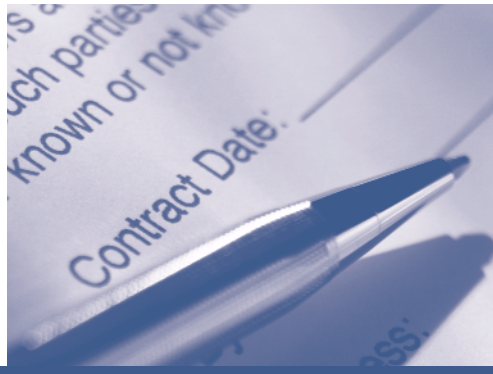
Grant Report

May 2000

Implementing State Contracts for Social Services: An Assessment of the Kansas Experience



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The PricewaterhouseCoopers Endowment for
The Business of Government

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Through grants for Research, Thought Leadership Forums, and the SES Leadership Program, The PricewaterhouseCoopers Endowment for The Business of Government stimulates research and facilitates discussion on new approaches to improving the effectiveness of government at the federal, state, local, and international levels.

Founded in 1998 by PricewaterhouseCoopers, The Endowment is one of the ways that PricewaterhouseCoopers seeks to advance knowledge on how to improve public sector effectiveness. The PricewaterhouseCoopers Endowment focuses on the future of the operation and management of the public sector.

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Foreword

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On behalf of The PricewaterhouseCoopers Endowment for The Business of Government, we are pleased to present this report by Professors Jocelyn Johnston and Barbara Romzek entitled, "Implementing State Contracts for Social Services: An Assessment of the Kansas Experience."

Since its inception in 1998, a major goal of The PricewaterhouseCoopers Endowment for The Business of Government has been to support outstanding academic scholars who are engaged in assessing the changing world of government. One of the recent trends in government has been the increased use of "contracts" with private sector organizations. The Endowment is committed to funding research to better understand both the strengths and weaknesses of the use of "contracts," as well as other new mechanisms and techniques in government management.

We believe that "Implementing State Contracts for Social Services" will be a valuable resource for other states either considering or already engaged in contracting for social services. Based on extensive interviews in Kansas, Professors Johnston and Romzek have developed a series of findings and recommendations that reflect lessons learned and insights gained from the Kansas experience.

This Endowment report focuses on the experience of a specific locality. Previous Endowment reports have examined workfare in New York City, charitable choice in Mississippi, brownfield redevelopment in Michigan, and competition in San Diego. In the years ahead, similar reports will follow. We trust that you will find them both useful and insightful.

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Executive Summary

The chief goals of this study are to identify and discuss the lessons derived from the experience of the state of Kansas with contracting for social services. Our research focuses on the decision processes and organizational adaptations associated with contracting with nongovernmental agencies for selected Medicaid and welfare services.

In recent years the state of Kansas has been aggressive in its efforts to contract with nongovernmental organizations to provide social services. Within the Department of Social and Rehabilitation Services (SRS), the state's main social welfare agency, support for privatization initiatives and reforms was emphasized and a shift to contract management ensued.[1] In the process, program responsibilities for one component of the Medicaid program were shifted to another state agency, the Department on Aging, and contracts for other services were let to various nongovernmental organizations. The result has been a substantial reduction in staff levels and program operation within SRS. SRS staff levels dropped by over 35 percent between 1995 and 1997 (Myers, 1997).

This research examines five specific state contracting initiatives. These initiatives represent different approaches to state contracting for social services. All of the initiatives involve programs concerned with alleviating or reducing problems related to poverty. Some reflect reforms stemming from the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996; others are associated with the Medicaid health care program for the poor. Four of the five contracting initiatives are relatively new, while the fifth has been used extensively for many years.

Our research indicates that the contracting decisions described in this report were driven primarily by ideological and political considerations, as opposed to economic justifications such as provider competition and related operational efficiencies. The decision processes often evolved rapidly, resulting in the need for a great deal of iterative policy design after the programs had been launched. Difficulties were encountered in projecting costs for contracted services and in establishing policy roles and responsibilities in advance. State agencies and contractors faced substantial institutional adjustments with regard to staffing, capacity, information technologies, and contract monitoring. Some of these changes were intended, particularly for state agencies directed to downsize; others were unavoidable and not necessarily anticipated, especially for contracting agencies.

The major findings of the study include the following:

- Despite their participation in the contract decision process, it is often the case that neither the state agency nor the contracting organization is prepared for the changes required under the contract arrangement.
- Genuine goodwill often exists between the state and most contracting organizations.
- Neither the state agency nor the contracting organization is able to accurately project program costs.

- The need for training in contract management/ contract monitoring is often underestimated.
- Contracting decisions and implementation processes are infused with political considerations.
- Contracting problems arise when there are only a few available service providers.
- Contract relationships can create problems of accountability.
- Contracting with advocacy organizations may be "too" successful.

The major recommendations from the study are:

- Take enough time in contracting decisions to adequately consider program design, staff, and cost factors, and to identify state and contractor responsibilities.
- Avoid the one-size-fits-all approach to contract design.
- Contract design and negotiations need to anticipate and include discussions regarding performance expectations for program implementation in advance of awarding the contract.
- Examine all costs.
- Identify the presence of multiple providers who have both the fiscal and administrative capacity to provide the service.
- State agencies and contractors need to examine and project financial consequences of contract proposals that shift risks from the government to the contractor.

Introduction*

In the mid-1990s, support coalesced among elected officials in Kansas for increased privatization and contracting out of government services.[1] Both the state legislature and Governor Bill Graves, whose professional background is in business, were supporters of the principle of privatization for state services. The Department of Social and Rehabilitation Services (SRS), which was viewed by elected officials as uncontrollable and unwieldy — a "monster agency" — provided a target of opportunity for pursuing this agenda (Myers, 1997). The then-secretary of SRS, Rochelle Chronister, was a supporter of the concept. As Governor Graves's appointee, Chronister brought her 17 years of experience as a state legislator to the job of reforming the state's social service programs. Her legislative experience, including her tenure as chair of the House Appropriations Committee, gave her the insights and networks to deal effectively with legislators and to garner their support for her efforts to privatize SRS activities.

The Department of Social and Rehabilitation Services had a history of repeatedly requesting mid-year supplemental appropriations to fund social service programs. These requests were driven by rising Medicaid costs from the mid-1980s on, by a traditional Kansas pattern of stringent budgets for all state agencies, and by the general difficulty of projecting the fiscal needs of entitlement programs. Partly as a result of this pattern, SRS developed an image of being too big and cumbersome to be well managed and accountable. For example, both the SRS budget and full-time equivalent (FTE) staff expanded by 21 percent between fiscal years 1993 and 1996 (Governor's Budget Reports, 1993-1998). Clearly the state could not afford to sustain these staff and budget increases for the long term. And demographic projections, especially for the Medicaid-eligible elderly, suggested even greater need for services in the future.[2]

The 1996 federal welfare reform, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), required a new intensity of employment services for recipients of Temporary Assistance for Needy Families (TANF), the cash assistance program that replaced Aid to Families with Dependent Children (AFDC). PRWORA came on the heels of new state discretion for the Medic-

** Funding from the PricewaterhouseCoopers Endowment for The Business of Government enabled the authors to expand previous research in this area, which was partially funded by the Rockefeller Institute of Government's State Capacity Study through the W. K. Kellogg Foundation and the University of Kansas (General Research Fund #2301148).*

[1] Although the terms contracting and "privatization" are used throughout this report, we note that state officials frequently refer to contracting for social services as "privatization." True privatization would entail a complete shift of responsibility and financing for a program to a nongovernmental agency. In the Kansas cases, the state retained ultimate responsibility for the contracted services.

[2] For example, in the mid 1980s, Kansas had a greater percentage of its population over the age of 65 living in nursing homes than all but two other states, and the average functioning level of those residents was relatively high, suggesting that expensive institutional care was probably inappropriate for many of the residents. The state doubled its expenditures on nursing homes between 1985 and 1989, despite the fact that its per diem nursing home costs were below average. In addition, Kansas had one of the oldest populations: it ranked fifth in terms of percent of the population age 85 and older (Johnston, Davis and Fox, 1998).

aid program. That discretion led many states, including Kansas, to contract with health maintenance organizations (HMOs) for health care services and to reconfigure services for the elderly to prevent unnecessary nursing home care. These program developments, combined with the privatization emphasis shared by the state's political leaders, led to a number of state contracts in a variety of social service program areas. Contracting occurs in all of SRS' individual units or "commissions."[3]

In order to better understand the dynamics of state contracting for social services, we conducted in-depth case analyses of five contracts associated with PRWORA and Medicaid (see Appendix A on research method). The contracts examined are:

- Medicaid case management services for the frail elderly
- Medicaid managed-care HMO services
- Contracts for administration and oversight of Medicaid managed care
- Provider agreements for employment preparation services
- Comprehensive employment preparation services contract.

The objective of the research was to focus on the contracting decision processes associated with these contracts and on the adaptations of the state and the contracting agencies to the new contractual arrangements. By drawing on previous research in the area, and by analyzing data from extensive interviews with state and contracting agency officials, we identified common themes and variations in decision making as well as adaptations across the five contracts. The research shed light on the motivations underlying the decisions and on the major administrative challenges and adjustments required by contracts for these types of services. What follows is a general discussion of the contracting process.

