Effective Contract Implementation and Management: A Preliminary Model

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ABSTRACT

Using data derived from an initial case of state contracting for social services for the elderly, this article builds a theoretical model to explain variations in the effectiveness of the implementation and management of state contracts. Contracts for complex social services often present unforeseen challenges and administrative consequences that make for difficult transitions for both the state agencies and their nongovernmental contractors. We expect that these challenges can compromise the effectiveness of contract implementation and management.

A preliminary test, based on the original case plus four additional cases of contracting, suggests support for the model. Successful contracting requires an extraordinary amount of advance planning, negotiation, and on-going collaboration among contracting partners. Our results indicate that contract implementation and management effectiveness can be enhanced by competition among providers, resource adequacy, performance measurement planning, training for state contract managers, careful evaluation of contractors' staff and financial management capacities, and the presence of a sound rationale for the reform. Effectiveness can be undermined by contracting with agencies that also advocate for their clientele groups, by complex subcontractor relationships, and by risk shifting to the contractors.

A number of state governments recently have enacted reforms that rely on contracting with private organizations for a variety of social services. The proliferation of state contracting is related in part to major reforms in the two largest federal-state social welfare programs—Medicaid and welfare. Devolutionary reforms in both programs have resulted in greater state discretion and the nonprofitization of social service delivery (Nathan 1997a and 1997b; Nathan and Gais 1998; Fossett 1998). By the early 1990s, waivers to experiment with alternative Medicaid service delivery systems,


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including Medicaid managed care, had been widely granted to the states. Welfare reform, enacted through the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, entails the reduction of federal control over state welfare programs. In addition, the new State Children’s Health Insurance Program (CHIP) created by the Balanced Budget Act of 1997, grants a great deal of flexibility to the states, many of which rely on nongovernmental organizations to deliver CHIP services (Goggin 1999).

In Florida and Texas, many components of welfare programs are now delivered through contracts with private for-profit and nonprofit agencies. Medicaid reforms, now well established in most states, have transformed Medicaid bureaucracies from bill payers for fee-for-service health care to purchasers, managers, and evaluators of costly contracts with managed care organizations (Fossett et al. 2000). The state of Kansas is no exception to this trend. In the areas of Medicaid, the State Children’s Health Insurance Program, and welfare reform, Kansas has contracted extensively with private organizations to deliver services. And in one field—child welfare—Kansas has been a pioneer, going further than any other state in privatizing case management and service delivery (Craig et al. 1998; Hudson 1999; Gurwitt 2000; Kansas Association for Children 1998; Lutz and Oss 1998).

Although states seem to be rushing to jump on the contracting bandwagon, scholars have been slow to examine the implications of these changes. Very few have studied the contracting phenomenon through the lens of the contract implementation and management process,¹ and fewer still have attempted to build a comprehensive model of contracting effectiveness. Contracting activity in large intergovernmental programs is particularly complex because in addition to the two to three governments involved (i.e., federal, state, and in some cases local level governments), contracting organizations add to the layers and relationships that affect implementation and accountability (Milward and Provan 2000; Posner 1999; Van Meter and Van Horn 1975).

We will address this gap by building on our previous studies of a Kansas contract for case management of Medicaid home and community based services (HCBS) for the elderly. In the case of the HCBS contract, it appeared that the state’s decision to contract overlooked or minimized the importance of several factors that influenced the implementation of the contract. We concluded that more careful consideration of these factors might have led to a more effective implementation and contract management process. For example, it appeared that the state did not fully understand the level of individual contractor preparation for the financial management

¹The policy implementation literature, which has been nicely summarized by O’Toole (2000) and Matland (1995), offers some insights into contract implementation dynamics.
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challenges that were involved in the contract. Consequently, one contractor nearly filed bankruptcy. Had the state conducted a more careful assessment of financial management capacity, the implementation of the contract and the contract management process might have been more effective.

In this article, we incorporate four additional Kansas social service contract cases. Our objective is to better understand those variables we identified as relevant to a sound contracting decision. Using our five cases, we provide preliminary tests of the relationship between each of those variables and the effectiveness of the subsequent implementation and contract management phase of the contracts. Our results, which provide support for most of our hypotheses, offer direction for policy makers who are considering contracts for social services.

CONTRACTING IN KANSAS

In the mid-1990s support coalesced among elected officials in Kansas for privatization of government services. Several of the state’s administrative agencies were perceived as unwieldy and unresponsive, none more so than the social welfare agency, the Kansas Department of Social and Rehabilitation Services (SRS). Both the state legislature and Governor Bill Graves, whose professional background is in business, were supporters of the principle of privatization of state services. Graves’ appointed SRS Secretary, Rochelle Chronister, was a widely respected former legislator and chair of the House Appropriations Committee who also supported the privatization movement. Arguments for privatization and contracting were based on parallel interests in downsizing government agencies and making them more efficient and accountable. In short, the Kansas political climate—characterized by wide support among the relevant political institutions, the relative weakness of client advocacy groups (Johnston and Lindemann 1998), and the 1994 elections, which had strengthened the conservative Republican wing in the state legislature—precluded vigorous debate about the contracting philosophy or about individual contracting decisions.

Research suggests that ideology, cost savings, and load shedding are the primary factors behind most decisions to contract out government services (Lowery 1982; Schlesinger, Dorward, and Pulice 1986; Kettl 1993; Sclar 2000). Kansas appears to fit this pattern; Kansas social service contracting is framed by the rhetoric of the market benefits of privatization. In an ideal situation, these benefits can include competition among providers for the state contract, which theoretically leads to better services at lower cost (Pack 1987; Savas 2000 and 1987; Donahue 1989; Kettl 1993;

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Schlesinger et al. 1986; Miranda and Lerner 1995; Kodrzycki 1998; Sclar 2000). The popular competition theory suggests that if providers cannot offer satisfactory services at the lowest possible cost, they are forced out of the market by competitors that can. Potentially, all parties come out ahead: program beneficiaries receive services comparable or superior to what was offered before the contract, and elected officials gain from the political benefits of cost savings and reducing the size of government (Wallin 1997; Gill and Rainey 1998; Myers 1997), and providers acquire a greater social services market share.

In some instances, decisions by the state of Kansas to contract out social service programs moved forward rapidly, in part to minimize the opportunity for opponents—political or administrative—to block the decision. Our interviews suggest that the genesis of each contracting decision is contingent on a variety of contextual factors. However, one common theme emerged: if SRS administrators saw a need for more personnel for service delivery, they were well aware that in the prevailing political environment, contracts with outside organizations provided the only likely method to staff such needs. This theme is echoed by other agencies in state government. The state’s Legislative Division of Post Audit notes that most state contracting decisions result from budget problems, as opposed to idealized agency evaluations of organizational strengths, weaknesses, and needs (Legislative Post Audit 1996). Yet in the view of Post Audit, the agencies also recognize that contracts are not likely to generate cost savings.

In contrast to the ease with which decisions were made to pursue privatization and contracting, the implementation experiences presented unforeseen challenges and administrative consequences that made transitions difficult for both the state agencies and the nongovernmental contractors. We found a divergence between the political rhetoric and contracting realities of the HCBS program, which was intended to keep the frail elderly living independently in their homes as long as possible rather than relying on expensive skilled nursing facilities. The reform embodied a level of management complexity that put severe strains on both the state agencies and the contracting organizations (Johnston and Romzek 1999 and 2000; Romzek and Johnston 1999). We also observed that the state moved quickly to implement the reform, and that neither the state agencies nor the contracting organizations were prepared for the shift in responsibilities. As a result, the first two years of the implementation experience were characterized by organizational disruption, financial crises, policy making on the fly, imprecise performance expectations, and problematic procedures for accountability.

