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THE EFFECTS OF PERFORMANCE BASED CONTRACTING ON PRIVATE
RESIDENTIAL TREATMENT FACILITIES IN ILLINOIS

by

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A Research Paper

Submitted in Partial Fulfillment of the Requirements for the
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Department of Political Science
in the Graduate School
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Introduction

Many private child welfare organizations are contracted with state organizations to provide services to children and families in need; some of these contracts are performance based. Performance based contracting allows for more oversight and scrutiny from public organizations and focuses on outcomes determined by performance indicators.

In the past, private child welfare organizations were granted contracts year after year despite their performance. Specifically residential treatment facilities, facilities who offer twenty four hour services to abused/neglected children and adolescents, anticipated yearly contract renewal by the Illinois Department of Children and Family Services (DCFS) unless they were highly negligent.

In 2007, the National Quality Improvement Center on the Privatization of Child Welfare Services chose Illinois as a demonstration site to evaluate performance-based contracting in residential treatment. The National Quality Improvement Center was created in 2001 by the U.S. Department of Health and Human Services' Children's Bureau to assess privatization through research and evaluation, facilitate dialogue between child welfare stakeholders, and promote the expansion of evidence based practices (Collins-Camargo, Ensign, & Flaherty, p. 72).

Prior to 2007, residential contracts were considered purchase of service, services purchased from private child welfare agencies by the government. Each agency was assigned a daily rate of pay per client and an agency's revenue was based on the number of days DCFS clients were in placement. Performance based contracting guarantees agencies fixed revenue by allowing DCFS to purchase a number of beds in residential treatment. Agencies are paid for the number of contract beds regardless of the number of clients in treatment.

Of course, a fixed revenue source is a huge benefit for non-profit organizations or any organization for that matter, but there are other effects, some potentially negative effects, of performance based contracting. Nine professionals who were directly involved with their organization's residential performance based contract (a clinical director, a treatment director, two treatment supervisors, an executive director, a chief executive officer, an aftercare coordinator, a manager of residential services, and a residential coordinator) were interviewed to evaluate how their agency has been affected by the change to performance based contracting. This paper will explore fiscal, program, and personnel effects of performance based contracting through a case study approach. As a professional who has worked in the field of child welfare for seventeen years, I expected predominantly negative effects reported during the interview process. In my experience, private agencies have difficulty adjusting and accepting change implemented by DCFS.

The study also reviews the principals behind performance based contracting and its framework for effectiveness. It specifically examines Illinois' Striving for Excellence Project implemented by the Department of Children and Family Services in 2007. The paper concludes by suggesting further research topics on the subject of performance based contracting.

Residential Care and Performance Based Contracting

Residential care in Illinois has taken many twists and turns over the years regarding need and programming. Residential care is significantly lower in census than in the past. The state has taken many strides to keep youth from entering residential care out of fear of institutionalization. Currently there are approximately 1,400 youth in residential care in Illinois. At one point within the last 15 years, there was over 4,000 youth in residential care (T. Duff, personal communication, February 20, 2012). As of now, the state has reserved the most

challenging youth for residential. These are youth who have not been successful in alternative forms of placement (home of relative, foster care). These youth have struggled with managing their own behavior, understanding mental illness, and do not have stable family systems. The residential facilities that work with these youth offer structure and consistency through therapeutic means. This consists of weekly individual and group therapy, behavior management systems and a milieu that offers structure and consistency on a daily basis. In the state of Illinois, the majority of these facilities are private nonprofit, contracted by the state to offer these services to wards of the state or court.

There are different tiers or levels of residential care in the state. These levels of care for residential treatment are based on severity of the youth (type of mental illness, IQ scores, physical aggression, legal involvement, etc) that are served within that particular agency. One of the main differences between the levels of care are staff to youth ratio. Facilities that serve higher end youth will have a smaller staff to youth ratio (1:3).

In times of fiscal struggle the state of Illinois, as well as the rest of the U.S., seeks to be assured that the entities that have been entrusted with contracts to perform services are actually meeting standards and can be measured in an objective and fair manner. Performance based contracting is also meant to help the state provide consistency across the board in the vision and standards of residential care. Before the implementation of performance measures, many different agencies measured success on their own program models, which may have been different than what the state expected. Performance based contracting allows the state to have input on how success is measured; however it still allows private agencies to have creativity in their program design to meet the expectations.

