Implementation of Control in Contracting for Human Services

by

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ABSTRACT

States have adopted purchase-of-service contracting for a wide variety of human services, and as much as two-thirds of Title XX funds may be spent through purchase of services. The promise of purchased services - many small providers delivering a variety of services in innovative ways at lower cost and higher quality than state delivered services - has not been met.

To examine this failure, this study looked at the interrelationships and the effects on the provider market of several control mechanisms which are or could be used by state agencies to shape provider behavior. Two states which exhibited very different provider markets were used as case studies. Actual use of control mechanisms was compared to potential use, and explanatory reasons were found for the shortfall between actual and potential use.

Implementation models were also used to provide a more general framework in which policies, such as purchase of service contracting, are put into force. Although each of the models used could explain the behavior found in the case studies, the models focused attention on different aspects of the contracting system and offered different points of intervention for changing the system through improving state agency ability to shape the behavior of its vendors.

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Title: Associate Professor of Urban Studies and Planning

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page of writing and provided the necessary motivation (intimidation) for keeping the dissertation on schedule.

To all these people, a very warm "Thank You!" is due.

BIOGRAPHY

Levi A. Sorrell holds undergraduate and Masters degrees from the Sloan School of Management at M.I.T. He has worked as a financial manager within state government and as a consultant to state government on such issues as reduction of staff turnover in state institutions, rate-setting, grants management and operations analysis. He enjoys problem-solving within a variety of contexts.

Levi is originally from Plattsburgh, New York and currently resides in Rhode Island. He enjoys sailing, bicyling, walking, and coveting Victorian homes. After earning his doctorate, his next major goal is to learn ventriloquism.

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A. Introduction

Various State departments currently purchase services for a variety of social service programs. Regardless of the specific program, the departments must be capable of effective management of these services. In order to achieve this goal, they must assess the effects of their policies and learn to identify those actions of the contracted services system which they control.

Two major factors have drastically increased the number and kinds of purchase-of-service contracts. The first was the passage of the 1967 amendments to the Social Security Act which authorized states to purchase services from public and voluntary agencies and subsequent passage of the Title XX program (the 1975 amendments to the Social Security Act) which accelerated purchase-of-service arrangements by allowing states to increase the types of services which could be bought by the states using federal money (Benton, Feild and Millar, 1978). Voluntary agencies, which grew out of the volunteer social service movement, are non-profit social service organizations with long-standing traditions of community service.

The second factor is deinstitutionalization: the process of moving people from large institutions (usually, "total institutions" in the Goffman sense) to smaller institutions (such as nursing homes), group homes and other community facilities. Goffman (1961) defines a "total institution" as "... a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." Deinstitutionalization was a response to

dissatisfaction with the institutions as a service delivery system, to the belief that community-based services would be cheaper, to changes in the prevailing treatment philosophy, and to the effects of the Title XIX Amendments (Medicaid) to the Social Security Act. The state institutions could not meet federal and state standards for reimbursement under Title XIX, but facilities such as nursing homes could meet these standards and became dumping grounds for the states' patients (Kinzer, 1978). Nationwide, over two-thirds of Title XX service funds are spent on purchase-of-service contracts (Benton, Feild and Millar, 1978). This heavy reliance on purchased services is expected to increase (Buckle and Buckle, 1977), bolstered in several states by court orders for improved or less restrictive care.

B. Background

Deinstitutionalization was expected to improve social services by producing competition among vendors which would lead to innovation, variety, and greater responsiveness to client needs (Arthur D. Little, Inc., 1977). The states expected that the innovativeness of the private providers would better facilitate the implementation of new programs and the cutback of unneeded ones (Buckle and Buckle, 1977). However, these expectations have not been met. The state departments' management control mechanisms have engendered conformity among programs (Finch, 1979; the Governor's Task Force on Contracting Out, 1976; Social Planning Services, 1976; Children's Services Task Force, 1978), and have encouraged the development of large vendors offering similar services in all of their facilities (Buckle and Buckle, 1977). This conformity and size characterize the very problems with the direct service system which led the states to develop the private delivery system (Childrens

Services Task Force, 1977).