[3] *These include Adult and Medical Services (which administers Medicaid and other health programs); Employment and Economic Support (which administers most components of TANF, including employment preparation services); Children and Family Services (which administers foster care and adoption services, which have been extensively "privatized"); Alcohol and Drug Abuse Services; Mental Health/ Developmental Disabilities Services; Rehabilitation Services; and Administrative Services.*

List of Acronyms

AAA Area Agencies on Aging: nonprofit agencies with which the state of Kansas contracts for case management services for elderly Medicaid clients.

AFDC Aid to Families with Dependent Children: the federal cash assistance program for welfare eligible households prior to 1997.

DOA Kansas Department on Aging: the agency with administrative responsibility for case management services for elderly Medicaid clients.

HCFA The federal Health Care Financing Administration: the agency within the Department of Health and Human Services that administers Medicaid, Medicare, and other federally financed health care programs.

HMO Health Maintenance Organization: a medical care entity that provides services in the private market, and to Medicaid recipients under contracts with states.

PRWORA The Personal Responsibility and Work Opportunity Reconciliation Act: the 1996 federal welfare reform bill that eliminated the federal entitlement to welfare benefits under AFDC, and which took effect in October 1997.

RFP Request for proposal: the strategy used to solicit nongovernmental agency proposals for state contracts.

SRS The Kansas Department of Social and Rehabilitation Services: the state agency with administrative responsibility for most of the state's social welfare programs, including TANF and Medicaid.

TANF Temporary Assistance to Needy Families: the program that replaced AFDC, as stipulated by PRWORA, the 1996 federal welfare reform.

The Contracting Process

Contracting for state social services presents a broad array of administrative challenges. The contract decision process typically involves both political and fiscal considerations, but the important issues of design and implementation often are not addressed until after the contracting decision has been made.

Implementation of these contracts requires substantial adaptation on the part of the agencies involved. Kansas' experience confirms that good contracts for social services are hard to write and equally challenging to manage. One of the major problems is that sound contracts often require more information about pre-contract program cost than public sector agencies have.

Good contracting requires a clear understanding of costs, understandable and clear statements of the scope of work, clear specifications of performance expectations, and defined obligations on the part of the contracting agency and contractor. Contracts need clarity regarding the contract deliverables, including contractor reports to facilitate state monitoring of cost and performance. While all players involved in state contracting know these conditions are central to success, they are not always able to meet these terms for social service contracts.

Effective contracting is also facilitated by appropriate institutional supports. For SRS, those supports are formally provided both externally by the state's Department of Administration and the recently formed Kansas Performance Review Board, and internally by the SRS Grants and Contracts Unit. The nature of support derived from these organizations varies from program to program, but in any case, SRS has access to external and internal advice as it considers contracts for social services.

Contract Monitoring Issues

As governments contract out social service programs, they take on increasing responsibilities for managing and monitoring the contracts. They face a number of issues related to contract monitoring. They must identify those who will monitor contract performance, as well as the components of performance to be monitored. Governments must stipulate how and from whom they will obtain reliable data on contractor performance. Once these data are available, the state must evaluate contractor performance and decide what, if any, response to make to its findings.

Who monitors?

The answer to this question is not always as straightforward as it appears at first glance. Sometimes the state agency will have its own staff serve as monitors. In other instances it will it rely on self-reporting by the contractor or ask a third party to monitor the contract performance.

The transition to contract monitoring is complicated by the fact that the contracting decision often is driven by cost-saving rationales that do not allow for hiring experienced contract management staff. The typical response is to have former program staff

within the state agency assume contract management responsibilities. Yet individuals who make this transition need substantial specialized training in the complexities and unique challenges associated with monitoring contracts. Such circumstances raise important questions about contract managers' skills, credentials, and degree of independence from the contractor.

If the strategy chosen is to shift state agency personnel from service provision to contract management, staff face new job tasks that often require a dramatic shift in emphasis from service provision and responsiveness to client needs to contract management and monitoring of contractor performance and client well-being. Often this shift is a wrenching one for program staff asked to make the transition.

What aspects of performance will be measured?
The issue of performance measures is a complex one. Good contracts specify performance measures in advance. But the reality of social service contracts is such that performance measures are difficult to identify and reliably measure. Performance measures originally specified in contracts frequently undergo extensive revision, and others are sometimes developed after the fact, based on experience with the contract.

Historically, contract management has focused on measuring inputs (such as costs and caseloads) and processes that typically emphasize paperwork and timeliness issues. Recent management reforms seek to shift the emphasis toward outputs (such as head counts, contact data, and client-satisfaction survey data) and outcomes (such as sustained independence for frail elderly, employment for former welfare clients, and improved health for HMO clients). The difficulty in outcome measurement lies in the fact that contractors' performance is often only one factor in a complex social context that affects the desired outcomes.

Access and reliability of performance data
Once the contracting agency and contractor agree on what performance measures to use, questions of data access and reliability must be addressed. Are the selected measures good indicators of success? Are the contract monitors able to access those data? Does the contract require the contractor to collect performance data and provide them to monitors? Or will these activities and their associated costs be borne by the state agency?

Contractor performance
All contract monitoring is ultimately targeted toward ensuring that the contracted services are appropriately and successfully delivered to the relevant clientele. Depending upon contractor performance, the state agency will face decisions regarding what to do about those findings. Should it continue the contract at its present levels? Should the contracting agency adjust subsequent performance measures to more accurately reflect the outcomes sought by the state? The state agency faces questions regarding its options when contractor performance is inadequate. Should it offer technical assistance? Revoke the contract? Let the contract run its course and seek a new provider for the next round of contracting? If the state terminates the contract due to poor performance, can it find another contractor? Or must the state be prepared to resume direct service delivery?

The Kansas Experience

The Kansas experience confirms that contracting for state social services poses substantial challenges to administrators of state and contracting agencies, in both the decision and implementation phases of the contract. In this section, we present research findings related to our examination of the contracting decision process. We also provide detailed case studies of five social service contract areas. We analyzed the decision process and contract management experiences associated with each contract to identify administrative strategies and their strengths and weaknesses. Our analysis revealed patterns and common themes in the decision processes and in the implementation phases of these contracts.[4]

The Kansas Contract Decision Process

In Kansas, state social service contracting decisions are made in a political environment that, until very recently, has strongly encouraged the use of contracting whenever and wherever possible in state government. In 1996 the legislature, led by proponents of alternatives to government service provision, created the Kansas Performance Review Board (KPRB). The purpose of the KPRB is to conduct

> a continuing process to review functions of state government to determine whether current programs, functions, or agencies are being executed in the most efficient and effective manner possible, and to recommend the privatization, elimination, retention, or modification [PERM] of them accordingly (Kansas Performance Review Board, 1998, p. 1).

All state agencies are supposed to follow the "PERM" contracting decision process as recommended by KPRB.

In some instances, the decision to contract out social service programs has moved very quickly, in part to minimize the opportunity for opponents — political or administrative — to block the decision.

The SRS contracting process tends to begin informally; formality increases with the incorporation of discussions with potential contractors, administrative staff, and other state agencies. After the contract is signed, a combination of formal and informal interactions occur between the state and its contractors. Frequently, these interactions develop into a "partnership" type of approach to the service, with mutual support systems serving to facilitate implementation of the contract and to ease the adjustments required by both parties to the contract.

[4] *Our research covers the period ending in the fall of 1999. It is important to note that developments in late 1999 and early 2000 indicate that state decision-makers are looking more critically at contracting. A number of highly visible problems, particularly in the areas of state contracts for foster care and adoption services, have led to executive and legislative review of contracting. In addition, a controversial state contract for consultant services to the Kansas Department on Aging raised the profile of contracting in general. This contract was rescinded, and the political fallout from the contract led to the resignation of the Secretary of Aging. The combination of this incident and the foster care and adoption problems has slowed the inclination for state contracting.*

The genesis of the contracting idea for any given social service contract typically comes from within SRS. If the idea is seen as viable by those with the power to carry it forward, a work team is formed. The SRS Grants and Contracts Unit can contribute by helping to formulate a statement of work (i.e., to specify and articulate the service SRS wants to purchase).[5] Although they may not be represented formally on the SRS team, the interests of the SRS secretary, the governor, and the legislature are also considered by the team.

Under standard conditions, the state's Department of Administration, which is responsible for overseeing state purchasing and contract negotiations, is formally involved in the contracting decision, but only relatively late in the process. The Department of Administration is charged with assisting state agencies with contract preparation, the bidding/ negotiation process, and the finalization of the contract. Once the contract is signed, Department of Administration staff are no longer formally involved in the contract, although they may be asked for help if contract problems arise. However, unless they are approached by the relevant state agency, they have no further role and may only hear about contract problems "through the grapevine." Contracts for Medicaid managed-care HMOs are exempt from Department of Administration oversight, and Administration has virtually no role in local provider agreements for employment preparation services.[6]

SRS (along with most Kansas agencies) uses an "any willing provider" approach to solicit proposals for most of its contracts. Reimbursement rates are not negotiated, but are published in the requests for proposal (RFPs). SRS requests proposals from all providers willing to accept the rates in return for specified services.

Ultimately, unsatisfactory contract proposals are eliminated after review. The work team then meets with all remaining organizations that have submitted proposals to the state. At that point, a final negotiation process ensues, and "bidders" are asked to submit their best and final offer. If agreement is reached with an organization, a final contract is signed.