In 1991, the U.S. Office of Federal Procurement Policy in the Office of Management and Budget introduced the concept of performance based contracting with regard to service contracting. Although the states were slower to implement the concept, by the late 1990's some states were mandating the use of performance based contracts for purchased services. Since that time, performance based contracting has become more prevalent in child welfare in Illinois, making it a more competitive arena (McCullough, C., Pindus, N., & Lee, E. 2008, p. 2).

In 1997, DCFS began to utilize performance based contracting in the foster care system to incentivize permanency outcomes for clients. The hope was to reduce the number of youth in out of home placements. Reports indicate that in 1997, at the contract's inception, there were more than 51,331 youth in out of home care and in 2009 there were approximately 16,000. Although there has been no empirical research done on the implementation of performance based contracting in foster care, it's implementation was largely credited to the reduction of youth in out of home placements (Kearney, McEwen, Bloom-Ellis, and Jordan, 2010, p. 40).

Through performance based contracting, private agencies are granted government contracts based on their past performance as defined by performance measures. Performance based contracting, a practice of managed care, is defined by Lawrence Martin (2003) as contracting that "focuses on the outputs, quality, and outcomes of the service provision and may tie at least a portion of a contractor's payment as well as any contract extension or renewal to their achievement" (<http://www.dshs.wa.gov/pdf/ca/CaseyFamilyPBCreview.pdf>). Performance based contracting focuses less on how the work is performed and more on results related to outcomes, output, and quality. It utilizes measureable performance standards with clearly defined objectives and timeframes. These measures could include number of successful discharges; number of clients served; client employment; client education status, etc.

Performance measures will differ from contract to contract depending on the program goals and objectives. In some cases, agencies may receive fiscal incentives or penalties during the course of the contract based on their progress toward achieving performance goals. Unfortunately, during times of budget restraints, fiscal incentives are often eliminated and the only incentive is contract renewal.

Not only do performance measures differ from contract to contract, but the quality of contracts also vary. Poorly defined outcomes and performance measures place private agencies at a financial risk. Those who write the contracts should be well versed on not only contract preparation, but also the purchased services in order to establish performance criteria. Ideally, the contracting agency and the private agency should collaborate on contract details.

Fortunately, for private residential providers in Illinois, more than 75 meetings were held between the Department of Children and Family Services and service providers during the first year of performance based contract development, but even then, ongoing clarification was needed to guarantee success (McCullough et al., 2008, p.3-4).

The idea of paying for outcomes rather than services is not new to the public or private sector, but according to Dr. Fred Wulczyn (2005), all systems, which utilize performance based contracting, should address the following questions:

- What is the target performance?
- Will savings be reinvested?
- What is the performance baseline and is it risk adjusted?
- How will risk sharing be managed?
- How will revenue be disbursed?

- Will there be upfront investment to stimulate improvements?

(http://www.ffta.org/publicpolicy_advocacy/pbcpaper.pdf).

In 2007, the Illinois Department of Children and Family Services launched its Striving for Excellence Project in response to the challenges of residential treatment for children and adolescents. These challenges include concomitant medical problems, chronic mental illness, pregnant and parenting youth with behavioral health challenges, youth with dual diagnoses for mental illness and developmental disabilities, chronic runaways, and chronic psychiatric hospitalizations. Youth placed in residential treatment are more likely to have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychotropic medication use. In order to address these challenges, the Illinois Department of Children and Family Services began to facilitate performance based contracting (Kearney et al., 2010, p. 41).

At the inception of the project, a core principle was to allow input from all stakeholders to increase the opportunity for success. Although the project addressed all residential providers contracted with DCFS, there were different populations served within the residential programs. There are currently 51 private agencies in Illinois with residential performance based contracts with DCFS, serving approximately 1400 youth. There could be little generalization about residential programs when discussing performance indicators. Some providers specialize in treating specific disorders (chronic mental illness, conduct disorder, sexuality issues) and differing age ranges. Even those that do not “specialize” in the treatment of a specific disorder may be more successful with certain populations. These challenges made input from stakeholders extremely important.

Three main goals were established for residential treatment in Illinois:

1. To improve the safety and stability of children and youth during residential treatment
2. To effectively and efficiently reduce the severity of clinical symptoms and improve the functional skills of children through residential treatment
3. To improve outcomes for children at and following discharge from residential treatment.

