



# Performance Based Contracting Experiences & Lessons Learned

Charlotte McCullough  
National Consultant

McCullough & Associates, Inc  
3903 Leland St.  
Chevy Chase, MD 20815  
[mcculloughassociates@yahoo.com](mailto:mcculloughassociates@yahoo.com)

# Topics

- Examples of Contracts in Other Jurisdictions
- Similarities & Differences
- Advantages & Disadvantages
- Challenges For All
- What's Working & What's Not?
- Success Factors & Lessons Learned

Implications for Phase 1 and Phase 2 –  
Facilitated discussion follows presentation

# Performance Based Contracting

- In the last 10 years many states have created performance-based contracts for some or all services
  - These contracts have explicit outcome expectations – performance is linked to payment).
- In 2009, the QIC-PCW identified 25 states that have current PBCs for at least one service.
  - Reference report titled “Examples of Performance Based Contracts in Child Welfare Services”, Quality Improvement Center, July 27, 2009.

# Performance Based Contracting (cont)

- Quality Improvement Center reviewed 16 PBCs:
  - 7 involve adoption (or foster/adoption resource family) recruitment, licensing, and/or placement services (IA, ID, MN, 2 in NC, ND, NM)
  - 2 involve in-home services (IA, NE)
  - 2 involve residential care (IL, WY)
  - 1 involves services for children in Independent Living and Transitional Living Programs (IL)
  - 4 involve foster care case management services (FL, IL, MO, TN)

# Performance Based Contracting (cont)

There are three basic PBC models:

- **Incentives and Penalties**

- » Providers receive base contract payments; on top of which agencies are paid incentives (or are charged penalties) for their performance on select measures. (IA, FL-CBC)

- **Caseload Models**

- » Agencies are required to accept a certain percentage of their caseload in new referrals, and move a certain percentage to permanency each year (IL, MO).

- **Pure Pay-for-Performance Contracts**

- » These contracts only pay providers when they have met a key milestone. Potentially pose the greatest risk to the private providers but they vary greatly in what is funded and on what schedule (NC, MA).

# Example - Minnesota/Adoption

- Pure pay-for-performance contract. Providers are paid only after completing an activity.
  - » Training and Education (\$200 per person)
  - » Home Studies (\$3,200)
  - » Home Study update (\$1,200)
  - » Child-Specific Recruitment/Home studies (\$6,000 – for each 6-month period of active recruitment for a child or sibling group; Up to \$24,000)
  - » Child Placement services (From \$7,500-\$18,000 depending on age)
  - » Post adoption services (negotiated)

# Example - Iowa/Recruitment, Retention & Placement Matching

- In 2007, procured one statewide contract with base pay and incentives (about 10% base pay)
  - Incentives tied to:
    - » Meeting recruitment targets in each service area,
    - » Timely and complete home study,
    - » Appropriate/timely placement matches,
    - » Child safety,
    - » Placement stability,
    - » Placement proximity.

# Example – IL/Foster Care

- In 1997, Illinois was first state to use a performance-based “caseload” model.
  - Today, private providers provide approximately 80% of the state’s case management, family preservation/support services, family foster care, kinship care, adoption, and respite.
- Foster and kinship care agencies are required to accept % of their caseload in new referrals and move % to permanency each year.
- Illinois’ foster care caseload has fallen by 65% since the introduction of PBC.
  - With caseload reductions, state retained better performing agencies and eliminated ineffective ones.

# Example – IL/Foster Care (cont)

- Payments are made in two parts
  - Maintenance payments passed through to foster parents
  - Administrative payments
    - » Cover all costs of case management; services provided to the child, the child's family, and the foster family/relative caregiver; and administration costs.
- Administrative payments are based on expected caseload ratios
  - 15.1 for traditional foster care and kinship cases/worker
  - 10.1 for specialized foster care cases/worker
- If agency fails to move children to permanency, caseloads go up, funding remains the same.

# Example - IL/Independent Living and Transitional Living Services

- Began in 2009 for youth 16+. Providers are rewarded or penalized based on their performance on aggregate outcomes using two measures:
  - Bonus (TBD) for agencies with highest ranking on positive discharges/self-sufficiency ratings
  - Bonus (TBD) for agencies with highest placement stability ranking.

# Example - IL/Residential Care

- Also in 2009, IL began PBC for residential care (QIC award).
  - Goal 1: Improve safety/stability during treatment
  - Goal 2: Effectively/efficiently reduce symptoms and increase functioning
  - Goal 3: Improve outcomes at and following discharge
    - » To establish specific measures the CWAC Data Group met for almost a year to review current and historical data

# Example – IL/Residential Care (cont)

- Approach
  - No competitive bid.
  - Standardized rates by classification - mild, moderate, severe.
  - 100% guarantee for beds purchased
    - » DCFS says how # in each category
  - In return for guarantee, there is no reject, no eject.
  - Fiscal penalty for exceeding the TODR benchmark (25% per day).
  - Bonus for exceeding sustainable, favorable discharge.