A Massachusetts study of purchase of services determined that most of the available money went to a few large providers. This was, in part, due to loyalties to the original providers. Small providers could not handle the cash flow problem caused by slow state payments. Furthermore, this study found that there was considerable confusion over which roles should be played by the contractor and vendor (Childrens Services Task Force, 1977). It was unclear whether the contractor should be controlling vendors or whether the state agencies and the vendors are all in the same boat battling the turbulent legislative seas (Massachusetts Taxpayers Foundation, 1980).

As service delivery through contracted community-based services has not been working as expected, it has become the focus of considerable adverse publicity. The typical crisis response by the departmental administrators (and the response usually demanded by the newspapers) is a piece-meal intensification of particular management control mechanisms, e.g., more monitors, or, higher rates, or higher input standards (Providence Journal, April, May and June 1979). A piece-meal response has a very limited effectiveness because it ignores the effects of different control mechanisms, the inter-relationships among the control mechanisms, the impacts of changes in particular mechanisms on the future vendor industry, and the many functions that each particular mechanism may service in different parts of the bureaucracy.

For example, there is a direct relationship between the degree of regulation, the cost of operations and the number of facilities: lower (higher) levels of regulation lead to lower (higher) cost of operations and more (fewer) facilities (Katzper, 1981).

This study looks at how best to use specific models of implementation and control mechanisms to shape the behavior of particular providers while maintaining a viable provider market. Ideally, this would result in cheaper, higher quality, and more accessible services.

CHAPTER 2: SETTING THE CONTEXT:

POSSIBLE MODELS OF IMPLEMENTATION AND CONTROL

A. Introduction

Several models of organizational and interorganizational behavior incorporate factors which influence the effectiveness of control mechanisms. Four generally accepted models can explain such implementation: 1) the systems management model, 2) the bureau- cratic process model, 3) the organizational development model, and 4) the bargaining and negotiation model (Elmore, 1978).

B. The Systems Management Model

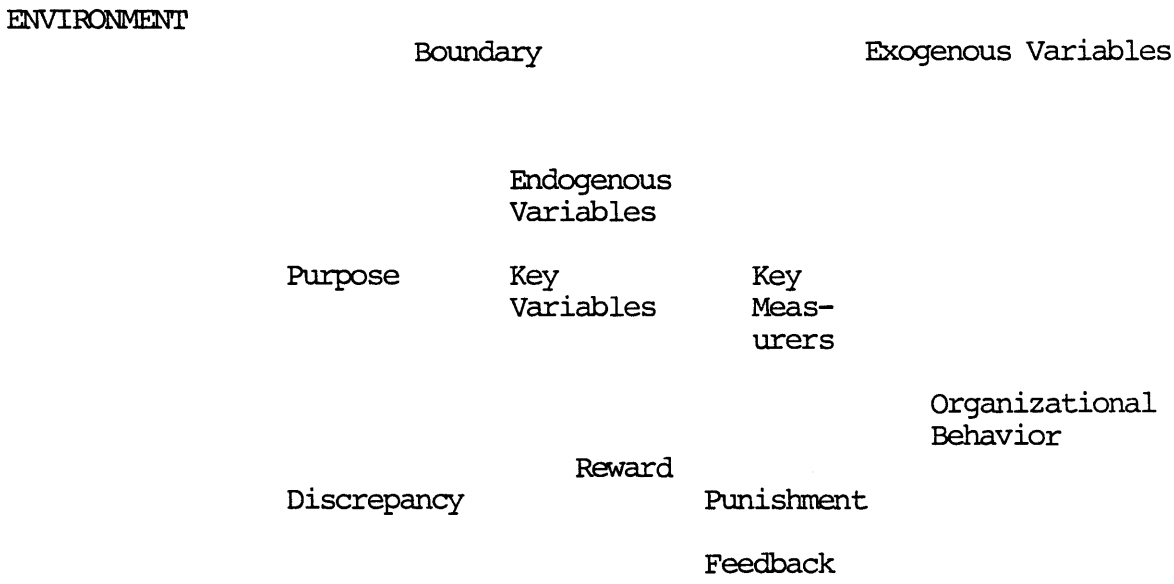
Management control represents an attempt to apply the elements of physical control theory to the operation of organizations. The main element of physical control theory is the use of feedback to make adjustments. A thermostat operates on this principle.

