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The Implications of Privatization on Low-Income People
Child Welfare Managed Care: Navigating a Policy Sea of Change

By Christina A. Zawisza

As many states experiment with the transfer of pieces of state government functions to private organizations, the area of child welfare services has found itself swept up in a similar sea of change.1 By 1999 twenty-nine states had one or more initiatives to change their management, financing, or child welfare service delivery practices by adopting two elements: (1) fixed or capitated prospective payments to one or more service providers rather than traditional fee-for-service reimbursement payments and (2) a single private entity responsible for providing appropriate and quality services.2

The majority of the twenty-nine states that operate child welfare “managed care” initiatives are experimenting with the delivery of services to emotionally disturbed children—only one segment of the child welfare population. In some states certain counties, most notably Jefferson and Mesa counties in Colorado, serve all children in foster care in privatized systems. Kansas was the first state to develop a statewide system of managed care for all of its child welfare services.3 In 1998 Florida joined Kansas in this endeavor; Florida called its enterprise “community-based care.”4

In this article I begin by describing the drivers of child welfare managed care: lawsuits, media attention, and bad outcomes for children. Next I describe—by highlighting the particular experiences of Kansas and Florida—the attributes of successful child welfare managed care. Next I discuss four major challenges facing child welfare managed care. I conclude the article with systemic and case-based advocacy tips for child welfare practitioners.

I. Drivers of Child Welfare Managed Care

The motivation for community-based care comes from different sources. One driver is the desire to shrink the size of state government and eliminate the need for civil service protections that make it difficult or impossible to discipline or fire...

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1 For purposes of this article, “child welfare” or “child welfare system” refers to the full range of functions and services operated to protect Florida’s abused, neglected, or dependent children. These functions and services include protective investigations, early intervention services, family preservation and support services, shelter care, foster care, therapeutic foster care, group care, residential care, independent living, postjudication case management, postplacement supervision, permanent foster care, and adoption.


3 Id. app. (CHILD WELFARE MANAGED CARE INITIATIVES’ OUTCOMES TO DATE) at 15–23.

incompetent employees. Community-based agencies can terminate ineffective employees at the supervisor’s will.5

A stronger motivation, however, is the desire to fix what most commentators describe as a broken child welfare system—one beset with escalating costs and a poorly integrated patchwork of services.6 State child welfare systems nationally are currently responsible for more than one million children needing protection or care.7 “Foster care is intended to provide a temporary safe haven for children whose parents are unable to care for them,” according to Michael Mushlin.8 Yet more than half a million children currently languish in government foster care at a cost of $12 billion.9 Among the problems of the current child welfare delivery system are

- lack of permanence: children remain in foster care too long without being reunited with their parents or adopted into a permanent home;
- compromised safety: children are sent back to abusive homes or placed with abusive foster parents or in overcrowded conditions;
- high number of placements: children move from foster home to foster home within short time periods, jeopardizing their safety and stability;
- heavy caseloads: social workers are responsible for far too many children to supervise all cases thoroughly; and
- caseworker turnover: foster children face many changes and have to adjust to many caseworkers.10

In the latter half of the 1990s the march toward foster care drift for abused and neglected children seemed almost inexorable. While 520,000 children were in foster care in 1996, by March 1999 547,000 children were in care. In 1996 11 percent had been in foster care for three to four years, and 10 percent had been there for five years or longer. By March 1999, 15 percent had been in foster care three to four years, and 18 percent had been there five years or longer. In 1996 approximately 54,000 were legally available and waiting for adoption; 117,000 were legally free and waiting for adoption by March 1999.11

Jill Chaifetz observes the incalculable human loss behind these statistics, the enormous personal pain and hurt, and the tangible, detrimental society costs. Children who have grown up and left foster care fill the nation’s jails, mental hospitals and welfare rolls, according to documented studies.12

These results have occurred despite the passage of good laws. The 1980 federal Adoption Assistance and Child Welfare Act attempted to address the decades-old phenomenon of a child literally growing up in foster care through fiscal incentives to states to prevent the removal of children from their homes unless necessary and to reunify them with parents or relatives as soon as possible.13 The Act required states to find adoption or other permanent living arrangements in the