Interviews suggest that the genesis of and processes used for each contracting decision are contingent on a variety of contextual factors. However, one common theme emerges: If agency administrators see a need for more personnel for service delivery, they are well aware that in the current political environment, contracts with outside organizations provide the only likely method to staff such needs. Medicaid managed-care administrators solicited contracts for several elements of managed-care oversight because they knew that the legislature would not support additional staff expansion for contract management or performance measurement of Medicaid managed-care providers. One Medicaid official noted that "we can get all the money we need for contracts. We just can't get money for staff." In the area of employment preparation services, the comprehensive state contract resulted in part because the SRS area office felt it would not be possible to hire new staff to devote to the services. This condition applies also to the multiple provider agreements for employment preparation service components in SRS area offices throughout the state.

This theme is echoed by other agencies in state government. The state's Legislative Division of Post Audit notes, for example, that most state contracting decisions result from budget problems as opposed to idealized agency evaluations of organizational strengths, weaknesses, needs, etc. (Legislative Post Audit, 1996, p.29).[7] Yet, in the view of Post Audit, the agencies clearly recognize that contracts are not likely to generate cost savings.

The preponderance of the evidence indicates that many of SRS' contracting decisions result from agency responsiveness to political pressures to con-

[5] *The SRS Grants and Contracts Unit was created recently, partially in response to a study by the Legislative Division of Post Audit that criticized SRS' grants and contracting activity. The study noted that SRS had no central registry of agency grants and contracts, that it sometimes paid grantees and contractors without verifying that services had been delivered, and that grant and contract monitoring activities were inadequate (Legislative Post Audit, 1995).*

[6] *Our interviews indicate that the Department of Administration has historically viewed itself as a service — not a regulatory — agency. The culture of the agency would preclude interference in other agency decisions. Department of Administration staff would not be inclined to tell other agency secretaries that they could not or should not engage in a particular contract.*

[7] *The Division of Legislative Post Audit staff have been substantially influenced by a "privatization" guide used by the Colorado State Auditor's Office. Post Audit's assessment of Kansas contracting decisions relies heavily on the Colorado model (see State of Colorado Office of State Auditor, 1989).*

tract, as opposed to analyses of the economic and provider supply conditions necessary for a good contracting environment. The state's Department of Administration and other observers recognize that for many SRS services, there may be only one potential contractor available to provide the service. This environment tends to complicate the contract management process because the provider efficiency theoretically associated with competition may not materialize.

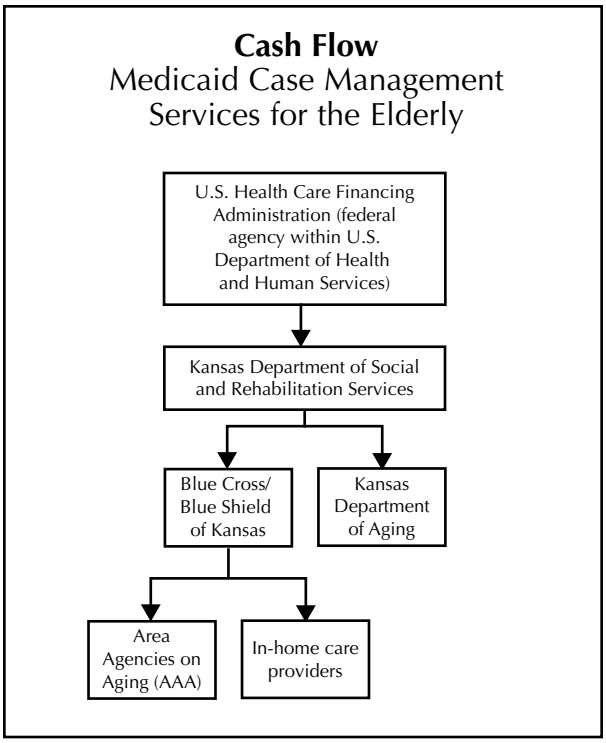
Five Contracting Cases

1. Medicaid Case Management Services for the Elderly

In 1996 Kansas received one of the earliest waivers from the federal Health Care Financing Administration (HCFA) to construct a new Medicaid service delivery system for the state's "frail elderly." A major objective of the reform was the consolidation of all services for the elderly and the creation of a "single point of entry" to state health and social services. The logic of the reform was to increase home and community-based services to minimize the use of more expensive skilled nursing facilities for the elderly. To accomplish this objective, the state adopted a two-pronged reform.

First, the state decided to contract out case management services for clients who needed assistance with daily living chores such as laundry, meals, bathing, and paying bills, and who might be forced into nursing homes without such services. In January 1997, the state contracted with 11 Area Agencies on Aging (AAA) located throughout the state for all Medicaid case management services for the elderly.[8]

Second, in July 1997 the state transferred administrative responsibility for Medicaid case management services for the elderly from SRS to the Kansas Department on Aging (DOA). SRS remains the designated Medicaid contact agency directly accountable to HCFA and is responsible for paying service providers for Medicaid-funded in-home services; it does so through a contract with Blue Cross and Blue Shield of Kansas, the state's Medicaid fiscal agent.



The experience of the state of Kansas with this reform has illuminated some of the opportunities and constraints associated with administrative reform and contracting arrangements. The policy reform moved quickly, in part because it enjoyed broad ideological support, including that of the governor and key department heads. The state legislature also was eager to reduce the size and cost of SRS, the largest state agency. The AAAs as a group had lobbied vigorously for the reform.

The reform required the DOA to grow quickly and substantially as it assumed responsibility for administering the Medicaid case management program. When DOA took on the elderly Medicaid program its budget increased from $18 million in FY97 to $302 million in FY98 and its staff nearly tripled in that same period, from 57 to 160 FTE. (Legislative Post Audit Report, 1999). And the AAAs around the state found that they, too, had to grow quickly and develop the capacity to provide services to a much larger and needier population than they had previously served.

Implementation of the policy reform was an iterative process, reflecting the fact that this reform was

[8] *AAAs were created under the federal Older Americans Act of 1965. The traditional role of the AAAs has been to serve as local facilitators and coordinators for state and federally funded elderly assistance programs. Eight of the Kansas AAAs are certified nonprofit agencies; three are county agencies that receive stipulated portions of property tax revenues in addition to the state and federal funds received by all AAAs.*

new territory for both the state and the contractors. Many aspects of the reform were worked out through negotiations among key agents as issues arose during the early months of implementation. Some aspects of the reform involved changes in state agency operations, such as the transfer of state agency authority from SRS to DOA, and the accompanying shift of some staff from SRS to DOA. Other issues related to contract management between the state and AAAs, such as contractor reimbursement rates, timeliness, quality and frequency of oversight and monitoring of case management decisions, and standards to be used for nursing home resident status reviews.

During the lead-up to the reform, SRS offered training sessions for AAA directors, case managers, and data-entry staff to help prepare them for their new roles. Of course, in a program representing such a massive shift of responsibilities, training is not a substitute for experience; the inevitable transition problems surfaced during the transfer.

The elderly Medicaid reform was designed to head off budget problems within SRS (related to escalating nursing home costs), but the reform itself created budget problems for contractors because early estimates of the cost of delivering the case management services were too low. Consequently, the contractor reimbursement rates were inadequate and were subsequently increased.[9]

Basic performance monitoring presented challenges as well. While extensive training was offered to the AAAs, there was minimal training for contract monitors within SRS and DOA. When SRS made the transition from direct service provision to contract management in January 1997, program staff were shifted to contract monitoring/quality review duties, but these staff had not received adequate training in their new responsibilities. Although they had extensive program and service expertise, staff were far less familiar with the skills required to monitor the performance of outside agencies. Interviews with SRS staff indicated that there was no formal internal agency training for contract management staff. One SRS manager observed that former program staff often take a "soft, people-oriented" approach to their jobs; as a result, as contract managers they are sometimes "softer on people than they ought to be." As individuals not personally inclined to ask tough questions about whether contractors have been successful, they typically need training to make a successful transition to monitoring duties.

By July 1997, when administrative responsibility for the elderly Medicaid program had shifted to DOA, performance monitoring of case management was handled by 30 DOA Medicaid quality reviewers, most of whom had previously worked as SRS case managers for the Medicaid elderly. Relations between SRS quality reviewers and AAA case managers were strained from the beginning due to lack of clarity regarding monitoring standards and status discrepancies between reviewers case managers.[10] Medicaid quality reviewers are required by legislation to review 10 percent of case plans of care on a monthly basis. As a result, 100 percent of all cases are typically reviewed during the year. (The AAAs view this intensity as excessive and inefficient.) These reviews include on-site file reviews, in-home visits, and interviews with clients. Although the long-term outcome sought is continued independence of the frail elderly, contract monitoring measures in the Medicaid program tend to emphasize process and paperwork issues. Plans of care are submitted for approval to DOA area offices through its electronic database, the Kansas Medicaid Information System (KAMIS). While there were the usual problems during the transition and start-up of the KAMIS, the system enables DOA to generate AAA performance reports without requiring periodic reporting from individual AAAs. However, performance outcome measures, such as extended independence or reduced nursing facility use by the frail elderly, have been difficult to develop.

