characteristics and service provision requirements; and 2) select performance-based contracting (PBC) indicators best aligned with high priority system performance issues and current data collection capabilities.

CY 2011

Rate System – Provider rates based on payment tiers and ranges. Individually negotiated agency adjustments to payment tiers may be explored. Pilot experimental PBC indicators in multiple provider contracts and require measurement of achievement of these measures, but no penalties/bonuses assessed.

New Rate System Methodology Activities – State, counties, and providers monitor PBC indicators and adjust PBC approach based on first-year data.

CY 2012

Rate System – Provider rates based on payment tiers with agreed upon PBC, but no penalties/bonuses assessed.

New Rate System Methodology Activities – State, counties, and providers monitor PBC indicators and adjust PBC approach for CY 2013 based on first and second year data.

CY 2013

Rate System – Provider rates based on payment tiers with PBC penalties/bonuses effective.

New Rate System Methodology Activities – State, counties, and providers continue to monitor PBC indicators. Legislative Committees on children and families evaluate the system performance under PBC and assess the feasibility and desirability of further modifications to financing system (per diem, case rates, capitation, global budget, etc.) State, counties and providers work with legislators to incorporate recommended changes.