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Despite strong political support for contracting, state administrators must deal with the devilish details of designing and managing the contracts (Thompson 1998), and contracting entities often undergo enormous changes in order to deal with the scale and complexity of providing government services. Because of the scope and complexity of the programs and services involved, the various parties to such contracts may face substantial organizational adjustments, especially in the areas of administrative culture and accountability relationships (Smith and Lipsky 1993; Kramer 1994; Romzek and Johnston 2000). Ultimately, these challenges can compromise the effectiveness of contract implementation and management.

THE CHALLENGES AND DIFFICULTIES OF MANAGING CONTRACTS: THE DEVIL IS IN THE DETAILS

Earlier research on the Kansas HCBS contract identified several factors that appeared to influence the effectiveness of the contract implementation and contract management process (Johnston and Romzek 1999; Romzek and Johnston 1999). This research extends that earlier work in depth and breadth, expanding the analyses into three new program areas (and four separate contracting cases) administered by SRS: Medicaid managed care (MMC), employment preparation services (EPS) for welfare recipients, and foster care and adoption services (FCA). The objective of this phase of our research is to construct and test a preliminary explanatory model of contract implementation and management effectiveness. In the interest of brevity, throughout the remainder of this article we will use the term effectiveness to refer to contract implementation and management effectiveness.

Effectiveness is influenced by a number of details that should be considered as the state weighs the contracting option. In the HCBS contract experience, we concluded that when these details are not addressed early in the contract decision process, subsequent implementation difficulties can include budget shortfalls, lack of clarity regarding performance expectations, inadequate contract monitoring, and lack of remedies for poor contracting performance.

Drawing from the relevant literature, and based on the experience of the state with the HCBS contract, we hypothesize that the following factors are apt to have a positive impact on effectiveness:

- Healthy levels of provider competition. Competition is likely to invoke the market discipline espoused by the contracting philosophy—incentives for strong performance at lowest possible cost.

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This incentive stems from the potential loss of the contract to more cost effective competitors. This discipline has the potential to facilitate contract management, as it provides incentives for the contractor to provide accurate and timely performance information. In addition, competition offers alternatives should the state encounter unsatisfactory performance, thereby strengthening the state's contract enforcement position. Contractors that monopolize the provider market, on the other hand, may feel less compelled to comply with performance and reporting requirements.7

- **Resource adequacy.** Our research suggests that state financial commitment is critical to successful contract management. Resources affect the capacity of the state to fund staff and other expenses related to accurate cost projections, analysis of contractor capacity, and training for new state contract management staff. In addition, resource adequacy affects the level of contract reimbursement rates, which in turn influences the ability of the contractor to deliver services. Inadequate reimbursement rates are likely to produce financial stress that will reduce the capacity of the contractor to deliver services and comply with performance reporting requirements essential to effective contract management.

- **In-depth planning for contractor performance measurement.** Accurate performance measurement facilitates evaluation of provider performance and cost effectiveness. States must be able to project the capacity of the contractor to provide regular, specific performance data, and the ability of the state to evaluate those data.

- **Intensive training for state contract management staff.** As Kettl (1993) and others point out, government organizations must retool and invest in staff development required for contract oversight. In view of the propensity of state agencies to assign former program staff to contract management positions, training becomes critical to the transition that is required to make effective contract monitors out of former social workers and other program staff. The absence of adequate training is likely to reduce the effectiveness of contract management.

- **Evaluation of contractor staff capacity.** Complex government contracts can put substantial demands on the contractors and can seriously alter the allocation of administrative and front-line staff resources. States should carefully consider the staffing capacity of contractors when they assess contract proposals. Contractor failure to staff-up in a timely fashion can compromise performance and will complicate a state's efforts to obtain appropriate performance information.

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7Sclar (2000) proposes three models of contracting. The traditional, or complete, model assumes that contractors will be disciplined by market forces such as competition, ease of seller access to the contract market, and ready and inexpensive availability of relevant contract information. A more common situation occurs under imperfect market conditions, which Sclar refers to as the incomplete contract scenario, characterized by frequent transactions among contractual parties and high levels of uncertainty about future situations covered by the contract and about product and process. The third type of contract is the relational model; in this model, the parties to the contract depend upon each other, and it is in the parties' self-interest to adjust flexibly to each other's concerns. Relational contracting frequently involves networks of organizations in service delivery.
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- **Evaluation of contractor financial management capacity.** States must assess the capacity of potential contractors to manage the financial side of service delivery. New contracts often entail demands on the contractor for greater sophistication of financial management and new reporting requirements. Contractors with low capacity are less likely to provide required performance information—including appropriate financial performance data. In addition, adequate capacity helps to mitigate the financial instability that characterizes the start-up phase of some contracts.

- **Theoretical integrity of the rationale for the contracting reform.** Success in contracting requires a sound rationale for the undertaking (i.e., the proposed administrative reform should address the relevant social service problem or program need). While the avowed rationales for contracting-out government services are based on economic reasoning, political ideology (i.e., downsizing, shrinking the role and size of government) often plays a significant role in such decisions. As Pressman and Wildavsky (1984) and others have pointed out, a policy reform based on a flawed rationale is probably doomed. As a result, the implementation and management of that reform will be particularly difficult.

Three other factors, listed below, appear to exert negative impacts on effectiveness:

- **The political strength of client advocate groups.** Politically powerful advocate/interest groups are apt to exert influence with elected officials who oversee the contract. Their influence with these officials—particularly legislators—can therefore lead to situations in which contract managers’ enforcement authority is undercut.

- **The complexity of subcontractor relationships.** Effective implementation in the social service area typically requires cooperation, if not integration of services, among separate contractors in the same program area. In addition, several of the state’s contractors may subcontract with separate agencies to provide services. As a result, contract managers may be unable to hold service providers directly accountable.

- **Risk shifting to the contractor.** Risk shifting is an essential component of many managed care programs, and several of the Kansas contracts essentially create managed care programs that are administered by contractors. Contractors receive a prepaid, or capitated, payment for each client, and they must provide all required services in return for that payment. Consequently, the contractor is exposed to loss in the event that the conditions under which it...
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negotiated with the state either change or prove to be more expensive than anticipated. Under such conditions, the contractor may suffer financial instability or losses; incentives may then exist for the contractor to find ways to reject expensive clients (despite state requirements for service for all eligible clients) or to cut back on staff. These developments can compromise the capacity of the contractor both to meet performance expectations and to provide required performance information to contract managers.

We caution that the relationships hypothesized above are fairly complex. For example, it appears that resource adequacy has separate impacts on several of the other identified variables; therefore, some of the effects of resource adequacy on effectiveness are indirect. Nonetheless, each identified variable is likely to have a direct influence on the state’s contract management process.

Most important, as we observed in the HCBS case, each variable is directly affected by the political elements of the decision. For example, the evidence is clear that for several of these contracts, the speed of implementation precluded adequate planning and training. The political interests of those who were dedicated to the contracting philosophy, especially as manifested by a rush to contract, often trumped administrative interests such as scrutiny of the provider market, detailed analysis of service costs, and evaluation of the implications of risk shifting and other incentives imbedded in the reforms. Just as Governor Engler followed the “ready, fire, aim” approach to welfare reform in Michigan (Weissert and Goggin forthcoming), Kansas moved very quickly to privatize foster care and adoption services (Gurwitt 2000; Kansas Association for Children 1998; Lutz and Oss 1998). Therefore, political imperatives for contracting exerted indirect influence on effectiveness. However, the political push for contracting affected all the cases in this analysis fairly equally. Thus, the impact on the intervening variables is fairly constant across the cases we analyzed.