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7 Id.
10 Id.
11 Id.
The absence of prevention or reunification.\textsuperscript{14} It required states to make “reasonable efforts” to prevent removal or to reunify through services; to develop written case plans to direct the provision of services for each child; and to review judicially or administratively the status of each child at least every six months and to hold a permanency hearing within eighteen months of placement.\textsuperscript{15}

The promise of the Adoption Assistance and Child Welfare Act was never fulfilled. The federal law’s financing scheme became an incentive to keep children in foster care. Lack of state funds for services, insufficient foster homes, and lax federal monitoring of state programs did not help.\textsuperscript{16}

The Adoption and Safe Families Act of 1997 sought to cure some of the defects of the Adoption Assistance and Child Welfare Act by making federal reimbursement contingent on speeding up the process of cases heading toward termination of parental rights; by removing the mandate for reasonable efforts to reunify children under certain circumstances; by requiring permanency hearings within twelve months instead of eighteen; and by providing fiscal incentives to states to foster more adoptions.\textsuperscript{17} Another impetus was President Bill Clinton’s challenge to states to double the number of children moved from foster care to adoption by 2002.\textsuperscript{18} The Adoption and Safe Families Act changes have placed enormous pressure upon child welfare agencies to improve service delivery.\textsuperscript{19}

Another force behind community-based care has been the influence of class action lawsuits and high-profile media stories about the “failure” of the system to protect and serve children.\textsuperscript{20} Class action lawsuits against public child welfare agencies on behalf of children have driven more than twenty states to operate under court consent decrees.\textsuperscript{21}

In 1989 a statewide class action lawsuit, Sheila A. v. Whiteman, filed in Kansas, challenged the conditions in foster care. Kansas had the highest incidence nationally of children reentering foster care after being returned to their parents. A settlement in 1993 required improved service delivery and systemic changes. Child welfare privatization arose out of this mandate.\textsuperscript{22}

Florida is currently plagued with three class action lawsuits. M. E. v. Bush, filed in 1990, challenges the failure of the state to provide mental health services to children in state custody.\textsuperscript{23} Ward v. Bush, filed in 1998, challenges unconstitutional conditions in the child welfare system in Broward County, while Foster Children v. Bush, filed in 2000, challenges such fail-

\textsuperscript{15} Id. § 671(a)(15); id. § 671(a)(16), 675 (1) (1988); id. §§ 671(a)(15)–(17), 675 (1), (5)–(6) (1988 & Supp. 1999).
\textsuperscript{16} Chaifetz, supra note 12, at 9.
\textsuperscript{21} Id.
\textsuperscript{22} Sheila A. v. Whiteman, 861 P.2d 120 (Kan. 1993), 913 P.2d (Kan. 1996). Plaintiffs’ lawyers, Children’s Rights Inc., say that meaningful change has occurred as a result of the lawsuit. The settlement has been extended by mutual agreement until June 30, 2002, in order to focus on the remaining problems in the system. See www.childrensrights.org/case_updates.
II. Attributes of Successful Child Welfare Managed Care

Community-based care is not a new phenomenon in child welfare. For much of this country’s history before the middle of the twentieth century, private agencies served abused and neglected children, while governments made fledgling efforts.29

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The federal government became financially involved through passage of


28 See Child Welfare League of America, supra note 20, at 2; Bosquet, Faith-Based Initiative Familiar to Florida, supra note 6, at 1A, 6A.

the Social Security Act of 1935 and the creation of the Aid to Families with Dependent Children program. Only with the passage of the Adoption Assistance and Child Welfare Act, Adoption and Safe Families Act of 1997, and the Child Abuse Prevention and Treatment Act of 1974 did the federal government assume a major role in the funding of child welfare services through incentive payments to states. Even with increased federal funding, however, states retained a great deal of discretion in the operation of their child welfare systems.30

The lessons of the past have led to increased motivation for systemic reform. Research has identified the following attributes of successful community-based care:

- **Design and pricing:** Good systems ensure access to the full range of services needed and adequate funding to support service delivery and ensure quality.
- **Quality:** Good systems have quality as the centerpiece and use best practices and procedural protocols that are followed.
- **Role clarity:** Public and private sector responsibilities must be clearly defined and delineated.
- **Outcomes:** Good systems have meaningful, measurable, and attainable outcome measures and performance benchmarks.
- **Management information systems:** Such systems must be capable of monitoring and evaluating critical information on an ongoing basis.
- **Inclusive planning process:** All stakeholders must be included in the design and evaluation process.31

### III. Kansas and Florida: Choices and Impact

In 1996 Kansas contracted with five non-profit agencies to provide child welfare prevention and adoption services. In March 1997 it expanded with three non-profit agencies to manage the cases of all foster children in out-of-home care by dividing the state into five regions.32 In Kansas the Department of Social and Rehabilitative Services used its broad statutory authority to administer its children and youth program to create this shift rather than look to the legislature to develop a privatization scheme.33

The Department of Social and Rehabilitative Services maintains legal responsibility for all children in managed care settings and investigates reports of substantiated cases of abuse or neglect. To the appropriate contractor, the department refers children ordered to be placed outside their homes. The contractor is responsible for developing a case plan for the child and selecting a foster care setting, recommending and delivering a variety of services for the child and family, managing the case and giving timely information to the department and to the court. The department ensures that case plans are followed and services provided by participating in the case plan, tracking progress, and consulting with the contracted social worker, by keeping the contractor informed about the status of legal actions and court dates, and by attending court hearings and providing reports to the court.34

The Florida legislature, in contrast, chose to accomplish community-based care through statutory prescription. Legislation requires its sixty-seven counties each to select a lead agency, a single agency that contracts with the Department of Children and Families to provide child welfare services, phased in over a three-year period beginning January 1, 2001. By statute the following parameters govern:

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34 *Legislative Div. of Post Audit, supra* note 32, at 4.
the ability to coordinate, integrate, and manage all child protective services in the community in cooperation with child protective investigations;

the ability to ensure continuity of care from entry to exit for all children referred by protective investigation and the courts;

the ability to provide directly or contract with a local network of providers for all necessary services;

the willingness to accept accountability for meeting the outcomes and performance standards established by the legislature and the federal government;

the capability and the willingness to serve all children referred to it from the protective investigation and court systems, regardless of the level of funding allocated to the community by the state, provided all related funding is transferred; and

the willingness to insure that each individual who provides child protective services completes required training.35

Reviews of the success of managed care in these two states have been mixed. In Kansas the timeliness of need assessments for children and families improved dramatically and needed services were recommended for most children and families. But people responsible for making decisions about foster children were not always involved to the extent they needed to be and did not always receive or give the information they needed. Foster children received most of the services recommended for them, but nearly 20 percent of the services were not started for two months after they were recommended. Many stakeholders thought the services to children or families did not adequately address their needs due to lack of funding, available services, social workers, and appropriate placements.

Children were moved on the average every two to three months for reasons related to their behavior and sometimes placed inappropriately in overcrowded or poorly staffed homes. Very few children, however, were neglected or abused while in care—the condition most salient in the *Sheila A.* litigation.36

Initial evaluation of Florida’s community-based care pilot projects also demonstrated mixed results. Improvements over the Department of Children and Families-run system included weekly in-person contact with the child in 65 percent of cases; reduction of number of children per foster home to 1.6, average caseload of 18.9, average number of placements per child of 2.79, length of stay in foster care shortened 66 percent; counselor turnover three or more times in only 12.8 percent of cases; and foster parent satisfaction in 78.9 percent of cases.37

On the other hand, for the three pilot projects for which data are available, two of the three were not successful in meeting performance goals: children not reabused during service provision, children not reabused one year after service closure, average length of stay for children whose goal was family reunification, and reentry into foster care within one year after reunification. Even the most successful project, the Sarasota County Coalition, failed to meet its performance goals regarding prevention of reabuse during the year following case closure.38

IV. Limitations of Child Welfare Managed Care

States face considerable challenges in implementing community-based care in a way that will produce consistently positive outcomes for children and families. Hot spots include (1) adequate funding, (2) limitation of legal liability, (3) preservation of appropriate state parens patriae