[9] *The state initially reimbursed for case management services at a rate of $30 an hour. After several AAAs reported severe difficulties providing case management at those rates, and one came close to financial failure, the reimbursement rate was increased by 33 percent, to $40 an hour.*

[10] *Shifting the case management services from SRS to DOA and the AAAs required the layoff of SRS caseworkers. Several former SRS caseworkers remained in state employment in the newly created DOA Medicaid quality reviewer positions. As a result, many of the reviewers were monitoring AAA case managers who had, in effect, assumed their former jobs and served their former elderly Medicaid clients. Early in the contract, this dynamic created some resentment on both sides of the contract: some former SRS caseworkers were dissatisfied with the AAA case management services, and some of the AAA case managers resented the oversight of former SRS caseworkers. This was especially problematic in the few AAAs that insisted on higher education and experience standards for their case managers, relative to those that had been required for SRS case managers.*

AAA case managers are well positioned to assess the performance of in-home direct care service providers for elderly Medicaid clients.[11] But they have no authority over these providers.[12] Consequently, AAA case managers are limited to reporting observed problems with in-home care providers and must rely on other agencies to terminate or enforce contracts with these providers in the event of performance shortcomings. They also encourage clients to report inadequate service to the state. This arrangement illustrates the complications that can arise from the use of multiple contractors and sub-contractors in one program area. Case management services can be compromised or limited by poor performance on the part of in-home service providers that also contract with the state, but that have no accountability to the case managers. Under the current system, client satisfaction is assessed separately for in-home services.

Two years into the reform some program stability is emerging. A recent audit of the performance of DOA and the Medicaid elderly program, conducted by the Legislative Division of Post Audit, found that DOA is doing a good job monitoring the case management program. It found a few potential weaknesses in the monitoring that related to lack of follow-up regarding subsequent resolution of minor problems, validity of decisions to deny services, and spot-checks when clients received fewer services than were approved in their plans of care (Legislative Post Audit, 1999).

While the state and AAAs are still wrestling with definitions of quality, the reimbursement rate problems are resolved. KAMIS is now up and running. The state can generate its own reports about comparative performance of the AAAs. There is greater consistency and consensus on quality review standards for case management. And most of those involved in quality reviews (reviewer and reviewed) have come to terms with interpersonal and status discrepancies.

AAAs are coming out of their crisis mode. Case managers now know their jobs, and performance expectations are well established. Agencies have confidence that they are doing something important by helping the frail elderly maintain independence. And they can see the outcomes of their cases. Previously, they might not know what happened to a client after the referral was made. Their role as advocates for the elderly regarding health has grown.

The major current problem for the program relates only tangentially to contracting. It concerns more traditional issues of funding scarcity. Facing a projected revenue shortfall due to a series of ambitious tax cuts, the 1999 Kansas legislature shifted its funding principle for the elderly Medicaid program away from an entitlement program. Instead it authorized a budget ceiling for the program, leaving DOA and the AAAs with more eligible clients than they had funds to serve. This situation has been exacerbated by the success of the AAAs in outreach efforts to identify and serve eligible Medicaid clients. This development illustrates the potential results of shifting service responsibility from a state agency to an advocacy organization. In this case, the AAAs, the advocacy organizations, have been successful in reaching out to eligible Medicaid clients. The state agency, on the other hand, played a more passive role in identifying clients and also adopted a "gatekeeper" function in its service provision. These different approaches reflect the tradeoff between serving all eligible clients and adding to budgetary strain, and serving fewer clients while holding spending growth. One could speculate that the AAAs have been "too successful" in their mission, and that the state's decision to contract with the AAAs is unlikely to reduce Medicaid cost growth despite the potential for reduced nursing home admissions.

In July 1999 the DOA announced the creation of waiting lists for elderly clients seeking Medicaid assistance with home and community-based care. As of late 1999 the details of the waiting lists were being worked out. Those individuals who are currently receiving in-home care services will be able to continue. But any new applicants to the program will be evaluated and placed on a waiting list depending upon need. In October 1999 the gover-

[11] *The HCFA authorized direct care services for the Medicaid elderly include 1. adult day care; 2. wellness monitoring; 3. respite care; 4. sleep cycle support; 5. medical and non-medical attendant care; 6. residential personal care; and 7. medical alert devices.*

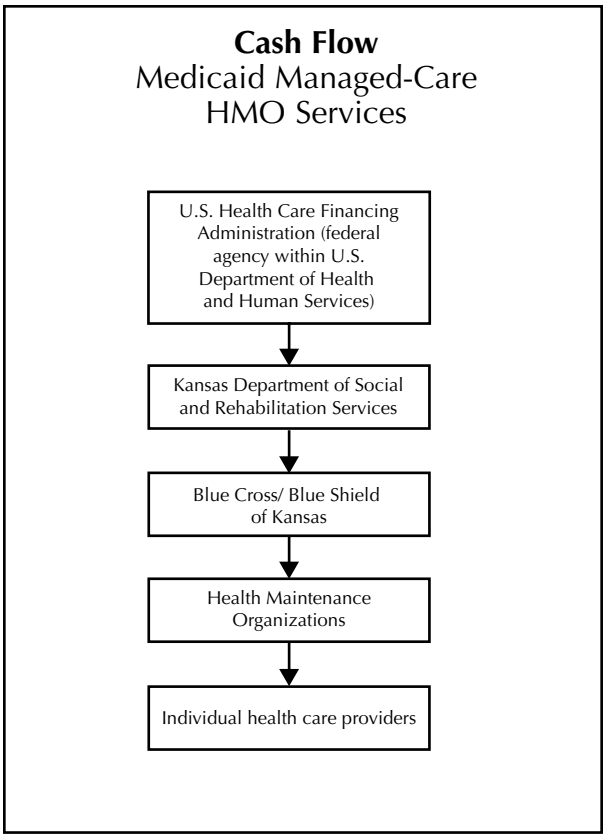
[12] *The in-home care providers do not contract directly with the AAAs or with DOA. Their contracts are negotiated directly with SRS, and are administered by Blue Cross and Blue Shield of Kansas in its role as Medicaid fiscal agent contractor for the state. Furthermore, in-home care providers are licensed by the Kansas Department of Health and Environment.*

nor announced that he would ask for (and that key state legislators would support) a supplemental appropriation for the DOA to allow services to clients currently on waiting lists. The irony is that the history of SRS requests for supplemental appropriations was part of the basis for supporting this reform. Now DOA looks a lot like SRS to state legislative leaders.

2. Medicaid Managed-Care HMO Services

In the spring of 1994, Kansas mandated that by July 1, 1997, most of its non-elderly and non-disabled Medicaid population would receive health care services through a managed-care program. This decision applied to all clients who qualified for Medicaid as a result of receipt of welfare benefits. In effect, the state had just 18 months to move from a system in which virtually all of its welfare Medicaid population was served through fee-for-service reimbursement to a statewide managed-care system. Like other states, Kansas had been plagued by high rates of growth in Medicaid expenditures during the late 1980s and early 1990s. Medicaid annual cost growth in Kansas had exceeded the national average between 1988 and 1993 (Winterbottom et. al, 1995). The legislature had grown exasperated with SRS requests for supplemental budget appropriations to cover unanticipated program cost growth during this period.

In November 1995, SRS was granted permission through an HCFA waiver to extend its limited pilot Medicaid managed-care program to all counties, and to contract for HMO capitated managed-care as warranted. The broad objectives of this waiver were to assure adequate access to quality care, prevent unnecessary utilization, reduce inappropriate utilization, and reduce costs for Medicaid beneficiaries. By August 1997, managed care was available throughout the state through a non-capitated managed-care program called *HealthConnect*.[13] *HealthConnect* technically met the objectives of the state legislative mandate, but the legislature



was very interested in using the capitation strategy wherever possible to maximize cost savings.

Kansas Medicaid HMO contract managers are caught between the political mandate for expansion of capitated managed care and an environment that does not support that expansion. Provider supply is a big problem, with HMOs expressing virtually no interest in Medicaid contracts.[14] Choice among capitated plans has been minimal for the state's Medicaid enrollees; only seven of the state's 105 counties were ever covered by more than one Medicaid HMO, and only for a year. By December 1998, only one financially shaky HMO, known as *Horizon*, continued to contract with the state.[15] Nonetheless, SRS has succeeded in enrolling 90 percent of the state's welfare-related Medicaid enrollees in either *HealthConnect* or the *Horizon* HMO.

[13] HealthConnect *is a primary care case management (PCCM) program in which physicians are paid a monthly case management fee for each Medicaid patient, but are reimbursed on a fee-for-service basis for all health services provided to that patient. Capitated HMOs, on the other hand, provide managed care through a pre-paid monthly arrangement; the HMO receives a monthly payment from the state for each enrolled Medicaid client, and the HMO must use that payment to cover all costs of care for that client.*

[14] *Low reimbursement rates and high administrative burdens preclude provider participation and competition for the state's business, as demonstrated by the withdrawal of all but one commercial HMO from the state's Medicaid program.*

[15] *Many HMOs have terminated state Medicaid contracts recently (Abelson, 1998; Steinhauer, 1998). In Kansas, this trend is complicated by the fact that the state never had many HMOs to begin with.*

Medicaid managed-care contracts with HMOs are exempt from the usual Kansas Department of Administration oversight of state contracts. While this exemption maximizes the flexibility of the Medicaid agency in soliciting and finalizing contracts, contracting for Medicaid is less accountable to normal contractual oversight by the state's top administrative agency. Potential Medicaid HMO contractors must meet the commercial health plan financial viability and licensure standards required by the Kansas Department of Insurance. Some SRS officials indicate that these standards may be too low for HMOs serving Medicaid clients, given the financial challenges faced initially by providers serving this population. Accordingly, after the Department of Insurance has approved the HMO, SRS conducts an additional review of the HMO's financial and corporate structure.