# Example - IL/Residential Care (cont)

- Tracks performance across 70+ contracts
  - “Treatment Opportunity Day Rate” (TODR)
    - » The % of time in treatment during a residential stay where the child/youth is NOT on the run, in detention, or in psychiatric facility.
  - “Favorable” discharge
    - » A step down to less restrictive setting or “neutral” setting (for MR/DD or other children who cannot be in less restrictive setting).
  - “Sustained” discharge
    - » Remain for 180 days or more.
  - “Unfavorable” discharge
    - » Negative step-up, disrupted placement, or lateral move to another facility or group home.

# PBC - Lead Agency Model

- Until recent years, was the most common model. This is relevant to WA in Phase 2.
  - Public agency contracts with one or a limited number of agencies within designated region to provide or purchase all specified services for target population from time of referral to case closure or at some other point specified in the contract.
  - Network development/management is often a requirement.
  - Case management (or care coordination) is included.

# PBC - Lead Agency Model (cont)

- **Goals**

- Ensure a single point of accountability at the local level.
- Build greater service capacity and/or service coordination.

- **Variations**

- Some provide most, if not all, services with few or no subcontracts; others procure most services; a few deliver no services directly (operating as MSOs).
- Some cap amount of services LA delivers; others don't.
- Some are single agencies; others are newly formed corporations or consortiums.
- VAST majority are nonprofit and most are accredited.

# Lead Agency Example – FL/CBCs

- 1996: 4 Pilots
- 1998: HB 3217 required “privatization” for entire state
- Protective Investigations in some areas transferred to local law enforcement
- HB 2125 created Community Alliances
- Transition to CBC complete 2005- 22 CBC agencies, 500 subcontracts
- Services :
  - family preservation
  - independent living
  - emergency shelter
  - residential group care
  - foster care
  - intensive residential treatment
  - adoptions
  - case management
  - family reunification

# Lead Agency Example - FL/CBCs (cont)

## Typical CBC Features

- 24/7 centralized intake
- Case management
- Data Collection/Reporting
- Resource specialists
- Coordinated assessments
- Placement matching/supports
- Family-centered practice, wraparound planning, and family conferencing
- Family Finding
- Linkage to other systems
- Broad service array through provider network
- Caregiver supports
- Ongoing utilization review
- Concurrent planning
- Court Liaisons
- Results-based contracts
- Continuous Quality Improvement
- Expanded prevention/aftercare

# Lead Agency Example - FL/CBCs (cont)

## Start-Up Deliverables

- System of Care Plan
- Network Development Plan
- QA/QI & Utilization Management Plan
- Foster/Adoption Recruitment, Retention Plan
- Community Involvement Plan
- Human Resource & Training Plan
- Financial & Risk Management Plan
- Cost Allocation Analysis
- Service Implementation Plan
- Policies & Procedures
- Hire & Train staff

# Lead Agency Example – MO/Foster Care

- Foster care consortium (QIC award)
  - Competitive bid.
  - Start-up phase w/ funding.
  - Awarded to 7 consortiums covering four regions (26 counties-about 40% of state's overall foster care caseload).
  - Includes all case management duties
    - » Assessment
    - » Case planning
    - » Placement planning, service planning, permanency planning
    - » All court-related work

# Lead Agency Example – MO/Foster Care (cont)

- Each year, each provider consortium has a set caseload (e.g. 100 children) and permanency rate (e.g. 30%).
- New children are rotated into the agency based on the agreed upon caseload and permanency rate.
- Missouri has 6 performance measures but only one –permanency-is directly linked to payment.

# Lead Agency Example – MO/Foster Care (cont)

- **Outcomes:**
  - Reduced reentry into foster care
  - Increased stability
  - Increased permanency
  - Increased safety
  - Decrease in residential utilization days
  - Development of resource (or foster care) homes
- **Penalty:** Referral holds if the consortium does not meet permanency performance standards. Referral holds result in a reduction of funding.

# Lead Agency Example – MO/Foster Care (cont)

- Evaluation compares private agency to public.
  - Matched criteria for public/private caseload, with random assignment between private agencies when more than 1 per region. Found difficult to maintain matched caseload.
    - » Case mix
    - » Caseload size
    - » Supervisory ratio
  - Differences between public-private
    - » Education/experience
    - » Salaries
    - » Flexibility in type of services purchase

# Similarities in PBC Contracting Models

- Both types of service contracts typically
  - Explicitly state expectations related to outcomes/outputs,
  - Emphasize results related to output and outcomes rather than *how* the work is performed,
  - Use measurable performance standards,
  - Provide performance incentives and/or tie some portion of payments to outcomes,
  - Often have some significant consequence associated with not meeting performance.