37 Snell, *supra* note 9, at 11.

38 OFFICE OF PROGRAM POLICY ANALYSIS & GOV’T ACCOUNTABILITY, FLA. DEP’T OF CHILDREN & FAMILIES, REPORT NO. 01-DRAFT 2, JUSTIFICATION REVIEW: CHILD PROTECTION PROGRAM 45–46 (2001). The Sarasota County Coalition has since become a lead agency. Among the factors in the success of this agency are the agency’s already established infrastructure and experience, a well-developed and active community stakeholder group, executive leadership, the county’s wealth of local resources, and a small child population. *Id.* at 48.
roles, and (4) incursion of for-profit corporations in the traditional work of private, nonprofit entities.

A. Adequate Funding

The vision of community-based care requires shared costs and risks with local communities. But community-based care often costs more than traditional child welfare service delivery.39 One of the attributes of successful programs is adequate funding to support service delivery and ensure quality.

Both Kansas and Florida have experienced a huge growth in the number of children in foster care.40 This increase has resulted in insufficient foster homes to meet the demand, resulting in overcrowded conditions, case management problems, unrealistic expectations for care and supervision by foster parents, rapid turnover, and failure in meeting statutory expectations for permanency within 12 months.41

In both states financial risk is an obstacle to successful implementation, a finding that is not surprising.42 Providers worry that the state will not give them the resources to do the job right and that community-based care is just another underfunded state mandate.43

Anxiety centers around the availability of a “risk pool” to protect managed care providers from the risks of uncompensated growth due to unexpected caseload increases, legislative and policy changes, and media awareness. Kansas had to pay contractors $45.2 million more than expected. Original case rates were too low, having been developed without adequate historical information, based on unrealistic estimates of how long children would remain in the system. The costs of start-up and monitoring were not considered.44 The Florida legislature set aside $4.5 million in budget authority for a “risk pool” in fiscal year 2000–2001, a minus-
cule amount compared to the Department of Children and Families’ projected 2002 child welfare budget of $761 million and the projected growth of numbers of children in out-of-home care.45

Resource issues need to be squarely resolved, or else potential providers will either decline to step up to the plate, will be unable to meet quality performance measures, or will embroil states in mounds of litigation.

**B. Limitation of Legal Liability**

Closely linked to the above discussion is the question of legal liability. While the state retains legal responsibility for children in its care, and sovereign immunity is waived for negligence in the performance of operational-level activities of caseworkers, a statutory cap in Florida limits the state’s financial risk.46 Private providers, on the other hand, do not have sovereign immunity and can be held legally responsible for negligence in the delivery of their services.47

Kansas law subjects managed care providers to the same legal liability as any private actor, while Florida has placed some limitations on liability.48 The 1999 Florida legislature required lead agencies and subcontractors to acquire a liability insurance policy of at least $1 million per claim and $5 million per incident. and also limited economic damages (past and future medical expenses, wage loss, and loss of earning capacity) to $1 million and noneconomic damages (pain and suffering) to $200,000 per claim.49 Liability remains of great concern in the decision to enter into contracts with the state.50

**C. Preservation of Appropriate State Parens Patriae Role**

Another attribute of successful community-based care is role clarity. Not only does Florida law and practice fail to delineate clearly the role of the state versus the role of communities in its “partnership,” but also the very nature of the “partnership” described in Florida law may run afoul of state parens patriae and police powers to protect children. Implicit in the state’s desire to “share costs and risks” is the desire to diminish the state’s liability. This, however, may not be legally possible.

The state may constitutionally delegate “functions” that are traditionally performed by governments to a private entity, but it may not delegate governmental “power”.51 A private entity exercises gov-

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45 Gen. Accounting Office, supra note 2, at 17–18; Office of Program Policy Analysis & Gov’t Accountability, supra note 38, at 58.