The main elements of a mangement control system include:

1. Purposes of the Control System
2. Boundaries of the Control System
3. Key Variables and Key Measures of Key Variables
4. Feedback about Efforts of the Control System Based on the Key Measures
5. Changes in the Controlled System based on Feedback
6. Reward/Punishment Incentives for Implementing Change

These ideas may be displayed as in Diagram 2a.

DIAGRAM 2a: The Systems Management Model



Endogenous Variables: Variables within the boundary of the control system

Exogenous Variables: Variables outside the boundary of the control system which may impact the control system

Key Variables: Endogenous Variables that are considered most important for controlling behavior

This model asserts that organizations are effective to the extent that they maximize performance with regard to their central goals and objectives. There is hierarchical control where top management makes policy and subordinate units are allocated tasks based upon specific objectives. For each task, there is an optimal allocation of responsibilities that maximizes an organization's performance with regard to its objectives. Implementation consists of defining a detailed set of objectives; assigning responsibilities and standards of performance to sub-units consistent with these objectives; monitoring system performance and making adjustments that enhance the attainment of goals. Changes within the environment impose new demands that necessitate constant adjustments. There is a mix of hierarchical control and subordinate discretion which results in "responsibility centers" which are held responsible for a certain level of performance. This provides a means of exercising control by focusing on the performance of sub-units rather than on their complex internal operations.

Effective implementation must contain five main ingredients: clearly specified tasks and objectives, a plan to allocate tasks and performance standards to sub-units, an objective means of measuring performance, a system of controls and social sanctions sufficient to hold subordinates accountable for their performance, and a means of receiving and evaluating feedback.

The pre-conditions for satisfactory performance are 1) the manager understands organizational expectations in terms of output, quality, costs, deadlines or other appropriate yardsticks; 2) the manager is given adequate resources, necessary freedom and the authority to deploy available resources; 3) the manager has reliable means of monitoring

performance so that corrective action can be taken in time (Williams, 1972). In this way, control becomes a process of monitoring feedback from activities; trying to implement strategies and realizing objectives; making decisions regarding whether the organization is on target and taking corrective action. Controls, then, represent an early warning system which must be built into the job so that subordinate and superior will know whether or not progress is satisfactory (Williams, 1972). In order for this to occur, the criteria of effective performance must be objective and attainable and thus valued (Williams, 1972). The emphasis in systems work must be on the transmittal of information to the right places, in the right form, and with the right content for taking action (Hurni, 1956). In management control the feedback loop requires both the report on control criteria and management action to be effective (Anthony and Dearden, 1976).

One or both of two types of feedback characteristics must be communicated in order for performance to be considered unsatisfactory:

1) the manager of the responsibility center must be motivated to take corrective action

2) and/or the plans may be revised (Anthony and Dearden, 1976).

Although it may be impossible to design a perfect system, it is important to design a system that is self-correcting: a system that knows its goals, can measure its performance and has incentives to apply this information to improving its performance (Jacobs, Christoffel and Dixon, 1976).

As in physical control theory, the key is in the use of feedback to make changes through an adjustment mechanism (reward/punishment).

One advantage of a management control system over a physical control system, however, it that it is possible to change the controlling system when discrepancies persist.

Another way of visualizing management control is to remember that stating a purpose is making a projection about future behavior. Unless there are ways of assessing that behavior, the projection can never be validated. The development of key variables and measures (criteria), feedback, and reward/punishment mechanisms provide the projection with an assessment.