# Advantages/Disadvantages of Models

- Issuing more, smaller performance based contracts by type of service has both advantages and disadvantages.
  - Contractors can specialize by service or population.
  - Wider range - and, as a result, a greater number - of organizations can compete for smaller contracts.
  - However, with many contracts you face added admin costs, challenges monitoring, variability in performance, struggle to build integrated and equitable services across state, limits PBC payment options.

# Advantages/Disadvantages (cont)

- Lead Agency model has inherent advantages and disadvantages.
  - Lower cost of contract administration and monitoring.
  - Economies of scale – infrastructure, management costs spread across more clients.
  - Greater coordination and service integration
  - Variability in performance reduced.
  - Potential downsides
    - » Public agency relies heavily on single, or small number of contractors.
    - » State may not have providers willing or able to function as Lead Agency.

# Challenges

- Regardless of the contract model there are predictable challenges
  - Setting outcomes
  - Pricing the contract and designing the PBC payment model
  - Handling procurement
  - Transition issues

# Setting Outcomes

- States often use federal mandates (ASFA and CFSR) as a framework for setting outcomes
  - Definitions/performance measures are often adapted.
- Challenges still abound in some contracts
  - Poorly defined outcomes/measures
  - Too many, too few, or not “right” outcomes
  - No alignment between \$ and expectations
  - Lack of balance between roles/authority and outcomes
  - What is linked to \$ & the threshold for success

# Setting Outcomes (cont)

- **Variability in what gets monitored**
  - Key to oversight are decisions about which outcome measures and indicators are monitored and how.
- **Variability in how measures are developed**
  - Some states negotiate measures with the provider community prior to procurement or during negotiations.
- **Variability in linkage to payment**
  - Decisions must be take into account what can be achieved given the target population, the scope of the services, case management authority, and the funding available.

# Setting Outcomes – Lessons Learned

- **MUST** periodically review/revisit targets
  - What is the trend over time?
  - Are agencies able to reach/sustain goals?
  - Have the right targets been set to support the performance goals?
  - Are incentive levels sufficient to change performance?
  - What are high performers doing that low ones aren't?

# Designing Payment Model

- Very few models are repeated across states.
- Must consider
  - Overall pricing (how much \$ in the pot)
  - How rates will be determined
  - How payments will be made (the schedule)
  - How risk/rewards will be introduced
  - How “savings” will be used/reinvested
  - When and how adjustments will be made

# Designing Payment Model (cont.)

- **Achieving flexibility, maintaining federal revenue, managing cash flow**
  - **Providers need flexible funding.**
    - » Not guaranteed under various risk-or results-based contracts.
  - **Prospective payments - the best for front-end flexibility.**
    - » Hard to achieve with cost reimbursement requirements governing federal and state funds.
  - **Achieving better outcomes for clients may produce higher costs for states.**
    - » Though overall costs decline
  - **Some states have worked around restrictions using IV-E waivers or blended funds.**

# Payment Model - Lessons Learned

- Risk must be balanced with control over key decisions.
  - The payment options for Phase 2 could introduce more risk than the payment options for Phase 1.
- The adequacy and flexibility of payments is critical in meeting fiscal or programmatic goals.
  - Are there start-up funds?
- You can't get something for nothing but cost savings (or a redistribution of expenditures) over time is possible.
  - May need to align fiscal expectations.

# Handling Procurement

- After all design decisions are made, different approaches have been used to transition from traditional contracts to PBC models.
- Competition required in most but not all states.
  - Procurement varies from a multi-phase process (FL) to a single RFP that leads to a contract.
- Some states have no competition on the front but ongoing survival is based on a contractor's performance (IL).

# Transition Issues

- Regardless of the contracting and payment model, there are predictable tensions during the early stages of ANY contract.
  - No shared vision
  - The fear of change
  - Lack of understanding about the contracts
  - Different understanding about outcomes and definitions of “success”
  - Lack of trust
- **Expect hurdles!**

# Transition Issues - Private

- The alignment of resources with expectations
- Limited understanding or capacity to assume risk
- Inadequate practice and business expertise
- IT requirements
- Performance contingent on factors outside of the contractor's control
- The practice culture...