Because of the lack of provider competition for capitated Medicaid managed care in Kansas, SRS is in a fairly weak position with regard to holding Medicaid HMO contractors accountable. It appears that fairly drastic performance failures would have to be evident before SRS would terminate a contract with an HMO. SRS has occasionally invoked mild corrective action when quality or access problems surpass a threshold of acceptability, but in the case of *Horizon*, SRS has gone to extraordinary lengths to keep the HMO afloat. And SRS engaged in a variety of efforts to maximize the retention of other Medicaid HMO contractors prior to December 1998, when two of the three HMOs decided not to renew their Medicaid contracts.[16]

In addition, in 1998 the legislature authorized $10 million to augment selected Medicaid reimbursement rates. However, SRS Medicaid officials viewed this augmentation as a mere "drop in the bucket," estimating that an additional $100 million would be required to allow reimbursement rates to approximate private rates. Another rate increase was authorized in the spring of 1999 when the *Horizon* Medicaid contract was purchased by an HMO known as *FirstGuard*. SRS also conducted a study of administrative oversight requirements (reporting, etc.) imposed on all managed-care providers in order to minimize compliance burdens. However, SRS officials found that most of their oversight requirements are required by HCFA and must be continued.

Throughout the program's history, Medicaid officials have had to administer contracts with some HMOs that they feel are unable to maintain financial viability and/or services to enrollees. On the other hand, Medicaid officials have urged some commercial HMOs to respond to the state's "any willing provider" requests for proposals, despite the fact that the HMOs are quite skeptical that they can meet Medicaid performance requirements. The implication is that Medicaid officials make judgments about the viability of potential contractors, and sometimes engage in efforts to solicit proposals from HMOs that are not interested in Medicaid contracts but which are seen by the agency as capable of providing high-quality services to enrollees.

Most of the SRS staff assigned to Medicaid managed care were program staff promoted from within SRS, with little or no experience with contract management. For the most part, the staff had to take the "learn as you go" approach. Training has been minimal.[17]

3. Contracts for Administration and Oversight of Medicaid Managed Care

The combination of the privatization and cost-control emphases by state political leaders has led SRS to contract out many of the administrative and oversight tasks associated with Medicaid managed care. The state has a major contract with Blue Cross and Blue Shield of Kansas, the organization that serves as the state's Medicaid fiscal agent, and a smaller contract with the Kansas Foundation for Medical Care (KFMC). Blue Cross and Blue Shield

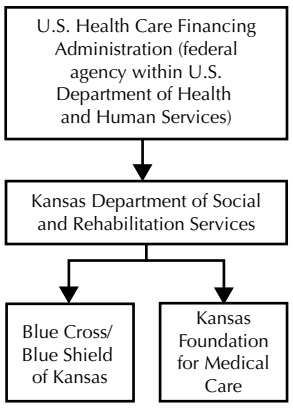
[16] *These efforts included mandated HMO enrollment for all Medicaid recipients in the seven counties covered by more than one HMO. In these counties, the non-capitated managed-care option was eliminated for welfare-related Medicaid enrollees. This measure was designed to maximize HMO market share of Medicaid clients in these counties.*

[17] *Most training for the managed-care staff has been obtained informally, often from the contractors themselves. Some staff attend professional conferences, where they are able to obtain management information from the staffs of other states. Periodic HCFA regional training conferences share "best practices" among the states in the region. In addition, funds have been authorized to subscribe to some professional publications and journals that serve managed-care professionals.*

is responsible for a variety of services, including claims and encounter data administration, management of client and provider enrollment, information systems administration, and customer services such as grievance procedures and toll-free hotlines.[18] KFMC helps the state to monitor HMO contracts by providing regular analyses of Medicaid HMO performance in the areas of health care quality and access and patient satisfaction. SRS officials estimate that the combined annual cost for the administrative contracts totals nearly $5 million.[19]

The state's ability to oversee the activities of the administrative contracts is clearly related to its ability to enforce contracts with the HMOs. Most reporting from the HMOs goes directly to the oversight contractors, where the information is compiled into reports for SRS. Yet HMOs have been chronically late in submitting data,[20] which limits the capacity of the oversight contractors to meet their contracts with the state. All contractors have experienced problems related to information management, in part because most of their systems are not compatible. This has further complicated the ability of the administrative contractors to produce performance reports. SRS has limited capacity to penalize the administrative contractors because of a classic problem with some government contracts: an inability for the state to quickly re-assume responsibility for tasks that have been contracted out. SRS would be very hard-pressed to handle even a small fraction of the administrative contractors' tasks.

Cash Flow
Contracts for Administration and Oversight of Medicaid Managed Care



These complications are exacerbated by the relationships between the SRS, the HMO contractors, and the administrative contractors. Capitated Medicaid managed-care HMOs consistently complain that SRS's reporting requirements are excessively burdensome, relative to what is encountered in the private sector. HMO officials indicate that they had "no clue" what they were getting into. Commercial HMO staff, like the staff of many government contracting agencies, are often unprepared for the level of regulation and scrutiny involved. The HMOs have also been exasperated by requirements to report to three organizations — SRS and its two administrative contractors.

Similar issues are cited by Blue Cross and Blue Shield (BCBS) and KFMC. Much of their reporting to SRS is contingent on getting timely and reliable data from either the HMO or another administrative contractor. For example, the bulk of KFMC reporting to SRS relies on data from Blue Cross and Blue Shield (which in turn relies on data from the HMO) or from the HMO. The dearth of HMO data hampers the efforts of BCBS and KFMC to comply with their contractual requirements. Interviews with KFMC staff indicate minimal SRS specification of contractor performance expectations in their contract. This lack of specification caused severe problems for KFMC because they encountered numerous situations in which SRS expected reports and services that were not really required under

[18] *In most state Medicaid programs, HMOs submit encounter data to document treatment of Medicaid clients. Encounter data is used to simulate claims submitted by fee-for-service Medicaid health care providers.*

[19] *Blue Cross and Blue Shield of Kansas is reimbursed on a per enrollee basis for its Medicaid HMO oversight and administrative services contract. Reimbursement rates were re-negotiated in the second year of the contract because of the drop in Medicaid enrollments (most likely attributable to declining welfare caseloads experienced in Kansas and many other states after the enactment of PRWORA). KFMC is reimbursed on a flat rate based on the number of active Kansas Medicaid HMO contracts. With only one current HMO contract, compared to the three contracts that existed in 1998, KFMC Medicaid contract revenues have declined.*

[20] *Most states have faced substantial difficulties in collecting data from capitated Medicaid HMOs. According to Landon et al (1998), twenty-two states reported collecting encounter data in 1996, but many "lacked the ability to analyze meaningfully encounter data from multiple health plans, " indicating that the capacity to engage in access, quality, and utilization comparison among plans continues to elude most state Medicaid contract managers.*

the contract; in essence, SRS dealt with KFMC as if the contractor were on a state retainer.

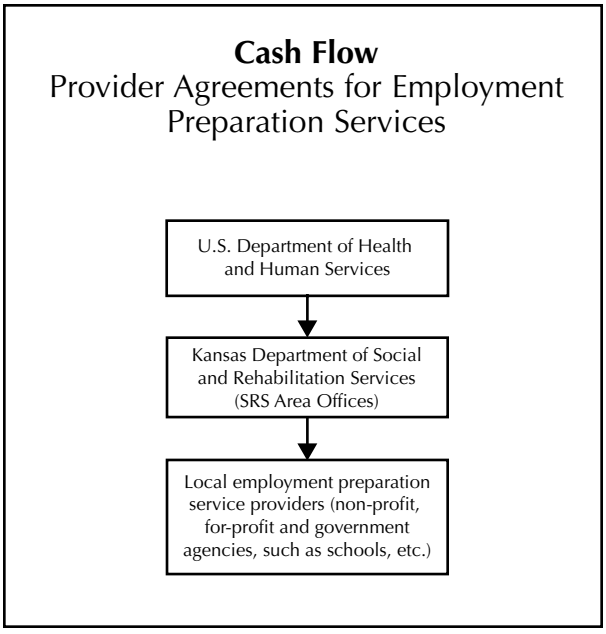
Most — if not all — of these complications in relationships with contractors are linked to resources. If HMO reimbursement rates were higher, and if the Medicaid agency had access to more resources for staffing and training, it is likely that the state would be more successful in inducing capitated managed-care providers to supply required information. This, in turn, would ease the plight of the administrative contractors.[21] As a contractor, KFMC faced tension between its desire to be responsive to SRS and its own efficient use of organizational resources. Likewise, if more resources were directed to reimbursement rates, HMOs would feel less pinched by administrative burdens and the required adjustments involved in government contracts. To paraphrase one contract agency official, "we can't continue to subsidize the state's underfunding of Medicaid."

Despite these difficulties, from a technical perspective, SRS capacity to oversee HMOs has generally improved over the years. Moving from a small managed-care pilot program to statewide mandatory coverage in a short time frame was a major accomplishment. Simply by virtue of time and experience, SRS officials have become more adept at contract management. Yet, like Medicaid administrators in other states, they are plagued by continued information challenges and difficulties associated with evaluating the work they have done (Fox et. al, 1998).