The primary use of management control has been in a single organization which is controlling its divisions in their interaction with the environment. In the health care sector there has been an increased use of regulation as a means of shaping provider behavior. The terms "control" and "regulate" have similar meanings in the physical sense, and, in this model, in the organizational sense. Health facilities regulation was intended to identify key variables of behavior and to find means of shaping behavior along the key variables. As a consequence, criteria for expected behavior (standards), means of reward/punishment (rate-setting, client placement), and feedback (auditing/monitoring) were established.

C. The Bureaucratic Process Model

The second model involves implementation process as a bureaucratic process. This model asserts that all important behavior in organizations can be explained by the discretion exercised by individual workers and the routines that these workers develop to maintain and

enhance their position in the organization. Power tends to be dispersed among many small units exercising strong control over specific tasks. The amount of control any unit can assert over another, laterally or hierarchically, is lessened by the fact that, as units become more specialized, they are able to exercise more control over their own operations. Organizational decision-making tends to be incremental since it must consist of controlling discretion and changing routines.

Proposals for change are judged by organizational units in terms of the degree to which they depart from established patterns. Implementation consists of identifying where discretionary decision- making occurs and which routines need to be changed. Newly developed routines must be sufficiently attractive to induce organizational units to replace old routines. The dominant characteristic of organizations is resistance to change, not simply passive resistance or inertia, but an active process of trying to remain the same.

In order to reduce the discretion practiced by lower organizational units, higher units tend to implement more controls in the form of increased monitoring of performance through reports, work rules, and increased involvement of superiors in the work of subordinates. The elaborate substructure of regulations, guidelines and management controls tend to have a weak and unpredictable effect on service delivery. This type of control is based on acceptance of the belief that employee behavior cannot be changed with consequent attempts to police it by reducing the degree of variability in an organization. However, this type of control has two dysfunctional effects:

1) controls become an end in themselves and procedures are followed when they are clearly inappropriate - the organization becomes

procedure-orientated, and cannot respond adequately to its environment;

2) subordinates rebel against the interference in their work caused by control mechanisms and either become apathetic or attempt to evade the regulations - either type of response is perceived by higher units as indicating the need for more of this type of control (Yorks, 1976).

D. The Organizational Development Model

The third model involves implementation as organizational development. It is based on the assertion that organizations should: 1) satisfy the needs of people for autonomy and control over their own work, 2) offer participation in the decision-making process, and 3) stress commitment to the purposes of the organization. Organizations should be structured so as to encourage participation at all levels. When hierarchical control is minimized, responsibilities and decision-making can be distributed throughout all levels of an organization.

Managers must be able to translate performance criteria into personal "spheres" of accountability (Williams, 1972). In order to obtain a qualitative feel for their unit's performance, they require both positive and negative feedback which can then be utilized to exercise control and solve problems (Yorks, 1976).

The implementation process is one of consensus-building and accommodation between policy-makers and implementors. Implementation should consist not of developing more sophisticated techniques for managing the behavior of subordinates, but of enhancing the self-starting capacity of lower units. At the project level, this

implementation would require: 1) a sense of involvement and ownership of the project 2) the centrality of face-to-face work groups which would break down the traditional isolation of many street-level bureaucrats and 3) the willingness to reformulate objectives and tasks.

The most any one level of government can do to effect implementation at another level is to provide supports that enhance the internal capacity of organizations to respond to change.

E. The Bargaining and Negotiation Model

The fourth model involves implementation through conflict, bargaining, and negotiation. It is based on the assertion that organizations are arenas of conflict in which people and subunits compete for relative advantage in the exercise of power and the allocation of scarce resources. The distribution of power is never stable and is dependent not only on formal hierarchical position but also on specialized knowledge, control of material resources, and the ability to mobilize external political support.