These goals lead to two performance indicators, treatment opportunity days rate and sustained favorable discharge rate (Kearney et al., 2010, pg. 43)

Treatment opportunity days rate (TODR) measures the number of days that a youth was in active treatment in residential. In order to be in active treatment, the youth could not be on runaway status, psychiatrically hospitalized, in detention or a corrections facility. Sustained favorable discharge rate (SFDR) measures how many times a youth's treatment is interrupted in a fiscal year by the aforementioned situations. Also measured are sustained favorable discharges, the number of youth who successfully complete residential treatment, move to a less restrictive environment, and remain stable without placement disruption for at least 180 days (Kearney et al., 2010, p. 44).

As previously stated, residential treatment facilities cannot be generalized, as each facility has diverse populations and specialties. This was addressed through a risk adjustment method that took into account factors beyond the provider's control. It was agreed that the following risk factors have a statistically significant relationship to the TODR and SFDR:

1. Demographic characteristics of youth (e.g., age, gender, geographic placement of origin)
2. Historical system involvement of youth (e.g., psychiatric hospitalization, detention or correctional placement, prior residential treatment)
3. Other placement characteristics (e.g., length of residential treatment, placement by severity level, specialty population, geographic location of the residential placement).

The risk adjustment is used to calculate expected performance for each facility's contract based on their population for that fiscal year. Although there are limitations to this process, as it cannot account for all possible risk, risk adjustment makes performance measurement more feasible in an uncontrolled setting (Kearney et al., 2010, p. 47).

Provan, Isett, and Milward examined a community-based network of mostly nonprofit health and human service organizations, which formed as result of a shift from fee-for-service to managed care. The results of the study indicated that organizations which banded together, forming a network, successfully addressed financial pressures of managed care without compromising service delivery (Provan et al., 2004, p. 506).

Even before the birth of the Striving for Excellence Project, residential treatment providers in Illinois had formed a network of their own. In the late 1990's, many private residential treatment providers in central and southern Illinois began to meet to discuss DCFS mandates forced upon them through their public contracts. This became known as the Residential Providers Meeting.

The Residential Providers Meeting is held monthly at a centralized location to allow the discussion of topics pertinent to residential treatment, such as performance based contracting. Treatment providers can gain insight on how others tackle obstacles of performance based contracting and this venue provides an opportunity for private agencies to be heard. Meetings are often closed to DCFS administration to ensure providers speak freely about their concerns without fear of backlash. Information from the meetings is reported directly to the appropriate DCFS administrators for consideration. Many hours of conversation have been held on the topic of performance based contracting, topics range from the quandaries performance based

contracting has put private agencies in to how performance based contracting is affecting the youth in residential treatment.

According to a fact sheet provided by the Child Care Association of Illinois (CCA), performance based contracting is needed to address the complex behavior challenges and clinical needs of youth in residential care. CCA also asserts performance contracts provide opportunities to develop new programming “to provide enhanced clinical treatment, improved stability, and eased transitions to school, home, and work for kids” and the long term savings from reduced psychiatric hospitalizations can be reinvested into the programs thus closing any treatment gaps (http://www.gocwi.org/communications/case_studies/case_studies/CCAI_FactSheet.pdf).

Often times service providers, even when supported by advocacy groups such as the CCA, view managed care and performance based contracting negatively. When the term managed care/performance based contracting is mentioned, it normally elicits a negative response, as it raises concerns regarding the availability and quality of service. For policy makers and administrators, it may evoke hope for a more efficient use of limited services. Both responses are common in the field of child welfare, as the current expectation is to do more with less (Jones, 2006, p.64). According to Jones, “managed care may be the considered the latest systematic fad to be adopted by some parts of the child welfare field. Managed care assumes the promise of increased effectiveness of treatment with a minimal input of resources. However, many have raised serious concerns about its ability to accomplish either effectiveness or efficiency, within the field of child welfare” (2006, p.65).

Stroul, Pires, Armstrong, and Zaro discuss how over the past several years, there has been an increase in funding and implementation of community based programming, predominantly in the public sector, for adolescents with serious emotional disturbances and their families. The

community based programming, also known as systems of care, offers and emphasizes a broad range of services, including:

- a comprehensive range of intensive nonresidential and residential services and supports
- treatment in the least restrictive, most appropriate setting
- individualized and flexible treatment and services
- interagency collaboration among the various agencies and systems that share responsibility for children and youth with serious emotional disorders
- family involvement in planning and delivery of services
- culturally competent services (2002, p.22).