A MODEL OF CONTRACT IMPLEMENTATION AND MANAGEMENT EFFECTIVENESS

Our objective in this article is to explain variations in the effectiveness of contract implementation and management observed in the five Kansas cases. We independently rated the effectiveness of each of the cases, using possible ratings of low, moderate, or high. These ratings were based on assessments of effectiveness derived from extensive interviewing of contracting and state agency officials, as well as document reviews (see Appendix 1). This dependent variable—effectiveness—reflects the capacity of the state to design, implement, and manage contracts for social services. This

10By independently, we mean that we sought to maintain distance and independence between our effectiveness ratings for each case (which were assigned first), and our ratings on each of the case factors believed to influence effectiveness.

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includes the capacity of the state to obtain timely and accurate reporting from the contractor and the ability of the state to use that reported information to evaluate performance and correct deficiencies. In a sense, these effectiveness ratings are relative, with the original HCBS contract used as a base case. Thus a contract that exhibited performance reporting judged to be more timely and accurate, relative to HCBS, and that facilitated state evaluation of performance, relative to HCBS, would be rated as more effective. Similarly, if we detected that the state or the contractors were inhibited in some way from meeting their responsibilities under the contract, we incorporated that information into our rating.

Based on our earlier analyses of the HCBS case, the factors outlined in the previous section were judged to be important potential determinants of those variations. While none of the cases we examined were problem free, our data led us to conclude that for two of the five cases, effectiveness was relatively weak when compared to the other three cases. The bottom of the exhibit displays these ratings. We rated the FCA and MMC contracts as least effective (each received a low rating) and rated the EPS-Comp (the comprehensive EPS case) and the EPS-PA (i.e., EPS provider agreements) effectiveness as high, relative to the HCBS case. Our assessment is that the HCBS case falls in the middle of this effectiveness continuum, with a moderate rating. The FCA case, which put Kansas on the child welfare map, provides examples of rushed, complicated contracts that have been plagued by financial and other performance problems from the outset. Implementation and management of the FCA contracts have been characterized by a series of highly publicized crises, including the near bankruptcy of two well-respected, faith-based, nonprofit contractors, and the erosion of trust and cooperation among the members of the preexisting provider market. At the other end of the spectrum, the provider agreements for EPS for welfare recipients, all of which are negotiated by SRS’ regional offices, are relatively simple to implement and monitor. These agreements entail virtually no risk to the provider, and because of the relationships between the SRS regional offices and the providers, state contract managers are well positioned to assess the capacity of the providers and provider performance.

In the remainder of this section, we will provide more detailed justifications for each of the factors, or variables, included in the top section of the exhibit, and describe the variables as they emerged in each case. We then will explain the results of the test of the model by discussing the relationships between those variables and our assessments of effectiveness for each case.11

11These data do not include a measure of effectiveness from the clients’ point of view, although in each of the cases the state has solicited client satisfaction or other outcome measures.

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### Exhibit 1

A Model of Contract Implementation/Management Effectiveness

<table>
<thead>
<tr>
<th>Factors with Positive Impact</th>
<th>Foster Care &amp; Adoption Services (FCA)</th>
<th>Medicaid Managed Care (MMC)</th>
<th>Home and Community Based Services (HCBS)</th>
<th>Employment Prep Services Provider Agreements (EPS-PA)</th>
<th>Employment Prep Services Comprehensive (EPS-COMP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of competition among providers</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Resource adequacy</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Planning for performance measurement</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Training for state contract managers</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Evaluation of contractor staffing capacity</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Evaluation of contractor financial management capacity</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Theoretical rationale for reform</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### Factors with Negative Impact

<table>
<thead>
<tr>
<th>Factors with Negative Impact</th>
<th>Foster Care &amp; Adoption Services (FCA)</th>
<th>Medicaid Managed Care (MMC)</th>
<th>Home and Community Based Services (HCBS)</th>
<th>Employment Prep Services Provider Agreements (EPS-PA)</th>
<th>Employment Prep Services Comprehensive (EPS-COMP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political strength of client advocates</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Complexity of subcontractor relationships</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Risk shifting to the contractor</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Overall Score (Ratio)</td>
<td>14 (.47)</td>
<td>17 (.57)</td>
<td>17 (.57)</td>
<td>19 (.63)</td>
<td>25 (.83)</td>
</tr>
</tbody>
</table>

**Contract Implementation/Management Effectiveness**

- Low
- Low
- Moderate
- High
- High

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1. Scores are assigned as follows: 1=low, 2=moderate, 3=high.
2. Numbers reflect reverse order due to hypothesized negative effect. 1=high, 2=moderate, 3=low.
3. Score: Sum of factor ratings for each case: e.g., for FCA, the sum of factor ratings is 14. Ratio: ratio, for each case, of the raw score to the total possible raw score (30 for each case). For FCA, the ratio is 14/30, or .47.
4. Effectiveness ratings (bottom row) are derived from independent assessments of effectiveness, based on interviews and document review.
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Facilitative Variables

Successful contract design, implementation, and management require state foresight and planning on a number of dimensions (Thompson 1998; Goggin et al. 1990). What follows is a discussion of the theoretical literature that is supportive of the relevance of each variable to the contracting experience and very brief outlines of observations of the variables in the five cases.12

Level of Competition Among Providers

The state’s consideration of the potential for competition is crucial to successful contracting; conversely, the displacement of that consideration is likely to reduce effectiveness. Contracting without competition raises serious questions about the potential for improved, more efficient service delivery (Kettl 1993; Kodrzycki 1998; Miranda and Lerner 1995; Schlesinger et al. 1986; Sclar 2000; Smith and Smyth 1996). When competition exists, the discipline of the market theoretically makes contract management easier because contractors face the possibility of being replaced if they fail to deliver efficient, effective, and responsive services to the state and its clients. In the social services area, this is complicated by the fact that most clients rely on several social service agencies and benefit most from integration of services that are provided by various contractors.13

Competition was not much of a factor in the state’s decision to contract the HCBS program to Area Agencies on Aging (AAAs) (Johnston and Romzek 1999). The state awarded the contract exclusively to one nonprofit group, the AAAs; this group lobbied vigorously for program responsibility and successfully influenced the legislative decision. Consequently, consideration of existing or potential provider competition under the HCBS reform was minimal at best, and we assigned a low rating for this variable.

In the case of MMC, the state’s market environment afforded low levels of provider competition. Kansas currently operates its capitated Medicaid managed care program with only one HMO. Administrative contracts, designed to provide third-party oversight beyond SRS’ limited capacity, were negotiated with agencies that likewise faced little competition.14

Competition for the FCA contracts was moderate. From the beginning, the state recognized that there were few potential providers in many rural sections of the state. RFPS specified contract terms to minimize disadvantages of Kansas nonprofit contractors vis-à-vis out-of-state contractors. This was apparently successful

12The nature of such qualitative research presents challenges in balancing brevity and comprehensiveness of explanation. Because we want readers to focus on the variables rather than on details of the Kansas experience, we have opted for brevity.