Decision-making consists of bargaining within and among organizational units. Bargaining does not require agreement on a common set of goals, nor that all parties concur in the outcome of the bargaining process. It only requires that the parties agree to mutually adjust their behavior to preserve the bargaining process as a means of allocating resources. Implementation consists of a series of bargaining decisions reflecting the preferences and resources of participants. Success can only be defined relative to the goals of one party. Implementation does not progress from a single declaration of purpose to a

zresult, but is instead characterized by constant conflict of purposes aznd results in the pursuit of relative advantage.

The behavior observed in the implementation process is designed to shape the expectations of the other actors. An agency might put a great deal of effort into developing an elaborate system of management controls knowing full well that it doesn't have the resources to make them binding on other parties. However, the expectation that the controls might be enforced is sufficient to influence the behavior of the other actors. The outcomes of bargaining are seldom optimal but are simply convenient, temporary points of closure.

F. Common Factors

All four of these models appear to have at least three factors in common:

1) feedback from and to the environment
2) contingency, that is, adaptation to changes in the environment
3) hierarchical regulations which have an impact on services, although the impact may only be to reinforce existing practices.

The concepts used in this analysis will draw on these three factors. The four models will be used to develop alternative explanations for the presence of the mechanisms and responses observed in the case studies, and alternative ways of changing the contracting system.

G. The Role of Contingency in Implementation

This study of management control mechanisms is designed to increase the effectiveness of states' purchase-of-service contracting by improving a state agency's ability to shape the behavior of its vendors. Effectiveness is a key indicator of the adequacy of a delivered service and is usually interpreted as indicating how well actual outputs match desired outputs (Blum, 1971). The measure of effectiveness to be employed here is based on the system attainment model (Baker, 1974), rather than the goal attainment model. The goal attainment model assesses whether an agency has reached a preset goal. The system attainment model assesses whether an agency has optimally distributed its resources and control mechanisms to provide for attainment of goals under a given set of internal and external conditions. By examining the effects, interactions, and exogenous variables (size of industry, for example), it is the intended result that a better "positioning" of mechanisms for possible success can be suggested.

Providers react to the control system with their own contingency models of their environment. Part of the providers' environment is the constraints imposed by state agencies. The more broadly the constraint is imposed, the smaller the chance for evasion and distortion of the delivery system by providers (Leveson, 1978). Narrow constraints imposed by a single program to control the health industry are inadequate because the system is too easily manipulated to meet that regulatory effort while the industry remains essentially on the same course as before (Schweitzer, 1978). Highly specific constraints, such as the staffing patterns dictated by nursing home standards, do not

allow management the discretion to choose optional ways of producing an output (Leveson, 1978). However, the pieces of the control system are not always identified as belonging to a single system. Consequently, the pieces have acquired a "life" of their own and often are spread across many organizations. When this point, is reached, simply trying to keep the other pieces of the control system informed can become a major waster of resources. Seldom is action concerted or cross-impacts duly recognized (Special Committee on the Regulatory Process, 1977). As a consequence, the control system tends to work against itself, but seldom in such a way as to be beneficial to providers (Kinzer, 1977).

In purchase-of-service contracting for social services, this disembodiment of the control system is not quite as advanced and varies considerably from state to state. Larger states tend to have more formalized and evolved (separate entities for each mechanism) control systems.

This study next looks at the use of the various management control mechanisms. A set of relationships among the control mechanisms and between the control mechanisms and the provider market is established. Then, these relationships are compared to the relationships found in a brief review of six states. Finally, preferred combinations of control mechanisms are established within three different constraints.

Chapter 3: The Use of Management Control Mechanisms in Purchase-Of-Service Contracting

A. Introduction

To review the variations in the control mechanisms, I have created for this chapter only a hypothetical state administrator, Mr. Pretend Admin. The administrator is faced with the problem of reshaping a vendor system in which all parties to the system appear to be dissatisfied with the services being delivered. Mr. Pretend Admin recognizes that the cost of social service residential care has increased considerably and a lesson might be learned from studying similar increases in costs in the health care industry. He decides to draw on some of the information available about health care. However, he understands that there are many differences between a control system for regulated institutional health care and a control system for the purchase of services in social service residential care.