Stroul et al. go on to discuss how systems of care, similar to residential treatment facilities in Illinois, are being forced to move from a fee for service payment plan to managed care as a way to reduce costs. The systems of care and managed care operate under two different philosophies and Stroul et al. set out to evaluate the impact managed care has had on these systems of care (2002, p.22).

Through a qualitative case study design, Stroul et al. facilitated data collection through telephone and on-site interviews. Subjects included stakeholders such as, site directors, key project staff, families, children's mental health service providers, representatives of the behavioral health management care organization (HMCO), case managers, clinicians, and staff from child welfare, juvenile justice, and educational systems (2002, p. 25).

Stroul et al. concluded that the systems of care philosophy could be preserved in a managed care setting under certain circumstances. Circumstances such as, the preexistence of a system-of-care philosophy prior to the integration of managed care; stakeholder involvement in

managed care planning and implementation; use of a broad array of providers and sufficient support for case management and care coordination activities; identification and support of highly utilized groups within the managed care system; and financial compatibility between managed care and systems of care (2002, p. 33).

There is a push for child welfare and social services to think more like for profit businesses. Desai and Snavely discuss how non-profit organizations, through government contracts, are forced to become more cost effective, sometimes resulting in a reduction of services offered to clients. Performance based contracting and market policies can create a focus on outcomes rather than best practices, resulting in clients who are statistics in a report rather than a case with individual needs (2012, p. 17).

Using the residential performance based contract in Illinois as an example, psychiatric hospitalizations are necessary at times to help stabilize a youth, but under the agency's contract with DCFS this is viewed as a negative disruption to treatment. The reality is that hospitalizations are often times part of treatment, but agencies are now more reluctant to consider hospitalization as it negatively affects their performance outcomes. This results in clients not receiving the services they need in return for agencies to receive the funding they need. Yes, this is a dramatic depiction of how performance based contracting and market policies challenge the overall philosophy of social services and child welfare.

The question remains, what effect has managed care and performance based contracting had on child and adolescent residential treatment facilities in Illinois. Based on the previously mentioned studies, even though managed care is often viewed negatively, especially in child welfare, the fiscal and service outcomes could be positive, but it can also create many barriers to success if not carefully implemented.

Method

Through exploratory research, this case study will discuss some of the effects of performance based contracting in residential treatment in Illinois. Although the study reveals no conclusive findings, it is suggestive of effects and suggests avenues for further research.

Information was gathered through both in person and phone interviews with professionals in the child welfare field. Brice Bloom-Ellis with Illinois Department of Children and Family Services, who is considered an expert in the area of performance based contracting, recommended contacting members of the Child Welfare Advisory Committee (CWAC) data test group. This group is comprised of quality assurance staff with DCFS, private residential agency administrators, and experts from Northwestern University, the University of Illinois at Chicago, and Chapin Hall Center for Children. Because this research focuses on the how residential facilities have been affected, only private agency residential administrators were contacted.

Initial contact was made through email with little success. After several email and phone call attempts, it was evident that the search for participants needed broadened. Cooperation increased when the researcher contacted administrators active in the monthly Residential Provider Meeting.

All participants were employed at private non-profit residential treatment facilities in Illinois. Currently, all residential treatment facilities in Illinois are affiliated with private agencies. The nine agencies represented in this study serve varying populations:

- males and females age 9-21
- males and females age 12-21 (four agencies)
- males and females age 12-20
- males and females age 5-21 (two agencies)

- males with sexuality issues age 11-20

The smallest agency serves up to sixteen youth at a time and the largest serves approximately 95.

These agencies are fairly representative of residential treatment facilities across Illinois.

Interviews were conducted both in person and by telephone, two in-person and seven by telephone. All interviews were voluntary, based on informed consent, and confidentiality. A form was created, listing all of the interview questions, which allowed the interviewer to easily take notes. Approval for the interview process was obtained through the Southern Illinois University Human Subjects Committee prior to the conduction of any interviews. Unfortunately, the low number of interviews limits the case study, but it provides a basis for future research. All participants (a clinical director, a treatment director, two treatment supervisors, an executive director, a chief executive officer, an aftercare coordinator, a manager of residential services, and a residential coordinator) have direct involvement with their agency's performance based contract with DCFS.