46 Dep’t of Health & Rehabilitative Servs. v. Yamuni, 529 So. 2d 258 (Fla. 1988) (calling actions of caseworkers investigating and responding to reports of child abuse operational-level activities and legally actionable), and Dep’t of Health & Rehabilitative Servs. v. Whaley, 574 So. 2d 100 (Fla. 1991) (calling the care of youth in detention an operational-level activity and legally actionable). But see Dep’t of Health & Rehabilitative Servs. v. B. J. M., 627 So. 2d 512 (Fla. 1993) (holding that decisions about where to place a child and the kind of services to give the child are planning-level activities and not actionable), and Lee v. Dep’t of Health & Rehabilitative Servs., 698 So. 2d 1194 (Fla. 1997) (holding that decisions about staffing and staffing levels are planning activities and not actionable). The limit is $100,000 per incident of negligence and $200,000 total per victim. Fla. Stat. § 768.28(5) (1999) (waiver of sovereign immunity tort action). A successful litigant would have to seek a special claims bill from the legislature to exceed the statutory cap.

47 The U.S. Supreme Court in Richardson v. McKnight, 521 U. S. 399 (1997), held that private persons performing governmental functions were not entitled to qualified immunity.


ernmental power whenever it deprives a person of life, liberty, or property under government directive, giving rise to a claim of “state action.”52 Under the “state action” theory, the state retains responsibility to protect the constitutional rights of the children and families over whom community-based care providers exercise control because the responsibility is non-delegable.53

The nondelegation doctrine is particularly applicable to the child welfare system for reasons other than the “state action” theory. The state is prohibited from interfering in family life except to protect children54 because of the state’s constitutional police powers and the state’s common-law parens patriae responsibilities.55

Historically the care and protection of children was the prerogative of the crown, a prerogative which devolved upon the state, as sovereign, that is, the parens patriae.56 Parens patriae responsibilities are vested only in the state and are the basis for state laws which protect children.57 These powers may not be surrendered, bargained, or contracted away.58

In the community-based care context, the state can lawfully delegate the performance of state “functions,” such as the delivery of shelter care, foster care, adoption and other services, to private providers, but it must retain the “power” and duty to protect children assigned to these services.59 The state may not delegate the removal of children from their homes to a nongovernmental actor. Nor may the state delegate its ultimate responsibility for children once they are in state custody and deprived of their liberty. The logical implication of this analysis is that the state may not require private providers to assume the costs and risks of fulfilling government obligations. The state may ask the community for assistance, but ultimately the state remains responsible for the adequacy of resources, for caseload sizes, and for the quality of services provided.60

Kansas has addressed this issue by maintaining a “hands-on” approach to its caseload, with state caseworkers intimately involved in cases.61 Although Florida’s child welfare agency has remained the child’s legal custodian, the exact parameters of the Department of

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52 Robbins, supra note 51, at 931.
53 Ancata v. Prison Health Servs., 769 F.2d 700, 703 (11th Cir. 1985). See Robbins, supra note 51, at 931; Note, supra note 51.
57 In re Beverly, 343 So. 2d 481, 485 (Fla. 1977). The Third District Court of Appeal in Simms v. Dept of Health & Rehabilitative Servs., 641 So. 2d 957 (Fla. Dist. Ct. App. 1994), recognized that two branches of government—the courts and the executive branch—can simultaneously exercise protective powers over children but did not reach the question of sharing power with private entities.
59 See Fla. Stat. § 39.521(1)(f)5 (2000) (dispositional hearings; powers of disposition), which does not alter the requirement for placing legal custody of dependent children with the Department of Children and Families, not with a private agency. See Office of Program Policy Analysis & Gov’t Accountability, supra note 38, at 58.
60 Some argue that the nondelegation doctrine has been for all practical purposes discredited, but it still holds firm in instances where the power delegated was never lawfully delegable. See the concurring opinion in A.A. v. State, 605 So. 2d 106, 108 (Fla. Dist. Ct. App. 1992), citing Chiles v. Children, 589 So. 2d 260, 265–66 (Fla. 1991), for an excellent summary of these points.
61 See text of section III supra.
Children and Families’ relationship with private providers is open for discussion. Some commentators would argue quite meritoriously that private providers should not be excluded from the child-parent-state traditional triad relationship. By opening up the closed triangle and making a foursome, they say, responsibility and resources for children can be more clearly explored and understood; private providers can and do provide valuable services and evidence to serve dependent children and their families better. By integrating private providers in the dependency court process without violating the principles of parens patriae remains one of the challenges of the community-based care movement.