In order to do all this, Mr. Pretend Admin has to determine the critical points where vendor behavior can be shaped and the effects of different techniques for controlling these critical points. He then has to determine what his alternatives are for each of the control mechanisms, to structure these alternatives in some way and to structure the relationships between the control mechanisms. To help him in all this strenuous mental activity, Mr. Pretend Admin has hired an assistant, Ms. Rhea Alty. Her sole job function is to be a good sounding board for his ideas, and to offer sage advice whenever it is specifically requested. After a couple of quick calls to his friends in the state health and welfare departments, Mr. Pretend Admin begins what he hopes will be the speedy task of jotting down his ideas in an admirably organized manner.

B. Endogenous Variables

At least five control mechanisms influence the behavior of providers. These mechanisms are standard-setting, rate-setting, monitoring and the use of data generated by monitoring, contracting processes and client placement.

In state health and welfare departments, these mechanisms have usually been used only to inhibit certain provider behaviors, such as mismanagement of funds, excessive costs, and low quality services. However, these management control mechanisms can also serve constructive functions aimed at molding the vendor delivery system (which consists, often, of fiscally marginal vendors) toward the service goals which the departments are beginning to identify for their programs. Some of these

control goals would still be oriented to restrictive functions (such as cost containment); and these functions may be at odds with the constructive goals. Since the same control mechanisms are used for many different regulatory goals, the choice of particular variants of the control mechanisms takes on additional meaning. Rate-setting may not only establish a means of payment, it may also restrict payment. Standards are not only guide-lines for behavior, but also restrictions on them.

To use the control mechanisms effectively, at least three aspects of the two-way effects between the control mechanisms and the provider market must be understood.

1. The main effects of individual management control mechanisms on providers and on the shape of the provider market.
2. The relationships that different provider markets may have with control mechanisms.
3. The interrelationships among the different control mechanisms.

In addition to shaping the behavior of individual providers, the viability, size and characteristics of the entire provider market will be affected by the choice of control mechanisms. For example, setting rigorous input standards increases the cost of entering and staying in the market, which may drive many small vendors out of the industry, even when these small vendors could meet standards based on performance. As another example, setting unrealistically low rates drives vendors from the marketplace, or induces them to reduce services below acceptable levels in order to remain solvent. The impacts of the provider market on the effectiveness of the control mechanisms will be taken up under the heading "Exogenous Variables."

There are interrelationships among the mechanisms and among the effects of the mechanisms. For example, standards for services form the basis for monitoring; new input standards require certain items which have cost impacts, and the rate-setting and contracting mechanisms must be able to recognize these higher costs for providers.

With a knowledge of the effects and the cross-impacts of control mechanisms, it becomes possible to anticipate consequences and coordinate the control mechanisms.

The main complication is that some management control mechanisms perform more than one function by serving more than one master. For example, the rate-setting process may be used to cap costs by the Department of Administration, to audit fiscal aspects of programs by the fiscal staff in the line agencies, and to provide an incentive for better or more varied services by the program staff in the departments.

> "This may not be as easy as I thought", Mr. Pretend Admin told Rhea Alty. "You'd better tell the boys I can't make it for coffee this morning."

C. Exogenous Variables

The boundaries of the purchase-of-service contracting system are drawn so that characteristics of the provider market are considered exogenous variables. While the characteristics of the provider market influence and are influenced by the control mechanisms, there is little in the short run that can be done about those characteristics. Two major characteristics of the provider market need to be examined.

1. Level of Competition

> "Rhea Alty, would you not agree that the number of providers available to service a particular area determines the degree of managerial freedom that a state department has in controlling vendors?" asked Pretend.
> "Just what do you mean?" wondered Rhea Alty. But

before she could verbalize her thoughts Pretend continued.