The following questions were asked during each interview:

- When did your agency become involved with performance based contracting with DCFS?
- Was this a big change for your agency? If yes, how?
- What has been the biggest challenge with performance based contracting?
- Do you think performance based contracting has enhanced your residential programming?
- How has performance based contracting affected the services your agency provides?
- Has performance based contracting affected your budget?

- Have you had to hire additional staff for Quality Assurance or Information Technology for data collection and management?
- Have you had to diversify your funding sources to compensate for performance based contracting?
- Is your agency getting adequately compensated for what DCFS is expecting through performance based contracting?

Research Findings

All of the participants became involved with residential performance based contracting at its inception except for one, which became involved approximately one year ago. The main difference being those agencies which became involved in 2007 were held harmless for the first year of the contract. Meaning, even though benchmarks and performance measures were set, agencies were not penalized for failure to meet contract expectations. Those agencies, which exceeded expectations, did receive incentive money the first year and penalties were imposed beginning the second year of the project.

The participant whose agency became involved approximately one year ago expressed both benefits and costs to postponing their involvement with PBC. Having the luxury of learning from other agencies mistakes was a definite benefit. Additionally, DCFS had assessed and attempted to make the process more efficient. The obvious downside to later involvement was not having the one year held harmless. Even though the agency was able to learn from others, there were still infrastructure and procedural changes that had to be made in order to be successful, as each agency is run differently.

When asked if performance based contracting was a big change for their agency, only two participants stated yes. One big change was the contract's no decline policy. Previous to

performance based contracting, agencies could more easily decline referrals from DCFS with little explanation. Through performance based contracting, agencies contract with DCFS for a certain number of beds per fiscal year and they are paid for those beds if they are filled with clients or not. For example, an agency's contract states that sixteen beds will be allocated for DCFS youth. If only fourteen youth exist in the program, the agency still receives payment for the sixteen beds, but as soon as DCFS identifies youth in need of residential treatment, it is expected that those agencies with empty beds will accept them, regardless of the effects on the milieu.

Some programs may have great success in treating specific disorders, for example post traumatic stress disorder, but through the no decline policy, DCFS could expect placement of a youth with borderline personality disorder in the same milieu. Although the administrator knows the program can treat the youth with borderline personality disorder, it is not a good "fit" for the program or the other youth. The admission could be disruptive for the milieu, impeding the progress of other youth, thus negatively affecting performance measures.

In return for the no decline policy, agencies have a guaranteed revenue source with performance based contracting. For example, one agency's daily rate of pay per contracted bed is \$263.64. Using the previous example of being contracted for sixteen beds, but only having fourteen beds occupied is a difference of \$527.28 per day. In a thirty-day billing cycle, that is a difference of \$15,818.40! Having a guaranteed revenue source is a definite benefit in any business, but especially in the non-profit sector. Agencies must decide if the benefit of guaranteed revenue outweighs the cost of the no decline policy.

Another change was data collection and tracking. For smaller agencies, this was not as significant, but for an agency with the capacity of 95 residents, the workload drastically

increased, resulting in acquisition of additional quality assurance and information technology staff. Larger agencies can more easily absorb the cost of hiring additional staff, but small agencies were forced to allocate additional work to existing employees.

Participants were asked to identify the main challenge performance based contracting imposed on their agency. Data collection was identified as one of the main challenges, not only because of the additional man hours needed to collect and manage the data, but also clearly understanding what data were needed to meet performance indicators. One participant shared that upon project inception, performance goals were unclear, but through much discussion with DCFS and assistance from his peers at the Residential Provider Meeting this is no longer an issue.

Another identified challenge was insuring clients meet performance indicators. One performance indicator that created an increased workload is clients' sustained favorable discharge. Clients are tracked after their discharge from residential programming to determine if they are successful in their new placement and agencies are now expected to provide aftercare services for discharged clients for up to 90 days, depending on the needs of the client. Aftercare, as identified through performance based contracting and the DCFS Residential Discharge Protocol, consists of weekly face-to-face visits with the discharged client and ongoing meetings or staffings that include multiple staff from both the sending and receiving agencies. It is agreed that increased aftercare improves a youth's chance for success, but what has not been taken into consideration is the cost this imposes on agencies.

Most participants agreed that performance based contracting has enhanced their programming. Although the types of services, other than aftercare, may have stayed the same, participants felt that services were strengthened. One agency went as far as contracting with

University of Illinois Chicago to develop their program to increase their effectiveness with youth who are more challenging, as the no decline policy gave them less control over their admissions. Other agencies rely on the Residential Provider Meeting to brainstorm among their peers on ways to strengthen their programs in order to achieve performance measures.