D. For-Profit Providers in the Child Welfare Managed Care Movement

A little-noted provision of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act amended the Adoption Assistance and Child Welfare Act to allow private for-profit corporations to provide child welfare services and to allow Title IV-E funds to be used for reimbursement. Empirical studies of the efficacy of such for-profit delivery are not available, however.

The introduction of the profit motive and distribution raises concerns among commentators because it adds further risk to the relationship between funding source and the service provider with the recipient removed from the exchange of authority and funds. The risk of misuse of funds and poor service delivery is heightened when return and not quality is the bottom line.

Further, the risk that children may be sent to placements far from home increases as the for-profit corporation seeks to aggregate housing in order to maximize profits. Not only corporate headquarters but also placement facilities may be out of state. Thus contacts to the child’s community are attenuated. Boards of directors are not drawn from the local community. Private providers are allowed to contract for placements in settings larger than twenty-five beds. These characteristics of for-profit corporations are in conflict with the Adoption Assistance and Child Welfare Act’s preference for home-like settings as close to the child’s home as possible. Additional levels of public oversight through contract monitoring are imperative.

On the other hand, for-profit delivery has advantages. New eyes and new stakeholders with strong financial and business capabilities join a field previously dominated by the “helpers.” This phenomenon may rejuvenate the child welfare system in ways more lasting than lawsuits and media criticism. Monitoring and research are extremely important as oversight tools.

V. Child Welfare Advocacy in Uncharted Waters

Child welfare managed care, as a movement, was forged with little regard to the day-to-day complexities encountered by advocates who daily represent parents, children, or foster parents in either systemic or case-based advocacy. We are in a period of “testing the waters,” trying things out, and reporting to each other on successes and failures. No case law or indeed scholarly production is there to assist us. One is supplied therefore with “food for thought,” creative opportunities, and pitfalls to watch for, rather than a primer on charting the new waters.
A. Systemic Advocacy Tips

Opportunities for systemic advocacy might include:

- participation in community forums struggling on a community-by-community basis with producing an improved plan for the delivery of child welfare services;
- remaining acutely aware of the need to incorporate preventive services, including legal services, in the community plan;
- vigilantly monitoring the community plan adopted;
- advocating legislative strategies to provide sufficient funding, deal with sovereign immunity issues, and the need to identify roles and relationships appropriately among parent-child-state-private provider;
- participating in designing evaluations and monitoring the results;
- speaking out about the successes and the failures of child welfare managed care;
- monitoring contract development: assuring that the basic protections provided to all parties in current state statutes, for example, notice and hearing rights, are carried over and made the responsibility of private providers;
- monitoring contract development to assure that all available funds, including mental health, Medicaid, flex funds, emergency assistance, and housing assistance, are available to community-based providers and that there is no “holding back”;
- regularly advising the media on the progress of child welfare managed care in the community; and
- insisting on adequate training for community-based providers and providing such training.

B. Case-Based Advocacy

The importance of legal representation for all parties and participants cannot be underscored:

- Create projects for parent, child, and provider legal representation.
- Request through subpoena or other discovery methods all reports, recommendations, and case file notes of both the state agency and the private provider for use in individual representation.
- Negotiate both with the state agency and with the private provider to obtain appropriate case resolution or services for parent or child client.
- Use outcome data as evidence either for or against private providers in individual court cases.
- Assist the client through consultation to understand the new waters.
- Advise the court of glitches or instances where the client falls through the cracks; seek appropriate remedies.
- Inform yourself about your local contract, state laws, rules of procedure, and local practice that may have changed in light of managed care.
- Remain true to traditional ethical obligations toward the client.

Design and pricing, quality, role clarity, successful outcomes, adequate management information systems, and an inclusive planning process are realistic expectations of any good child welfare system, whether it be a traditional system or a managed care system. Advocates must insist upon the accomplishment of these attributes through systemic and case-based vigilance if child welfare managed care is to mean more for children and families than just “change for change’s sake.”