13While contractor competition can enhance the contract implementation experience, in Kansas the state showed no interest in having state SRS employees bid competitively against the nongovernmental entities for the programs targeted for contracting. This contrasts with the approach used by Mayor Stephen Goldsmith of Indianapolis, who developed a model that allowed city employees to compete for contracts against nongovernmental bidders. The success of Goldsmith’s approach has been attributed to the mayor’s willingness to develop a relational contract with city employees, which was built upon trust and a “genuine willingness to take the units employees seriously” (Sclar 2000, 114). Sclar finds relational contracts to be less susceptible to the worst features of government contracting: uncertainty about product and processes, transactional costs, and moral hazards. That there was no interest among Kansas political leaders in having SRS employees compete for these contracts suggests that downsizing of SRS was a primary motive behind these initiatives.

14Some SRS officials indicated that agency and legislative dissatisfaction with the prior administrative contractor (EDS), combined with a “lowball” bid, led to the current BCBS administrative contract. Another administrative contractor competed with one out-of-state provider with “deep pockets,” and acknowledges that it, too, sought reimbursement rates that are probably too low.

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because all the contracts were awarded to in-state entities; most were well established and respected nonprofit agencies that had provided FCA services on a moderate scale. When contracts were awarded during the second round of contracting (for FY 2001), the state changed contractors in some instances. These changes indicated a willingness to tap the benefits of competition (where there were multiple viable bids) by shifting responsibilities among the same group of service providers (e.g., the expansion of responsibility for one contractor and reduction of responsibility for another).15

The other two contracting initiatives in this study exhibited moderate levels of competition among potential providers. In the area of EPS provider agreements, the state's SRS regional offices often have working relationships and detailed knowledge of a number of provider possibilities, with more densely populated portions of the state offering more competition. In the EPS comprehensive contract with Curtis & Associates, most regional office staff saw Curtis as preferable to available local providers, many of which would have been unable to meet the comprehensive requirements of this contract.16

Resource Adequacy

The issue of resource adequacy, which is critical to successful contracts, is often complicated. When adequate resources are available, contractors can devote time and staff to the development of appropriate administrative systems to meet their new program responsibilities. Without adequate resources, these considerable adjustment challenges are exacerbated; typical problems relate to financial uncertainty, staff shortages, and role overload.

Rate setting often takes place in an environment of cost containment and budgetary pressure (Fossett 1998). Further complicating matters, accurate cost estimates for existing state services prior to the contract are elusive due to the traditional cross-subsidies within state agencies. Hence it is often difficult for the state to develop firm cost projections and adequate reimbursement rates. Likewise, nonprofit contractors, which historically use a niche approach to service delivery, often have little experience with case-load and service demands characteristic of comprehensive public delivery systems that must serve all eligible applicants. As a result, reimbursement rates are occasionally set too low.

FCA resources have been a serious problem from the onset of the contracts. Many of the problems are associated with familiar factors: inadequate initial caseload and cost-per-case projections (Shields 1998).17 Low resource adequacy also characterizes the

15For the second contracting cycle, beginning in FY 2001, the state switched adoption contractors for two of the five service regions (regions one and four). However, the agencies that lost those contracts did retain contracts for foster care services for regions two and five (Ranney 2000).

16The regional office made the decision to let the contract based on their familiarity with and respect for the quality of materials that the contractor had developed previously for employment service programs in other areas of the state. This is consistent with Kettl's (1993) observation that many social service contracts are based on previous relationships between the parties, and that familiarity and certainty with contracting agencies are highly valued by state agencies as they contract for services. Sclar (2000) refers to this as relational contracting.

17Part of the increased caseload is due to greater capacity on the part of SRS investigative workers who no longer have responsibility for direct provision of foster care and adoption services; they now have adequate time to examine child abuse complaints and identify clients for foster care or adoption.
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MMC and EPS-PA cases. In MMC, as in other contracting areas, the state has been reluctant to dedicate adequate resources to the program. As a result, throughout the program’s history there has been minimal provider interest in the contracts.\textsuperscript{18} Medicaid officials have had to administer contracts with the few HMOs (now only one) willing to accept the state’s low reimbursement rates. Periodically, meetings with stakeholders result in augmented reimbursement rates, but these tend to be short-term Band-Aids based on assessments of the most critical rate needs.\textsuperscript{19} Reimbursement rates under EPS provider agreements are capped by the SRS central office. These are characteristically small contracts with low reimbursement rates that are unique to each provider agreement and typically designed on a process, head count basis.

HCBS reimbursement rates were too low, particularly in the start-up phase. After several months of financial difficulties among contractors, the reimbursement rate was increased by one-third. Even then, resource questions persisted because the state legislature began to cap its annual funding for the HCBS program. We rated resource adequacy as moderate for this case because although rate enhancements have reduced financial stress, the contractors are unable to serve all applicants, and therefore they have been forced to reduce service levels and to create waiting lists for program applicants.

In contrast to other cases, resource adequacy was relatively high for the EPS comprehensive contract. Several SRS staff noted that with the funds that were available to the contractor the SRS staff could have done an equally good job. However, hiring authority for additional SRS staff was unlikely in the prevailing political climate.

Contractor Performance Measurement

Ideally, good contracts specify explicit, unambiguous, and sufficiently detailed contract performance measures in advance (U.S. GAO 1997; Kettl 1993; Kelly 1998). Historically the emphasis in contract management has been on measuring contractor inputs (such as costs and caseloads) and processes that typically emphasize paperwork, documentation, and timeliness issues. Recent management reforms shift the emphasis toward outputs (such as head counts, contact data, and client satisfaction survey data) and outcomes (Romzek 1998). In social services, these outcomes can include broad goals such as sustained independence for the frail elderly, sustained employment for former welfare clients, and better health indicators for HMO clients (Johnston and Romzek 1999).
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The dynamic of social service contracting does not often allow for clear performance measures to be detailed in the contract. Initial program details can be vague and performance expectations in the contract are specified in only the most general language. Frequently, performance measures originally specified in contracts undergo extensive revision, and others are sometimes developed after the fact, based on experience with the contract, a common pattern in relational contracting (Sclar 2000). If good will and trust exist between the agency and the contractor, then the parties often proceed with the understanding that performance expectations will be negotiated, and if necessary adjusted, as the program unfolds.

The level of planning for performance measurement under EPS provider agreements tends to be low. The working relationships between the state regional offices and the providers are long-standing and informal, and the regional office often is quite familiar with the quality and nature of the contractors’ work before the contract is let. Expectations for these contracts are usually easily clarified through informal and frequent communication between the contractors and the regional offices. Performance measurement often relates to process and output (i.e., attendance reports) rather than outcome measures. For those agreements that reimburse based on job placements, payment may be contingent on such factors as the number of weekly hours of work associated with the job or whether the job includes benefits.

Moderate levels of activity were related to developing performance measures in the HCBS and MMC contracts. Some HCBS performance standards for the AAs were subject to negotiation after the contract was underway, such as the frequency of oversight and monitoring of case management decisions and the standards to be used in those evaluations. Although the HCBS contract aims at a long-term outcome of continued independence for the frail elderly, contract monitoring measures tend to emphasize process and paperwork issues as well as the usual federal Medicaid requirements. Performance outcome measures, such as extended independence or reduced nursing facility use by the frail elderly, have been difficult to develop.