4. Provider Agreements for Employment Preparation Services

Compared to the other two areas of this investigation, the provider agreement approach to contracting for welfare-related employment preparation services follows a relatively decentralized model that has been used successfully for quite some time. But the federal Personal Responsibility and Work Opportunity Reconciliation Act, with its focus on fostering independence among the unemployed, brought a resurgence of activity in this area. The Kansas response to PRWORA has been to emphasize work first, focusing more on short-term, job-specific skills training programs and to reduce spending on long-term education and training for welfare recipients. Most employment services contracts take the form of provider agreements between SRS local area offices and local social service organizations, including government organizations (such as local vocational schools) and nonprofits. The SRS central office Grants and Contracts Unit estimates that there are between 5,000 and 8,000 provider agreements covering a wide range of program areas throughout the state. In contrast to the Medicaid arena, dollar amounts are very small, and the entire process is far less burdensome for providers.

This decentralized provider agreement approach allows area offices to contract for services that are tailored to local capacity, clientele, and workforce needs. Typically the area office decides to enter into a provider agreement based on a number of criteria; key among them are whether the area office can the do program in-house and, if so, whether they can do it "better" than alternative providers. Provider agreements are often the result of long-standing relationships between community social service providers and local area offices, where the area offices know which services the local agencies are able to provide well and are able to obtain services suited to local population



[21] *KFMC submitted a low bid for its contract with SRS and consequently had a lean staff. KFMC officials were comfortable relying on informal negotiations to work out performance expectations. But turnover within SRS meant that it was difficult for KFMC to maintain long-term interpersonal relationships, and SRS developed little institutional memory regarding informally negotiated agreements about performance expectations. As a result, KFMC often had to resort to reviewing minutes of meetings to document agreements regarding expectations.*

needs. Area offices tend to contract for small, discrete components of employment preparation services (e.g., job club, job search, etc). Likewise, available providers know the area office staff and what they need; they sometimes approach an area office with a proposal to provide services.

For example, the Wichita Area Office has long-standing collaborative relationships with employers in the area to provide targeted employment training. Sometimes these provider agreements reflect formalized training and job-placement programs for welfare recipients, such as the celebrated 21st Street Project sponsored by the area office and Cessna.[22] At other times the working relationships are much more informal.[23]

Provider agreements are subject to relatively little SRS central office oversight; performance monitoring of the providers is the responsibility of local area offices. Monitoring under these provider agreements tends to be relatively informal; performance is monitored primarily through process measures such as head counts of client program participation or through provider contributions to job placements. There appear to be relatively low conflict levels between providers and area offices, and agreements are easily terminated.

Compared to the Medicaid contracts, these provider agreements seem to offer more provider choice, more flexibility, more goodwill, and a closer connection between program staff in area offices and contract agency staff. Many of the agreements for employment preparation services are well established, yet it is relatively easy for the area office to re-assume services in-house if necessary. The agreements are smaller in scale and relatively easy to manage. Significantly, there is no state dictated "one size fits all" approach as we see in Medicaid contracts. To the extent that contract complications exist for employment preparation services, they are associated with the large, formal, outcome-oriented contract used by one area office (described next), as opposed to the dozens of small, process-oriented, tailor-made local provider agreements.

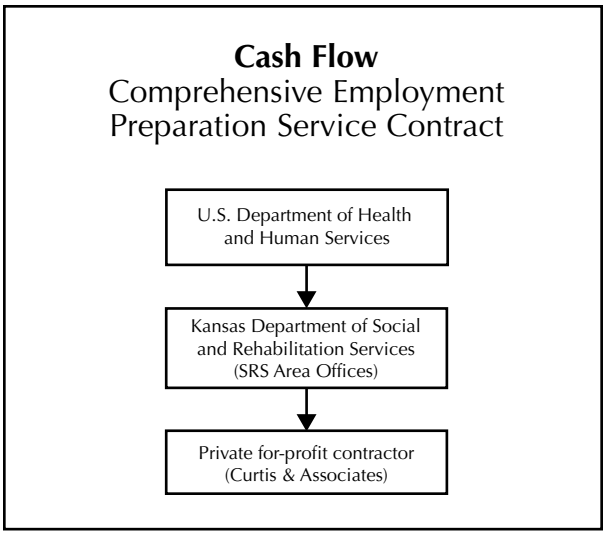
5. Comprehensive Employment Preparation Service Contract

An exception to this pattern is the contract between one area office and *Curtis & Associates* for a comprehensive employment preparation service program. In contrast to most provider agreements, this contract was negotiated in conjunction with SRS headquarters staff. The decision to pursue such a contract was driven by the PRWORA mandate to get welfare recipients into the workforce and the recognition that the local area office (which is responsible for an 11-county area of the state) would not get the funds necessary to hire staff to handle the increased employment service workload. While there are arguments for retaining employment preparation services in-house, such as reduced span of control, reduced coordination/time costs, and better accountability, these arguments were insufficient to overcome the lack of area office flexibility in hiring staff with the necessary skills. For this area office, the decision to contract was more about political responsiveness to pressure from the governor and state legislature to privatize rather than about effective management or cost control. Recognizing the need to contract for the services, the area office made the decision to go with *Curtis & Associates* based on their familiarity with and respect for the quality of materials that *Curtis & Associates* had developed previously for components of employment service programs in other areas of the state.

Management of the *Curtis & Associates* contract tends to involve many of the dynamics associated with contracting for Medicaid case management and managed care. The area office and *Curtis & Associates* both found the contract tasks to be more challenging than they had anticipated. *Curtis* had a hard time coming up to speed, specifically with regard to hiring sufficient staff and opening offices to provide services to all clients in the 11-county area covered under the contract. Unlike most SRS contracts, this contract reimbursement is contingent on success as measured through outputs and employment outcomes. Reports from participants in the negotiations indicate that central SRS admin-

[22] *President Clinton visited Wichita in November 1997, and hailed the 21st Street program as a "model for the nation" (McLean 1997).*

[23] *Collaborators in the Wichita employment services network pride themselves on avoiding written rules and using common sense. But, as one Wichita area office official put it, both the providers and area office staff are always careful to "act as if [ABC's investigative news show] 20/20 were going to investigate."*



istrators were somewhat resistant to the performance-based contract because it was so different from the employment preparation services process measures — or client "nose counting" — with which they were more familiar.

From the perspective of SRS' central office and area office welfare caseworkers, the contract is perceived as more expensive than necessary.[24] Several SRS staff noted that, with the funds available to the contractor, the SRS staff could have done an equally good job.[25]

Area office staff have acknowledged that they have a vested interest in seeing the *Curtis & Associates* contract succeed. But they also have concerns about contractor performance. Contract monitoring started out at a very intense level.[26] Initially the area office contract manager developed a checklist, met weekly with the contractor, and maintained her own duplicate database to monitor client services and placements under the contract. While this was very costly in terms of communication and time, it was deemed necessary to establishing a level of trust between the area office and the contractor. After six months the area office had gained sufficient experience managing the contract and had enough confidence in the contractor's performance to relax the intensity of its monitoring. The contract manager now relies on the contractor's reports and contacts with clients for performance monitoring.

As noted in the discussion of the Medicaid contracts, issues of coordination also challenged staff associated with this contract. Area office staff emphasize that it would be far easier and less cumbersome to have employment service staff in-house. Discussions about clients would be less time consuming and more straightforward. Everyone would have ready access to relevant client information and could engage easily in group approaches if necessary. Area office staff now have to "depend on others for information," and they feel like they're not "always in tune with what's happening with the client."

In sum, the contracting problems that we observed in the three Medicaid contract areas have emerged here as well. Program people were "converted" to contract management; they were often left to learn contract management skills on the job, with little if any training or professional development on the subjects of quality control and contract monitoring. There are extensive coordination and management costs associated with the contracts, and the coordination and management of information systems posed significant problems.

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[24] *Curtis receives $1,000 for each client placed in a 30 hour-per-week job, and generous bonuses are included at the end of 180 days of sustained employment, and also for jobs with starting wages that exceed $6 per hour or that include medical benefits.*

[25] *This sentiment has been echoed for other service contracts as well. A highly visible example is provided by SRS contracts for foster care services. Contractors have recently engaged in widely noted lobbying in the legislature for contract reimbursement increases from the state. In the 1999 session, the legislature agreed to increase rates by 47 percent from the previous year, from $68 million to $100 million (McLean, 1999). Many former and current SRS employees, and several interest group observers note that had those resources been allocated to SRS, the agency probably could have provided the services more effectively without the painful disruptions that have plagued the contract.*

[26] *No one trained the area office staff member dedicated to managing the contract; she just used "common sense." However, she was guided by a supervisor who had come from the private sector and was familiar with performance measurement, and who was determined to use a performance contract model.*

Study Findings

Finding 1. Despite their participation in the contract decision process, it is often the case that neither the state agency nor the contracting organization is prepared for the changes required under the contract arrangement.
All parties seem to fully understand the elements of a good contract, but executing a contract proves to be surprisingly difficult for all parties involved. Participants often underestimate the time required to design, implement, and work out the contract. Contractors reported, in hindsight, that they had "no clue" what they were getting into regarding the scope of programs, costs, and accountability obligations.

Implementation of the contract is likely to entail an iterative policy decision process. The implementation of the contract results in consecutive rounds of negotiation and "give and take" that continue as the contract is implemented. This iterative process allows both parties to the contract to address new policy issues that inevitably emerge during the startup phase; however, issues continue to change as the contract matures.

Parties underestimate the "mechanics" of the implementation process. Contract management capacity is usually sorely tested, partly as the result of complications for which parties to the contract are not prepared. The "devilish details" challenge all contractual parties. For example, DOA has all the responsibility and none of the authority to administer Medicaid case management services. The statutory requirement that SRS remain the single Medicaid contact agency has placed a barrier to the free flow of communication between DOA, the agency managing the program, and HCFA, the federal funding agency.