An important aspect of performance based contracting is oversight or monitoring. Prior to performance based contracting, the Department of Children and Family Services, loosely monitored contracted agencies. It was rare to see DCFS personnel at private agencies much less observing the milieu. Performance Based Contracting forced the Department to become more involved in the service delivery process through monitoring. The Monitoring Division of DCFS closely scrutinizes residential facilities through unannounced visits to the milieu, active participation in client staffings, meetings with residential administrators to discuss progress and barriers to progress, and client file reviews. Most agencies see the Monitoring Division as a tool to enhance or strengthen their programming, as they provide feedback to providers on ways to meet performance measures.

Most participants indicated that performance based contracting affected the services their agency provides. Most generally, participants indicated an increase in aftercare services in order to meet performance indicators. The performance indicator of sustained favorable discharge forces agencies to provide post-discharge services for up to 90 days. These services include but are not limited to weekly therapy sessions, increased case management, follow up staffings, etc.

All participants agreed that performance based contracting has affected their budget. One participant, whose agency serves approximately 95 youth in their residential program, recently had to evaluate the increased mileage on their agency vehicles, which were mostly vans. Upon evaluation, it was determined that the increase was due to the travel to and from weekly aftercare

visits. In some instances, staff travelled over 200 miles round trip for aftercare visits. One visit could take up a staff member's entire day, with four hours being unproductive in a vehicle, not to mention the financial cost of wear and tear on agency vehicles and the cost of fuel. The agency resolved to trade in their vans for more economical vehicles in the hopes of a cost reduction.

Of the agencies represented in this study, none of them has diversified their funding sources to compensate for the costs of performance based contracting, but rather have been more creative in their use of resources. When asked if their agencies are adequately compensated for what DCFS is expecting of them through performance based contracting, all participants gave a resounding no. The consensus is that DCFS is expecting agencies "to do more with less" resources. Although agencies now receive additional compensation for aftercare services, it is questionable if the compensation is adequate for the amount of services required. Incentives were only paid to agencies the first year of implementation. It would be interesting to know if the perception of performance based contracting is affected by the lack of incentives.

Only two participants reported their agency hired additional staff to assist with the requirements of performance based contracting. One agency hired an additional quality assurance staff to track data and the other hired an additional therapist to aid in meeting performance indicators. All other participants stated any additional tasks created due to performance based contracting were assigned to existing staff, creating an increased workload.

It seems the overall important effects of performance based contracting include:

- Budgets – agencies are expected to provide more services without increased funding or resources
- Programming – agencies are enhancing their programming to meet performance measures

- Services provided – through performance based contracting, all agencies must provide aftercare services to youth upon discharge from residential treatment with the hope the youth will transition smoothly into their new placement. Typically, increased services create better outcomes.

Although this research is limited to its participants, the researcher speculates the overall important effects of performance based contracting are common throughout residential providers in Illinois.

Conclusion

Many of the participants felt that PBC forced them to focus more on statistical outcomes rather than what is in the best interest of the client, which is contradictory to the philosophy of child welfare. This topic warrants further discussion, as this creates a division between private providers and DCFS. Further research into how agencies can be more cost effective, while preserving the foundation of child welfare is imperative. Desai and Snavely speculate, the trend will continue toward “the integration of market-oriented management with social purpose organizational goals” (2012, p. 1).

During one of the interviews, a participant stated, “although each agency’s contract is risk adjusted, some necessary adjustments have not been considered. For example, females are four times more likely to have incidents that could result in placement disruption.” When creating contracts and adjusting for risk, are agencies adjusting appropriately for risk and how can agencies be more individualized in their contracts. Yes, the current risk adjustment model considers several factors, but are the most significant factors accounted for? This will require ongoing research and discussion between private agencies and DCFS.

Performance based contracting has definite benefits and costs that agencies must weigh when determining their involvement with government entities. Unfortunately, for the agencies involved in this research except for one, performance based contracting was forced upon them, as they had existing contracts with DCFS and performance indicators were added to their existing contracts. Through the interviews, it seems that initially performance based contracting was viewed negatively, but surprisingly over time, agencies have experienced benefits from the process. In sum, performance based contracting has negative fiscal affects especially when financial incentives are discontinued, but it is credited to strengthening residential programs. However, it is still questionable if the benefits outweigh the costs.

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