The MMC program has a similar pattern regarding contractor performance expectations. The health services area enjoys greater consensus regarding definitions of good outcomes than is characteristic of most government programs. Program goals were clear enough: increased access to quality medical care and reduced costs to the state. But translating these program goals into contract performance expectations presented difficulty; external evaluators (Fox et al. 1998) noted inadequate communication between the state and

20Performance measurement includes comprehensive on-site file reviews and in-home visits and interviews with clients. Initial plans of care for clients must be submitted to the state electronically and are subject to prior approval. Appropriateness of client assessments and plans of care for HCBS services are monitored by state Medicaid quality reviewers. Case managers also undergo monthly desk reviews by state Medicaid quality review monitors; they review files of case management clients and interview a subset of clients in their homes regarding the adequacy of documentation, client satisfaction, and client well being.

21For example, mortality and morbidity, physical functioning, and immunization rates are widely accepted measures of good outcomes in health care (Guadagnoli and McNeil 1994).
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its contractors regarding data requirements under the MMC contracts. Monitoring in the MMC program frequently resorts to such tactics as crisis management (i.e., no problem exists if the clients are not complaining) and reliance on impressionistic data and incomplete reports. Because of inadequate performance data, the state was hard pressed to evaluate financial performance (Fox et al. 1998).

FCA planning for performance management was rated as relatively high. Expected performance was detailed in contractor benchmarks associated with children moving through the FCA system with the ultimate goal that of permanent placement, either through family reintegration or adoption. In developing these benchmarks, state administrators initially used their best guesses as to reasonable benchmarks. As it did in other areas, the state hired an outside, third-party contractor to evaluate and periodically audit the performance of the FCA contractors. When the benchmarks were judged to be unrealistically high—because contractors were consistently unable to meet them (Bell Associates 1999a and b)—the standards were lowered.

The pilot comprehensive EPS contract adopted an explicit outcome measurement strategy, and the contractor and the regional office had extensive precontract negotiations regarding expectations for client contact, staffing credentials, and performance data. Client placement rates and the length of subsequent sustained employment of clients are the primary performance criteria. We rated this case as relatively high on performance measurement planning.

Training for State Contract Managers

Contract management training increases the ability of the state to monitor contractor performance and provide technical assistance to contractors as they assume their new responsibilities (Derthick 1970; Williams 1980; Peterson, Rabe, and Wong 1986; Van Meter and Van Horn 1975). The typical pattern when government agencies contract with nongovernmental entities is to move former program staff into contract management responsibilities (Kramer 1994). As state employees shift from service provision to contract management, they need new skill sets and new mindsets to manage relationships with the contractor organizations, skills that are often different from those needed to deliver social services (Frederickson 1997; Kettl 2000; Kettl et al. 1996).

The pattern in four of these five cases exhibited low levels of attention to and investment in training for state contract managers.
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This is due in part to the budgetary pressures that motivated the decisions to contract in the first place. Typically, former program staff were used to oversee contracts in their areas of program expertise. Little to no training was provided to help them shift mindsets from service providers to contract monitors. Although such shifted staff have extensive program and service expertise, they are far less familiar with the skills that are required to oversee contractual relationships with outside agencies. For example, SRS retained some caseworkers as contract monitors for the new HCBS program. These caseworkers were in the position of overseeing the performance of agencies that were serving their former clients. Similar patterns of underinvestment occurred in EPS and FCA areas. The regional office staff member charged with the comprehensive EPS contract personally developed the contract management process through trial and error, using such strategies as devising monitoring checklists, visiting schedules, and database systems. The initial plan included a great deal of formality and detail and relied extensively on close contact between the monitor and Curtis and Associates staff.

Training for MMC contract management was slightly more intensive, earning this case a ranking of moderate. The legislature provided low levels of training resources to the agency, but because Kansas was following the program designs of other states, they were able to take advantage of connections with administrators in other states to prepare staff. In addition, the federal HCFA provided some training seminars.24

Evaluation of Contractor Staffing Capacity

When nongovernmental entities contract with the state, they receive an infusion of funds and program responsibilities that often dramatically alters their operations (Smith and Lipsky 1993; Kramer 1994; Gidron et al. 1992). Typically, the contractors must increase staff capacity in new program areas and staff size to meet new caseloads. Staffing-up can be quite complex. Research indicates that as nonprofit organizations enter into contracts to provide services beyond their traditional programs, they experience substantial changes in their organizational cultures, including increased formalization, bureaucratization, and professionalization of their staff and operations (Smith and Lipsky 1993; Weisbrod 1997; Romzek and Johnston 1999; Alexander 2000).

Our research suggests that effectiveness will be enhanced if states conduct thorough analyses of potential contractor staffing capacity prior to granting contracts. Contractor staffing capacity can affect the state’s contract management experience in fairly

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Contract implementation and management straightforward ways. Contractors that are unable to quickly hire and train staff often cannot meet the terms of the contract, thereby presenting challenges for the state's contract management staff.

Staff capacity was not a significant factor in the EPS-PA area, nor was it an issue in the MMC area. In both program areas, contractors did not face serious staffing issues as they assumed their contractual responsibilities, and the state did not need to concern itself with potential staff shortages that could result in service delivery problems. In contrast, staff capacity was a significant complication in the other three cases—a complication for which the state was inadequately prepared.

Staffing issues presented major difficulties for FCA contractors. In designing the FCA program, state and prospective contractors erroneously assumed that most state social workers would take jobs with nonprofit contractors once the state no longer provided those services directly. This did not happen, leaving the contractors with the extraordinary challenge of staffing their new responsibilities without a qualified workforce capacity to meet their needs. Contractors aggressively recruited new staff, oftentimes hiring relatively inexperienced, recent college graduates due to a regional shortage of social workers. In addition, the state imposed stricter caseload limits on the contractors than those that had existed when SRS operated the program. One FCA agency went from 225 employees to more than 900 in one year (Shields 1998). These staffing shortages placed overwhelming demands on those social workers who were employed by foster care and adoption contractors; these stresses in turn resulted in higher than normal turnover among FCA staff. Some of the stress on contractors' capacity during the transition resulted in one contractor receiving a suspension order and a fine for overcrowding in a residential facility and untrained or undocumented staff.

The AAAs encountered moderate levels of difficulty in staffing-up for the HCBS contract. AAAs hired a substantial number of new case managers so that they had higher levels of professional credentials among case management staff. And they upgraded their administrative capacity more generally. A similar pattern developed in the EPS comprehensive contract. The contractor reported difficulty in finding qualified field staff for its offices in the eleven-county service area, and these difficulties were not fully understood by the state prior to the contract.

Evaluation of Contractor Financial Management Capacity

As nonprofit contractors take on new programs, they often face new demands on their financial management capacity; this in

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turn affects their ability to provide services. If states thoroughly assess the financial management systems of potential contractors, they can reduce potential contract management complications. Contractors with adequate financial capacity can cope with cash flow and reporting requirements, thereby facilitating state contract management. Key components of effectiveness of financial management subsystems include the ability to engage in accurate revenue and expenditure forecasting, planning for contingencies, awareness of the linkage between cost and performance, and appropriate flexibility (Meyers 1996; Ingraham and Kneedle 2000). Our research suggests that state agencies may be unable to accurately estimate the costs of services contracted-out, which can create serious fiscal stress for the contractor.