There are dramatic impacts on all parties to the contracts — impacts that require major institutional adjustments. Common themes emerge across programs, including contractor surprise at government regulatory requirements, information systems problems, resistance to change among some state agency staff, and coordination burdens (such as weekly meetings and phone tag) for both parties to the contract.[27] Many contractors reported difficulty finding qualified staff.

It is difficult to guard against bureaucratic drift and the "governmentalization" of some contracting organizations, particularly nonprofits. Although the state may initially contract with a nonprofit advocacy and service organization, over time that organization is likely to evolve into a new and different agency partly in response to the new contract and to related revenue concerns.[28] These nonprofits have become more "government" like in their operations. On the other hand, state contract managers

[27] *For example, once the AAAs took on the Medicaid case management program, AAA caseloads ballooned in size, resulting in significant jolts to the organizational culture, both positive and negative. AAA missions have been distorted by size, clientele needs, and the regulatory demands of Medicaid. Increased caseloads required accelerated new hires and those new hires brought higher levels of professionalism to the AAA staff.*

[28] *The AAAs, for example, now find that their former service orientation has been altered by their assumption of the Medicaid case management program, which accounts for up to 50 percent of their budgets and a large portion of their staffs.*

must also be prepared for the development of more "businesslike" behaviors and attitudes on the part of the contractors. Contracting agency staff may shift to strategies designed to enhance "billable hours." For example, one contract agency director instructed staff to "think like attorneys" when billing hours under the contract. These contracting agency adjustments require corresponding adjustments on the part of state contract management staff. As contracting organizations respond to incentives, they may develop in ways that undermine the very traits that made them attractive as contractors.

Finding 2. Genuine goodwill often exists between the state and most contracting organizations.
Most state and contractor staff exhibit goodwill to one another. There is a sense of shared mission among policy professionals. Most parties to the contracts use words like "team" and "partnership." All parties to these contracts favor a collaborative approach to contracting. Parties to the contract note that "we're all friends here." Contractors dealing with more than one state reported positive feelings about dealing with Kansas social services staff, and felt that Kansas staff try hard to work with contractor concerns. Staffs at both the state agencies responsible for managing the contracts and the contracting agencies share common commitments to serving the targeted populations.

A shared professional service mission does not make up for insufficient resources or inadequate planning, nor does it overcome the disjoint between the government agencies accustomed to dealing with regulations and the contractor staff who are used to more flexibility. This is especially challenging for Medicaid and other intergovernmental programs, which are highly regulated.

Finding 3. Neither the state agency nor the contracting organization is able to accurately project program costs.
State policy reformers found it difficult to accurately project costs for the contracted services. These officials frequently did not have good initial figures on the real cost of providing the programs, partly due to the cross-subsidies often built into state program administration and to pressures to live within budgets. Initial figures generated are often "guesstimates" and result in unrealistic contract cost projections.

The cost-saving motive that drives much of state contracting also contributes to state cost estimates erring on the low side. Both state agencies and contractors tend to underestimate necessary resource investments. State pressures on contract reimbursement rates, especially if they result in unrealistically low rates, are likely to constrain contractor performance. For example, some contractors have had to cover short-term deficits with reserves. This is a real hardship for many of the service-oriented organizations that seek to contract with the state. At the same time, investment in state staff preparation for contract management is likely to be minimized in order to reduce costs. This combination is one that is likely to generate serious complications for all parties to the contract.

The monetary costs associated with administrative adaptation and coordination under contracting tend to be underestimated by the state and by contracting organizations. Examples include staff training, contract management activity, and consultation time in which state and contracting organization staff interact during and after the implementation phase.

Costs tend to become more visible under contracting because nonprofits and other nongovernmental organizations typically have more experience in costing out their services and have a greater incentive to do so.

Several of these contracts use a "one size fits all" cost approach. For example, the AAAs all receive the same case management reimbursement rate, despite substantial variations in staff and other program costs in different areas of the state.[29]

Tensions between the state and contracting organizations are higher for those contracts that used a "fixed" reimbursement approach, which entails a shift of financial risk to the provider. In such cases, unanticipated costs are problematic and may generate ill will among parties to the contract. This has been especially evident in the contracts with HMOs for Medicaid managed-care services. HMO

[29] *The state's initial reimbursement rate did not allow for AAA case manager travel time, yet in some rural parts of the state, case managers had to travel great distances to see their elderly clients. Over time, this cost issue has been addressed by allowing the AAAs to count travel time as client contact time eligible for reimbursement.*

reimbursement rates are based on legislatively driven, pre-existing fee-for-service rates for individual health care services, such as newborn delivery, and are regularly adjusted through actuarial analyses. SRS and the HMO staff agree that the HMO reimbursement rates are woefully inadequate. On the other hand, contracts involving reimbursement on a for-service basis, such as the provider agreements for employment preparation services, generate fewer conflicts, but may be less likely to produce reliable cost savings.

Without realistic cost/benefit assessments that factor in the full (or more realistic) costs, it is extremely difficult to assess whether contracting generates cost savings.

Finding 4. The need for training in contract management/contract monitoring is often underestimated.
Because contracting is often undertaken in response to budgetary pressures, the state is typically not in an investment mode and is loath to invest the resources necessary to train contract management staff to monitor performance.

Most state contract management and monitoring staff are former program personnel; their familiarity with clients and services facilitates their assessment of contractor performance. But as former program staff they can sometimes have difficulty shifting from a service mentality to a monitoring mindset. Ironically, their familiarity with the program may interfere with their oversight of the contract.

Contract management training is particularly important in an environment devoid of provider competition. In such cases, contract managers are in an especially weak position with regard to contract enforcement.

Development of performance measures is slow. There is a temptation to rely on easier process and paperwork reviews rather than outcomes. This, in essence, substitutes a public bureaucracy with an increasingly bureaucratized nongovernmental organization.

The dynamics of performance evaluation and contract enforcement may conflict with a partnership arrangement between state agencies and contractors.

Finding 5. Contracting decisions and implementation processes are infused with political considerations.
Most contracting decisions are driven by current political imperatives to contract out as many state social services as possible. These imperatives flow from both the governor's administration and from the legislature. Despite the absence of provider competition for many of the contracted services, the state has forged ahead with many contracting initiatives.

A substantial portion of contracting activity results from legislative antipathy toward SRS, which has been perceived as too large, unwieldy, and insufficiently accountable to the legislature. Several SRS officials commented that they could get the legislature to fund service contracts, but could not get adequate funding for the programs if they continued to be provided in-house. This observation holds across all programs reviewed for this study, as well as for other contracted services, such as foster care and adoption.[30]

Several contracting decisions have moved very quickly, in part to head off potential political resistance from interest groups, opposing legislators, and others. This speed has given rise to several complications in contract implementation and management for both the state and contracting agencies.[31]

Finding 6. Contracting problems arise when there are only a few available service providers.
For most of these contracted services, only one or two potential providers exist. As a result, many of the benefits associated with competition among providers are absent, such as comparisons regarding acceptable contractor costs and performance. Without competition, contract management becomes much more difficult for government overseers. Typically, state contract managers do

[30] *The SRS secretary's decision to "privatize" foster care and adoption services was motivated in part by recognition that legislative funding for foster care caseload reductions would not materialize, and that the only way to obtain the resources from the legislature necessary to increase program effectiveness was to "privatize."*

[31] *The state's decision to "privatize" foster care and adoption services has followed this pattern. The SRS secretary purposely accelerated the contracting decision in order to head off potential opposition.*

not have complete information about the possibilities and constraints within the contracting agency environment; as a result, state monitors are not well situated to urge greater operational efficiencies on contractors.[32]

The pressure to contract out means that the state is sometimes desperate to seek and retain contractors. This can lead to contracts with providers who have not had to withstand close scrutiny by state administrators regarding their capacity to provide services and meet performance expectations. In some cases, in the interest of obtaining multiple proposals, the state has asked providers to consider contracting with the state despite doubt on both sides that the provider is capable of meeting performance expectations.

The provider agreements for welfare employment preparation services, which are far less formal, more closely resemble the idealized market environment in which there are multiple providers available to provide the service. In such instances, if one provider proves to be inadequate, other contractors are available for the state to recruit. These provider agreements, which are highly decentralized and which build on relationships between local service providers and regional staff offices, rely on process measures and are limited to discrete components of the total employment program. There is no "one size fits all" approach to these agreements, and state retention of services in-house is a viable option frequently used, especially in rural western Kansas, where few nongovernmental providers exist.

Finding 7. Contract relationships can create problems of accountability.

All contract parties appear to have strong commitments to ensuring accountability for contract performance. The iterative policy implementation process gives contractor organizations the opportunity to influence state policy and the contract accountability mechanisms used to assess their performance.

Contractor organizations face high costs related to complying with the regulations inherent in most intergovernmental social service programs. Reporting requirements are mentioned by all contracting organizations as costly, both in terms of staff time and related administrative burdens such as information systems compliance. These issues are particularly salient for the two Medicaid program reforms.

All parties need better understanding and implementation of accountability measures. Contractors are "shocked by the [state's] scrutiny and need for accountability," and some contractors in programs that we did not include in our study indicate that SRS officials "were impossible to work with in a businesslike manner" (Shields, 1999). Contractors sometimes expect total privatization of the service and cannot understand why the state retains regulatory and monitoring authority.