"For example," said Mr. Admin, "if there are only a few providers, the state may use its management control mechanisms to preserve provider viability, while if there are many potential providers, the state may use its management control mechanisms to take advantage of provider competition."

"That sounds logical to me", Rhea agreed.

2. Regional Market Participation

"It seems to me, Rhea Alty, that if demand or supply is part of a multiple state, regional market, then one state may drive vendors away from doing business with it through the particular control mechanisms that are used," Mr. Pretend Admin stated.

"I think there may be some truth to that," Rhea responded.

D. Differences Between Health-Related and Social Service Residential Care Facilities

As Mr. Pretend Admin walked by with two armfuls of books, Rhea Alty couldn't help but notice that the majority of them appeared to be about hospitals and nursing homes.

"Mr. Admin," Rhea called out, "I see that you have some books on health care institutions. Aren't there any differences between health care institutions and other human services?"

"Oh my, yes," stated Mr. Pretend Admin, "I suppose I'd better write some of them down so that I won't forget about them. I do know that in 1977, Piasecki and Pittinger concluded that group homes and nursing homes shared cost determining variables, based on a study using three nationwide surveys, one of nursing homes and two of group homes and half-way houses."

Unlike hospital services and some nursing home services, residential social service programs require fewer technical supports and less technical training or workers; care is more likely to be long-term than acute; and protocols for care are less developed. Other differences include the mitigated role of the physician in client placement, and the absence of utilization review and certification of need. Much of the demand for hospital services is controlled by physicians who benefit financially from their decisions. This is much less true for nursing home services; and, for the most part, it is untrue of client placement in other residential human services. Utilization review, the review of

appropriateness of care, has a low priority in non-health care residential human services because the state is substantially involved in client placement, leaving less discretion to the providers and other care givers. Certificate-of-need legislation has not yet been applied to most types of residential human service care. As of yet there is no comparable mechanism for restricting expansion. Residential mental health and retardation facilities and some centers for alcohol abuse, however, have now been included in the certificate-of-need legislation making it important to review the effects of the certificate of need process.

> "Mr. Pretend Admin, I've read your passage on some of the differences between health care and other forms of residential care," informed Rhea.
>
> "And, what do you think?" asked Mr. Pretend Admin.
>
> "Well," suggested Rhea Alty, "I think that if certificates-of-need have been expanded into parts of residential care, then you ought to at least mention some of their effects."
>
> "I thought you might, Rhea Alty, so I've already written a piece," gloated Mr. Pretend Admin.

One study (Salkever and Bice, 1978) of certificate-of-need laws found that this mechanism did <u>not</u> reduce the <u>total</u> investment in a facility. The mechanism accomplished its aim of restricting investment in new beds, but investment increased in auxiliary services and non-bed facilities, such that the plant and assets per bed increased. Further, net revenue and changes in income had no appreciable effect on investment; while insurance coverage, residents and interns per bed had a more direct relationship to assets per bed than with the number of beds. Certificates of need have reduced the volume of inpatient services, but also slightly increased the cost of services. Further, the impact of certificate-of-need regulation is limited to facilities seeking changes. These are more likely to be innovative or modernizing

facilities. Certificate-of-need legislation protects existing hospitals from new competition (Rosenthal, 1978), and is welcomed if it limits competition among existing providers (Posner, 1978).

"Rather like nailing jello to a tree, this business of changing provider behavior, isn't it?" questioned Rhea Alty.

"I think you might have something, Rhea, after all, any group that can turn something negative into a tool that works for them must move pretty quickly," sighed Mr. Pretend Admin. "Rhea Alty, I think part of my problem is that you make things more difficult instead of more clear," said Pretend.

"Just doing my job, sir," said Rhea Alty with a small smirk.

"Well, in the future," offered Pretend, "why don't you wait until after I've written something down before you try to change things?"

E. RATE SETTING

The first type of control mechanism is rate setting which consists of four axes of variation: the method of rate negotiation, the method of pricing, the method of reimbursement, and the payment period.