The small dollar amounts associated with provider agreements in the EPS-PA arena means that financial capacity was not particularly salient in these contracts. Consequently, the state’s relatively low levels of attention in this case were unlikely to seriously threaten contract management, if only because the provider agreements are very easily terminated. The HCBS contractors—the AAAs—faced problems of financial stability when they took on the HCBS program, and the state failed to anticipate most of these problems. Contractors’ financial problems derived from three facets of the program: the tasks associated with gearing-up for the new program, including increasing staff capacity through hiring and training; the difficulty of obtaining timely reimbursement from the state’s designated financial agent for the program, Blue Cross/Blue Shield of Kansas; and the initial state reimbursement rate for case management services. Early state estimates of the cost of delivering the case management services, and hence reimbursement rates, were inadequate. After eighteen months of financial struggle and lobbying by contractors, the case management reimbursement rate was increased by 33 percent.

In the FCA area, the state’s attention to contractor financial management was somewhat higher than that devoted to the HCBS contractors. Many of the contractors, as traditional nonprofit social service providers, were unfamiliar with the managed care model of service provision. Some of the less sophisticated FCA contractors encountered moderate challenges to their fiscal management capacity because of the slow pace of reimbursement and because, for the first round (four years) of contracts, reimbursements were pegged to identifiable service milestones related to children’s success in moving through the system. In response to fiscal stresses on contractors, the new one-year contracts negotiated for FY 2001 abandoned the managed care model and switched to monthly payments to contractors based on the number of children in each

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contractor’s care rather than child placement milestones. Because of inadequate evaluation of financial management capacity, the state continues to deal with the remnants of the near bankruptcy of two contractors. The contractors’ financial management weaknesses have been cited as a major contributor to their financial crises.

We assigned a moderate rating to the state’s evaluation of MMC contractor financial management capacity. Although the state viewed the financial management capacity of most of the contractors, including the HMOs, as adequate, the state was not prepared for the financial stresses that were created by low reimbursement rates. In the comprehensive EPS case, the state was quite careful in its assessment of the financial management capacity of the contractor and was familiar with the contractor’s financial record.

Theoretical Rationale for Reform

Sound theoretical rationales for the various contracting initiatives should increase the ease and effectiveness of the state’s contract implementation process (Pressman and Wildavsky 1984). Many social services contracts operate in environments that preclude an economic justification under the commonly understood market framework for contracting (Sclar 2000). Hence, while privatization often seeks to take advantage of market forces, social service reform rationales often include other considerations related to such issues as service delivery and the enhancement of program quality for captive clients.

The rationale behind the FCA contracting initiative was driven more by pragmatic administrative politics than by any commitment to alternative service delivery strategies. The Secretary of SRS recognized that caseloads for FCA staff were excessively high and that the only way to get increased funding for FCA from the legislature was to contract for services with well-established and well-respected nonprofit agencies in the state. But a major cornerstone of the reform—the capitated managed care model and the shifting of risk to the contractors—was rejected in the second round of contract. Thus the theoretical rationale for this reform was relatively weak.

In the MMC area, lawmakers, aware of SRS managed care pilot programs, decided both to emulate the trend toward capitated managed care that dominated other states’ Medicaid policies and to rely on HMOs to contain Medicaid cost growth and increase budget predictability. The state assumed that HMOs could be effective in delivering health care services more efficiently and that their emphasis on preventive care could reduce costs associated with
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preventable hospital admissions, emergency room use, and so forth. Capitation, or prepayment, offered the promise of budgetary control and accurate spending projections. But the problems associated with rural capitated managed care, such as the undersupply of primary care physicians, were not adequately addressed in the reform. Consequently, this case was assigned a moderate rating on the rationale dimension.

The HCBS case management contract was designed to take advantage of the close working relationship between the AAAs and elderly Kansas residents to shift to a more streamlined system entry process and integrated case management for clients. Two other motives were critical to the contract decision. Cost containment, and the legislature’s particular interest in stemming the increase in Medicaid nursing home expenses, prompted the state’s application for a waiver to provide HCBS. The political pressure to downsize SRS also was fundamental to the decision. The theoretical rationale for this case was rated as moderate.

In the EPS area, the proliferation of contracting in Kansas is partly due to strong policy consensus among elected officials and SRS staff regarding the importance of employment preparation under the new welfare paradigm (Johnston and Lindamann 1998). Area offices’ use of provider agreements is a long-standing practice, especially in areas with multiple potential providers. The theoretical rationale is straightforward: the purchase of services available in the market when the regional office cannot (or chooses not to) offer the service in-house. The decision to pursue the comprehensive EPS contract, which embodied the same rationale, was driven by the welfare reform mandate to get people into the workforce and the recognition that the relevant SRS regional office was unlikely to get the funds necessary to hire staff to handle the increased employment service workload. For this regional office, the decision to contract was more about political responsiveness to the governor’s and state legislature’s pressure to privatize and downsize SRS than it was about effective management or cost control.

Complicating Variables

The variables described in this section were generally expected to exert negative effects on contract implementation and management.

Political Strength of Contractors and Client Advocates

Contractors are not limited to negotiations with state administrators when contract terms are problematic. Contractors are often
also client advocates, or they may enlist client advocacy groups as allies in their efforts to influence state legislators and administrators (Milward and Provan 2000). The relationship of the advocacy side of the contract organizations with the legislature is likely to dampen some elements of contract management, and it may offer additional complications in the implementation of the contracts. Contract managers might be expected to be less rigorous in their enforcement oversight if they are aware that the contractor might complain to the legislature about the state’s heavy hand.

This dynamic was also observed in the FCA contracts; contractors—mostly organizations identified with child welfare advocacy as well as with direct service provision—appealed to the legislature for financial relief as their costs exceeded expectations and the state’s reimbursement rates, and they obtained a 59 percent increase.29 The relatively high levels of attention and sympathy gained by the FCA contractors in their appeal to the legislature indicated that in the FCA case, the political strength of the advocates was relatively high when compared to the HCBS case.

The HCBS contractors—the AAAs—were not only service providers, they were also skillful client advocacy organizations. First, the AAAs, as advocacy groups, lobbied the legislature to contract-out Medicaid services for the elderly, and they managed to obtain an exclusive contract for HCBS. In addition, as one state official noted, the AAAs, like other nonprofit contractors, are constituents of legislators. As a result, they have the ear of the legislature when contract problems arise. As testimony to their success, the AAAs obtained a one-third reimbursement rate increase early in their contract with the state. We assigned a moderate rating to this case, primarily because the media attention to the advocacy role was so much higher in the FCA case.

Complexity of Subcontractor Relationships

In an intergovernmental context, policy implementation is directly affected by the number of actors involved in the reform (Agranoff and McGuire 1998; Van Meter and Van Horn 1975). When contractors subcontract with other organizations, or interact with separate state contractors in the same program area, implementation complexity can increase exponentially. This dynamic is increasingly common in social services, which rely heavily on the use of networks of providers to deliver complex services. As Milward and Provan (2000) and others note, the more “hollow” the state, the more difficult it is to construct and maintain accountability structures and relationships. Because networks are fluid, they afford weak buffers against external shocks and are inherently difficult to

29State reimbursement increased from $68.3 million in 1998 to $108.5 million in 1999 (Ranney 1999).
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manage (O'Toole and Meier 1999). Under such conditions, implementation is likely to be far more complicated, as is contract management.