Subcontracting arrangements complicate contractor performance and state contract management. For example, contractors providing administrative oversight for the state's Medicaid managed-care program interact directly with HMO contractors in order to obtain data required for performance studies and to facilitate other contractual oversight activities. As a result, HMO contractors feel that their compliance burdens are duplicated by the need to communicate with both the state agency and the administrative oversight contractors. On the other hand, administrative contractor performance is dependent on HMO performance and cooperation in order to provide required performance reports to the state. If any of the parties are not performing, the system breaks down. Similarly, AAA case management for the Medicaid elderly is affected by the quality of care offered by in-home service providers, yet these providers contract with a different state agency and are not accountable to the case managers. Consequently, when case managers observe poor-quality in-home care, they have limited ability to rectify the situation.

Reliance on advanced information systems to reduce costs and increase accountability is an unreliable strategy. Nearly all parties report serious difficulties with information systems. And it always takes longer to get new information systems up and running than projected. These difficulties include adjustments to new systems, requirements to create

[32] *For example, in the area of Medicaid managed care, the limited number of HMOs willing to participate in the program reduces the enforcement position of state contract management staff.*

new reporting systems, staff training on the new systems, and coordination between existing systems in contracting organizations and state systems.

From the perspective of contracting agencies, there has been too much emphasis on process and paperwork compliance and not enough on output or outcomes measures.

Finding 8. Contracting with advocacy organizations may be "too" successful.
State agencies tend to simultaneously provide services and act as gatekeepers that ration services. Advocacy organizations, on the other hand, are likely to adopt highly successful outreach mechanisms in order to maximize service provision to needy clients. This approach may threaten cost savings associated with the contract. Recently, the Kansas legislature "capped" the Medicaid frail elderly program and, because of budget constraints, instituted waiting lists for eligible elderly in need of in-home services. The legislative response was driven in part by the unanticipated growth in eligible elderly Medicaid clients. However, the legislature was challenged by a wide range of advocates for the elderly and has been forced to reconsider its decision. This experience underscores the point that the political consequences of budget cutting are very different when the budgets affect advocacy organizations as opposed to government agencies.

Recommendations

The findings reported give rise to several recommendations for governments considering the contracting option for the provision of social services.

Recommendation 1. Take enough time in contracting decisions to adequately consider program design, staff, and cost factors, and to identify state and contractor responsibilities.
Speedy decisions can yield reasons for regret on both sides of the contract. In considering decisions to contract out, it would be helpful to make sure the "rationale" for the reform has some basis in the reality of the contracting plan. For example, if the proposed contracting rationale is to save money, have firm cost estimates in hand before making the decision to contract. Likewise, if the proposal is to downsize an agency, have plans for reductions-in-force in place, including some understanding of who will do the work that remains to be done after the downsizing is complete. If the proposal anticipates the need for contractors to hire new staff, have analyses of workforce availability and detailed staffing plans in hand before shifting responsibilities to contractors.

If accurate cost projections are not available, the contracting decision needs to be subjected to extraordinary scrutiny and extended planning. If accurate cost and caseload projections are not possible, then the government needs to rethink the decision to pursue contracting. Realistic cost/benefit assessments are important to both the state and the contracting organizations.

Once the decision is made to contract out for a service, contracting agencies need to undertake substantial planning regarding the necessary funding and program changes that the reform will entail. This is especially important in the area of identifying responsibilities.

Recommendation 2. Avoid the one-size-fit-all approach to contract design.
While it is tempting to try to build upon the experience of other states that have engaged in similar contracting programs or use uniform statewide reimbursement rates, be sure to tailor the contract specifications to accommodate any important regional and/or unique policy circumstances.

Recommendation 3. Performance expectations for both state agencies and contractors should be negotiated in advance of awarding the contract.
States must be reconciled to some loss of control over program performance.

Contractors need to recognize that they will have more regulations and different accountability relationships even if the program is promoted under the rubric of privatization.

Both state agencies and contractors must carefully consider the disruptions likely when high-tech information systems are planned as a way to monitor performance with reduced staff. Problems in the development and implementation of complex information systems are common.

Recommendation 4. Examine all costs.
When estimating contracting costs, factor in increased costs due to contract management, training, and accountability requirements for the contractor.

Expect high administrative costs for administrative adaptation and coordination. Recognize the importance of investing in training for state contract management staff and budget for it.

Former program staff will need training to develop new attitudes, language, and skills to effectively perform their new contract management duties.

Recommendation 5. Identify the presence of multiple providers with both the fiscal and administrative capacity to provide the service.
States seeking contracting partners need to identify an adequate number of providers to insure a competitive provider environment. Otherwise, contracting could merely shift from a governmental monopoly of service provision to a private provider monopoly.

Organizations that face viable competition for the government contract will face greater pressure to be responsive and to perform efficiently and effectively.

Recommendation 6. State agencies and contractors need to examine and project financial consequences of contract proposals that shift risks from the government to the contractor.
All parties to such contracts should have contingency plans regarding funds and staff. In addition, the state needs to develop contingency plans in the event of contractor failure.

Appendix A: Research Method

For each of the five contract program areas covered in this report, we interviewed numerous state agency officials and managers, and contracting agency employees. The state officials included key state administrators within the Kansas Department of Social and Rehabilitation Services and the Kansas Department on Aging, the Kansas Performance Review Board, the Kansas Department of Administration, the Kansas Legislative Division of Post Audit, the regional federal Health Care Financing Administration office, and key members of the legislature, including members on committees charged with overseeing these contracting initiatives. Other state officials included administrative and case management staff in SRS area offices around the state. Among the contracting agencies' staffs, we interviewed Area Agencies on Aging directors and case managers, representatives of a Medicaid HMO and the Medicaid administrative contractors. We also interviewed staff from agencies that provide employment preparation services through provider agreements, as well as staff from the organization with the state contract for a comprehensive employment preparation service program.

Our analysis is based on 75 interviews conducted over a two-year period. (The interviews were conducted in four waves: spring 1997, fall 1997, fall 1998, and spring-summer 1999). The PricewaterhouseCoopers Endowment partially funded 33 of these interviews, all of which were conducted in the spring and summer of 1999. These latest interviews included follow-up work on earlier contract program areas and the addition of two new contract program areas to broaden our analysis.

Using semi-structured personal interviews, we asked members of each group of administrators and staff (state, contracting agency, etc.) to respond to a standard list of questions designed to identify key issues in the contract. We also sought assessments of their understanding of the contracts, including the contracting decision process, performance oversight features, and state and agency capacity for managing the contracts. To supplement the interview data, we obtained and reviewed a number of relevant administrative and legislative documents concerning the contracts. The use of both types of data enabled us to better understand the impetus for the actual contracting decision, as well as its execution.

Appendix B: Five Contracting Cases

	Number of Contracts	Contracted Services
Medicaid Case Management Services for the Elderly	11	AAAs provide case management services for elderly Medicaid home and community-based services
Medicaid Managed-Care HMO Services	1*	HMO provides capitated (pre-paid) comprehensive health care services for eligible Medicaid clients
Contracts for Administration and Oversight of Medicaid Managed Care	2**	Various administrative and oversight tasks. Kansas Foundation for Medical Care assesses HMO performance through data analyses. BCBS collects HMO data and manages client and provider enrollment, consumer hotline, and other program components
Provider Agreements for Employment Preparation Services	not known***	Wide variety of organizations provide components of welfare-related employment preparation services
Comprehensive Employment Preparation Service Contract	1	One contractor provides all components of employment preparation services for welfare clients in 11-county area

* *Kansas had contracted, at various times since the 1997 inception of Medicaid managed care, with five different HMOs. For a brief period, ending in December 1998, the state contracted simultaneously with three HMOs. Since that time, only one HMO has contracted for Kansas Medicaid services.*

** *Although not discussed in this report, Kansas contracts with other organizations for Medicaid managed-care related services, including external evaluations, consulting for various program issues, actuarial analyses, etc.*

*** *The SRS central office Grants and Contracts Unit is presently devising a strategy to consolidate information on SRS local office provider agreements. The Grants and Contracts Unit estimates that between 5,000 and 8,000 provider agreements currently exist statewide. The Unit is unable to identify the number of employment service provider agreements. SRS is attempting to rectify this problem.*

	Dates of Contracts	Reimbursement Method	Performance Measurement Focus	Related Subcontracts or Other State Contracts
	January 1997, ongoing	Reimbursement based on client contact hours	Performance measurement focuses on client plans of care	Blue Cross and Blue Shield of Kansas, in-home care providers
	State began annual contracts with HMOs in 1997; current HMO contract began May 1999.	Reimbursement based on pre-existing fee-for-service rates for individual health services	Performance measurement based on health indicators, utilization patterns, and client satisfaction	BCBS, Kansas Foundation for Medical Care, others
	BCBS: 11/96 (for three years); KFMC: three-year contract through 6/99; currently under extension	Reimbursement varies; ranges from per enrollee fee (for BCBS) to per HMO fee (for KFMC)	Performance measured through contract deliverables, data and analytic reports, focus studies, etc.	HMOs, other contractors for administration and oversight
	Ongoing for several years; often open ended	Reimbursement typically based on services rendered to welfare clients	Performance focuses on client contact — hours of program attendance, etc.	
	Services began June 1998	Reimbursement based on outcomes such as client employment with performance bonuses	Performance based on outcomes such as employment, process for client contact, etc.	

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