# Transition Issues - Shift in Focus

## Program Focus

- Structured, integrated components
- Delineated progression
- Little variability
- “Preferred” length/path
- Staff attached to program

## Performance Focus

- Menu of services available
- Services individualized based on needs
- Progression tied to client needs/functioning
- Highly variable
- Length determined by client progress
- Staff become attached to client

# Transition Issues - Public

- Balancing performance measures with mandates that are still compliance based.
- Lack of understanding of public agency role in making the contract successful.
- Internal opposition to contracting out services.
- Few or no potential providers.
  - HUGE issue
- PBC requires a different type of “partnership.”
  - May take time (and willingness on both sides) to cultivate

# Efforts to Find Out What Works

- Independent Evaluations (FL, KS, for example)
- Title IV-E Evaluations
- The ACF-funded QIC-PCW is using R& D projects to advance knowledge and learn more about what works.
- HHS-ASPE produced a series of reports synthesizing what is known and not known about various aspects of the new contracts.
- CWLA, Children's Rights, Chapin Hall, PAL-Tech have conducted numerous surveys & studies.

# What's Working & What's Not?

- Results are mixed.
  - Some contracts exceeded expectations; some were dismantled; many were modified and expanded.
- Without rigorous independent evaluations it is hard to tell why individual contracts succeed or fail.
- Many (most) have resulted in stronger public-private partnerships.
- We are beginning to understand the factors that contribute to success.

# What's Working & What's Not?

- Some cost far more than expected, others redirected resources to serve more people for same dollars, a few resulted in actual savings
  - Florida
    - » The overall conclusion contains good news but points to the need for patience. Similar average expenditures for first 4 years, last 3 years average expenditures were lower for CBC, and far fewer dollars are spent on OHC.
  - Illinois
    - » A dramatic reduction in caseload in 3 years. A byproduct was that there were not enough referrals to meet the contracted intake obligations. Saved funds were “reinvested” in system.

# What's Working & What's Not?

- **Effectiveness findings are mixed.**
  - FL has had rigorous evaluations for over 7 years. Consistently show variability across CBC sites.
    - » Agencies that perform best in reducing LOS and achieving permanency are also more likely to have higher rates of re-entry.
    - » The number of children reunited with families within 12 months continues to increase; monthly visitation has improved but still variable across CBCs.
    - » Caseloads and vacancy rates have decreased substantially.
    - » Number of adoptions dramatically increased. (In 2009, Florida received the highest adoption incentive bonus in the nation).

# What Works Best?

- **No comparative data to say which contract model or payment option works best.**
  - Innovative practices and improved results have been shown across all models; but there are examples of failure across all models, as well.
- **Regardless of model, State administrators often cite the following benefits**
  - True public/private partnerships are created.
  - Whole system more accountable and outcome-driven.
  - New services and non-traditional supports are added.
  - Financial incentives aligned with programmatic goals.

# Success Factors

- **SUCCESS DOES NOT DEPEND ON THE TYPE OF CONTRACT OR PAYMENT MODEL.**
- Success appears to relate to
  - Alignment of design and payment decisions.
  - Contractor's capacity and flexibility to introduce or enhance business and casework practices.
  - Overall adequacy of funds and rates.
  - Public agency's effectiveness in monitoring/partnering with agencies and communities.

# Success Factors (cont)

- **A decade ago**, the GAO did a study of what were successful contract efforts. It found six common factors that are still true today.
  - Political champions (public and private).
  - Adequate implementation structure/time.
  - Reliable flow of performance and cost data.
  - Legislative support.
  - Strategies for workforce transition and/or training.
  - Effective monitoring, oversight, improvement capabilities.

# Commentary

- Changing the culture is hard for both sides.
- You get what you pay for. Contracting out is NOT a short-term answer to state budget woes.
- There are no quick fixes. PATIENCE!
- Some challenges are the same for public and private agencies (i.e. workforce, for example).
- Even with perfect plans, transitions are challenging.
- Cross-training and problem-solving is essential.
- The power of public-private partnership can't be overstated; but shared accountability is essential.

# For Additional Information

All of the ASPE topical papers can be accessed online:

Assessing Site Readiness: <http://aspe.hhs.gov/hsp/07/CWPI/site/index.shtml>

Program and Fiscal Design:

<http://aspe.hhs.gov/hsp/07/CWPI/models/index.shtml>

Roles of Public & Private Agencies:

<http://aspe.hhs.gov/hsp/07/CWPI/roles/index.shtml>

Evaluating Privatized Efforts:

<http://aspe.hhs.gov/hsp/07/CWPI/guide/index.shtml>

Preparing Effective Contracts:

<http://aspe.hhs.gov/hsp/07/CWPI/contracts/index.shtml>

Quality in Contracted Services :

<http://aspe.hhs.gov/hsp/07/CWPI/quality/report.pdf>

The ASPE series builds upon field research and the work of the [Quality Improvement Center for the Privatization of Child Welfare Services](http://www.uky.edu/SocialWork/qicpcw/) (<http://www.uky.edu/SocialWork/qicpcw/>). The QIC site contains links to other research reports.