The FCA case exhibited relatively high complexity on this dimension. In FCA, subcontractor complications emerged when contractors and subcontractors disagreed over who had responsibility to provide services under the managed care model. One child advocate noted reports of haggling between FCA contractors and subcontractors over who should pay for young clients’ services. FCA is also characterized by a unique feature—most, if not all children who enter the FCA system are also clients of the judicial system. Consequently, most staff who are involved in serving these clients must interact regularly with judges and other judicial actors. Because courts often have primary jurisdiction over cases, the contract managers must monitor case management in the context of court activity. For example, the FCA contracts include incentives to return foster care children to their homes whenever possible, yet the courts may decide against this objective.

Another complication involved “musical contracts” in the second round of FCA contracts, issued in the spring of 2000 (for FY 2001). In some instances the lead contractor in the earlier round of contracting becomes the subcontractor to another nonprofit in the second round. The complexity in this contract area can be daunting. It is not unusual to find a lead contractor that may contract with another organization for a portion of the state’s eligible population, which then in turn contracts with an umbrella organization that oversees contracts with multiple community mental health centers. There is little doubt that contract management and implementation are highly complicated under such circumstances.

HCBS case management work necessarily entails some contact with agencies that are under contract with the Department on Aging (DOA) to provide in-home care to the elderly Medicaid clients. AAA case managers are well positioned to assess the performance of in-home service providers for elderly Medicaid clients, but they have no authority over these contractual providers, who are selected by clients. Instead, they are limited to encouraging clients to report inadequate service to the state. Under the current system, client satisfaction is assessed separately for in-home services. Yet here, too, the client may not be able to disentangle the roles of the case manager and the in-home service provider. The AAA contractors dealt not only with the state, but also indirectly with state contractors responsible for other portions of the Medicaid HCBS program, including the in-home care providers and the organization providing client and provider enrollment services. From the state’s

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perspective, this web of contractors also posed substantial challenges to contract oversight staff.

Similarly, the complicated relationships among the parties involved in the various MMC contracts affect performance across the board. The state’s ability to oversee the activities of the administrative contracts is clearly related to its capacity to enforce contracts with the HMOs. The HMOs in Kansas and in many other states have been chronically late in submitting performance data (known as encounter data), which limits the capacity of the oversight contractors to submit required reports to SRS (Fox et al. 1998). All contractors have experienced problems related to information technology, in part because most of their systems are not compatible, yet they are required to communicate across these systems. If one link in this network of agencies fails to adhere to performance expectations, the system quickly fails.

By contrast, complexity in the two EPS cases was assigned a low rating. In both cases, the subcontractor relationships appeared to be relatively uncomplicated.

Extent of Risk Shifted to Contractor

Under the managed care approach embodied in many of the Kansas contracts, the contractors received a regular per-client payment (sometimes called a capitation payment) in return for the commitment to provide each client with all required services under the contract. For contractors in these cases, the risk entails unforeseen or increased costs that exceed the per-client payment. In the event of such costs, the contractor is likely to suffer financial instability, losses, or perhaps collapse. As the impact of financial instability takes hold, the contractor’s performance is likely to suffer; this affects the capacity of the contractor to comply with reporting requirements as stipulated in the contracts.

For all five cases, the contractor organizations are nearly unanimous in reporting that they were unprepared for the costs—financial and organizational—associated with the contracts. As a result, contractor bids may have failed to adequately account for the costs of contract reporting requirements, which exacerbates the burdens of risk assumption. A common theme is the unanticipated increase in reporting intensity. Nonprofits and other contractors are often unable to comprehend the complexity of intergovernmental program accountability; consequently, it is difficult for these organizations to fully prepare for the costs associated with reporting and other compliance requirements associated with such programs as Medicaid and child welfare.
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We observed a full range of risk arrangements across the five cases. EPS provider agreements entail the lowest level of risk for the providers; providers are reimbursed on a head count, or process basis. Each client who receives a particular service, such as a resume preparation seminar, generates a reimbursement for the provider. The provider is usually under no obligation to accept all clients, and the agreements are easily terminated or renegotiated.

At the other end of the spectrum, the FCA and MMC contracts shifted significant levels of risk to the contractors. Under MMC, for example, the widely recognized pre-paid/capitated HMO reimbursement approach is used; HMOs receive a per-member, per-month payment for each enrollee. The assumption is that if the HMO has an efficient management system, it may generate some profit under the contract; however, if the system is not efficient, it will bear the resulting financial losses. The MMC administrative contractors face somewhat less risk; they agree to provide a specified set of administrative activities for a per-enrollee reimbursement rate. But because of precipitous welfare caseload drops that greatly reduced the number of Kansas Medicaid recipients, Blue Cross/Blue Shield of Kansas faced financial difficulties in their contract as the state’s Medicaid fiscal agent.31

The FCA contractors also bore substantial risk, particularly under the first round of contracts, which covered the period from 1997 to 2000. A managed care approach was used in the contracts, with capitation payments similar to those we have described. In the FCA situation, mental health costs, most of which were provided through subcontracts with mental health organizations throughout the state, exceeded expectations. Nonetheless, the contractors were obliged to cover those costs, and several contractors experienced significant financial problems as a result. At least two contractors threatened bankruptcy, and several of the subcontractors still have not been fully reimbursed.32 Nearly all contractors were unprepared for the personnel costs associated with staffing-up for the contracts, especially as social worker shortages in the state worsened when caseloads took an unexpected upward turn.

By comparison, the risk borne by HCBS and the EPA comprehensive pilot contractor was moderate. The HCBS contract set an hourly rate to be paid for all case management provided by the AAAs. Although the rate was renegotiated, with the AAAs receiving an increase of nearly one-third the original rate during the first year of the contract, the AAAs nonetheless bore the costs associated with start-up activity. The EPA pilot contractor received a capitation payment for each welfare client identified by SRS as eligible for services.33 The risk associated with this contract was less onerous than that assumed under the FCA and MMC contracts.

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Testing the Model

The results of our analysis, reported in the exhibit, indicate general support for our hypotheses. The independently determined ratings for contract implementation and management effectiveness for each case are found at the bottom of the exhibit.\textsuperscript{34} In the top section of the exhibit, we list the hypothesized independent variables and provide ratings for each.

For each variable in each case we assigned a rating of low (1), moderate (2), or high (3), depending on the observed level of the variable. For example, in the HCBS case, we observed low levels of provider competition and therefore assigned a variable rating of 1. In each of the five contract cases, we scored the combined impact of the independent variables by summing the total variable ratings. (Note that the top portion of the exhibit contains those variables that we expected would exert positive impacts on effectiveness; negative variables are listed in the lower portion of the table, and the ratings are reversed: low [3], moderate [2], and high [1].) For example, the total score for the HCBS case is 17, based on the sum of its variable ratings.

When they are considered in the aggregate, those variables that we expected would facilitate effectiveness appear to exert a positive impact, while those that we expected would hinder effectiveness seem to have the anticipated effect. Although this cannot be viewed as a rigorous multivariate analysis, it is a first step toward analyzing the contracting experience, identifying and testing the impact of theoretically important variables on effectiveness. The results suggest that the relationships may be generalizable to other cases.

The results indicate that the cases with the highest variable scores (25 and 19) were independently assigned the highest effectiveness ratings. Similarly, the case with the lowest variable score (14) was assigned a low effectiveness rating. The argument for the model fit for the HCBS and MMC cases is less straightforward: Despite identical variable scores of 17 for the HCBS and MMC cases, the MMC effectiveness rating is \textit{low} while the HCBS rating is \textit{moderate}.

One potential explanation for this result is the relative stability of the HCBS program. For example, while most of the MMC contracts have been rebid at least once since their inception, the HCBS contract has not. In fact, the state statute that authorizes the HCBS contract names the AAAs as the contractor of choice. As a result, there have been no readjustment periods such as those that

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\textsuperscript{34} We assigned effectiveness scores of low, moderate, or high \textit{independently of}—i.e., prior to—our consideration of the factor rating process. In addition, as we noted earlier, we (the authors) assigned the effectiveness scores independently of each other.
have created uncertainty and instability in the MMC contracts. Contract implementation and management has therefore followed a relatively stable course, compared to the MMC cases. This explanation is consistent with the findings of Milward and Provan (2000), who suggest that stability is a key determinant of the success of networks that provide mental health services under contract with Arizona. Similarly, recent research (O'Toole and Meier 1999; Agranoff and McGuire 1998; Frederickson 1997; Kettl 2000) emphasizes the management contrast between traditional, stable, hierarchical management systems and the relatively unstable network systems that are increasingly used to deliver social services. Of course, stability is the antithesis of competition. Interestingly, of the five cases we analyzed, the HCBS case most closely resembles the traditional government model of service delivery: stability, continuity, the absence of competition. One implication of the HCBS rating is that system stability may be an important factor to consider adding to future explanatory models. Refinements of this modeling effort should also incorporate variable rankings and the assignment of corresponding weights to those variables that are most likely to exert the strongest influence on effectiveness. For example, risk shifting might be expected to exert stronger effects than some other variables, if only because of the cascading impacts of financial stress.

SUMMARY

This review of the contracting experience in the State of Kansas confirms that good contracts for social services are difficult to write and equally challenging to manage effectively. Successful contracting requires an extraordinary amount of advance planning, negotiation, and on-going collaboration among contracting partners, especially in the imperfect market conditions of "relational" contracts (Sclar 2000). Our preliminary model suggests that several factors we identified as influential in the implementation of the Kansas HCBS contract were important in the other cases as well. Writing contract specifications, seeking bids, and managing the implementation experience require capacities on the part of the state and the contracting entities that are often elusive, particularly at the outset of a contracting relationship.

Our results indicate that contract implementation and management effectiveness can be enhanced by competition among providers, resource adequacy, performance measurement planning, training for state contract managers, careful evaluation of contractors' staff and financial management capacities, and the presence of a sound rationale for the reform. Effectiveness can be undermined by contracting with agencies that also advocate for their clientele.

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groups, by complex subcontractor relationships, and by risk shifting to the contractors.

That the model fit is less compelling when we compare the MMC and HCBS cases suggests that our model is not capturing the entire picture. We suspect that the variable that is missing from the model is that of contractor stability, which appears to reduce implementation and contract management difficulties in the HCBS case. Milward and Provan (2000), Sclar (2000), and others argue that contracting system stability allows agencies to work out problems and contributes to provider effectiveness. Because social service provision typically involves webs of overlapping networks that require coordination, stability may be especially critical to provider effectiveness and, therefore, to the success of contract implementation and the state's contract management process. Although stability conflicts with the widely touted market model of government contracting—the model based on provider competition—contract management is clearly enhanced by the establishment of inter-organizational cooperation and trust, which requires time and environmental stability. Theoretically, contract managers would be confronted by a far less complicated management task in a highly competitive environment. In reality, contract management requires some minimal level of stability to allow networks of contractors and government managers to cushion the unforeseen impacts that inevitably occur in the delivery of complex social services.

These results indicate that the challenges to contract implementation are substantial. They are partially due to the inevitable contracting transition—as the state downsizes and shifts to a contract management role while contractors staff-up and expand their service delivery roles. Other key features relate to funding levels and service demands. The implementation challenges in these cases emerged under fairly favorable conditions, with strong economies and high levels of political support for program changes. In light of the softening economy and revenue shortfalls in so many states, we note these important questions for future consideration: Do these contracts afford effective accountability relationships? In other words, do such contracting milieus include adequate provisions to insure acceptable contractor performance? And if contractor performance is not satisfactory, what recourse do states have available? Do the states that have off-loaded such programs have any recourse if the work of these contractors proves unsatisfactory? As contracting for social services becomes more widespread nationally, such issues warrant close attention.

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APPENDIX 1
Research Method

Our research methods rely on qualitative case study techniques (Yin 1989). Our intent is to identify and analyze key variables associated with social service contract implementation experiences. We do so by examining several cases of contracting, developing explanatory propositions, and then providing a preliminary test of those relationships. Subsequent research will be necessary to conduct independent tests of the effect of these variables.

We interviewed state agency officials and managers and employees of the contracting agencies in each of the five program areas. The state officials included key state administrators within the Department of Social and Rehabilitation Services (SRS), the Kansas Department on Aging (KDOA), the Kansas Performance Review Board, the Kansas Department of Administration, and key members of the legislature, including members on committees charged with overseeing these contracting initiatives. Other state officials included SRS staff in local area offices around the state. We also interviewed an official in the regional federal Health Care Financing Administration (HCFA) office. Among the contracting officials were Area Agency on Aging directors and case managers, representatives of Medicaid Managed Care (MMC) contractors, and in the Employment Preparation Services (EPS) area we interviewed a representative of the contractor in the comprehensive pilot program as well as representatives of agencies that provide employment training under local provider agreements. In the foster care area we interviewed contractors, subcontractors, a judge, and representatives of advocacy organizations.

In the Home and Community-Based Services program we conducted interviews in four waves: spring 1997, fall 1997, fall 1998, and summer 1999. Interviews in the MMC and EPS areas were conducted in spring 1998 and spring and summer 1999. Interviews in the foster care program were conducted in summer 2000. In all we conducted over eighty interviews in five contract areas; several of the interviews included more than one respondent.

Using semistructured personal interviews, we asked members of each group of administrators to respond to a standard list of questions designed to identify key issues in the transfer. We also sought assessments of their understanding of the new system, including its contractual features, and their capacity for managing the transfer. To supplement the interview data, we obtained and reviewed a number of relevant administrative and legislative documents concerning the transfer. The use of both types of data enabled us to better understand the impetus for the actual privatization decision, as well as its implementation.

APPENDIX 2
Five Contracting Cases

Our study analyzes five social service program areas in Kansas (see exhibit), all related to new state discretion for Medicaid and welfare programs:

- Case management for elderly Medicaid clients under a Home and Community Based Services (HCBS) waiver from the U.S. Health Care Financing Administration (HCFA), which administers Medicaid. This waiver is designed to help poor, elderly Medicaid recipients stay in their homes and avoid expensive and disruptive nursing home residence.

- Medicaid managed care (MMC) for welfare families offered through capitated HMOs and less restrictive forms of managed care. Managed care incorporates incentives for providers to emphasize preventive primary care in an effort to enhance services and to reduce the high costs of preventable hospital and emergency room care.

- Employment preparation services (EPS)—statewide—for welfare recipients. These services have been intensified under the current welfare reform legislation (PRWORA), but they were also used in previous waivers in an effort to foster employment and economic independence among welfare recipients.

- Employment preparation services (comprehensive pilot for one location) for welfare recipients. This program differs from the statewide approach. One SRS regional area office (regional office) has opted for an intensive, comprehensive contract with one vendor for all phases of its employment preparation services.

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- Foster care and adoption services (FCA) for children legally under state custody due to child abuse or neglect; it does not encompass children in the juvenile justice system. The design of this reform follows a managed care model. Contractors have financial incentives to provide good services and contain costs for case planning, service provision, and day-to-day decisions concerning family preservation, foster care, and adoption.

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