Rate-setting is the set of activities by which a state agency establishes the basis and amount of money it will pay for the provision of services. Traditionally, the prices paid in social services contracts are inadequate to cover costs. Funds from endowment, United Way allocations and fund-raising activities are used to make up the difference. Contract agencies often operate on the financial margin. Generally, prices are negotiated, and there are too few suppliers to allow much competition (Fisk, Kiesling and Muller, 1978). The rate-setting act is the fulcrum on which the purchase of service contracting system balances (Massachusetts Task Force on Social Service Rate-Setting, 1978).

1. Method of Rate Negotiation

This axis reflects decreasing flexibility in negotiation as one moves from left to right (see Graph 3a). There are six types of rate negotiation: prior rate, bid and negotiation, informal principles of reimbursement, bid, unilateral determination, and formal principles of reimbursement. The first type of rate negotiation is based on a vendor's prior rate and the state's projected budget. In some cases a projected vendor budget is used as well. In this type of rate negotiation, there is a natural pull on vendors to keep their costs as high as possible in order to insure that the next year's rate is

sufficiently high to cover projected costs. The rate change guidelines might include changes in the level of services among the pool of vendors, as well as inflation and budget change guidelines.

The second method of rate negotiation is by bid and subsequent negotiation. Bidding may favor larger providers if economies of scale exist. This method offers the advantage of price and quality competition associated with bidding, but also allows some room for providers and the state to refine their expectations of the service to be provided. Changes usually concern the components of the service to be offered and the resulting cost changes.

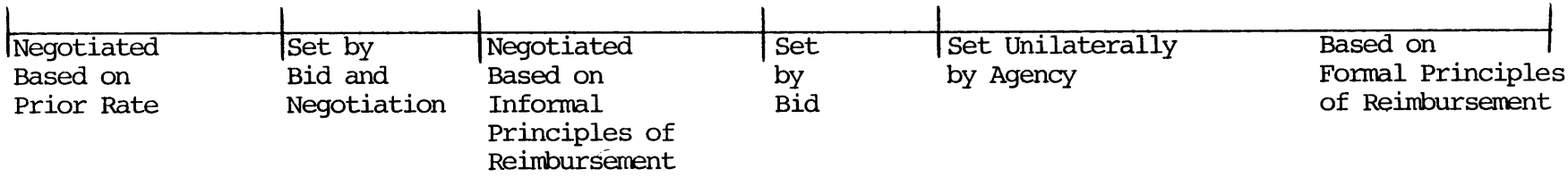
The third type of rate negotiation is based on informal principles of reimbursement whereby changes follow specified rate change guidelines for different cost centers: increases and decreases may still be negotiated with providers. Lacking formal rate change guidelines, this type of rate negotiation is still vulnerable to vendor manipulation through lobbying with the legislature.

The fourth method of rate negotiation is by bid. Bidding locks the provider and the state into a price and type of service that both agreed should be sufficient. Bidding may favor larger providers if economies of scale exist. Bidding requires standardized unit-of-service costs or standardized inputs to be specified by the state agency.

The fifth method of rate negotiation is where the rate is set unilaterally by the state. In this method, the state assigns a rate to a service. The state may also request proposals from vendors to deliver the service at the fixed price. If rates are set to reflect budget limitations, then rates and services will be set by fiat, on the basis of scarce resources. The burden of economizing is decentralized to

RATE SETTING: METHOD OF RATE NEGOTIATION

Graph 3a



providers in health care who must adjust their costs and quantity of services to that allowed by the prevailing rates (Mead, 1977).

In health care, restrictive fee schedules have limited the supply of physicians willing to participate in the Medicaid program and have contributed to a high volume, less personal practice style among participating physicians (Schweitzer, 1978).

The sixth type of rate negotiation is based on formal principles of reimbursement. While this method provides non-negotiable rate change guidelines, it is also renowned for causing delays in reimbursement. Such delays may result in a less innovative provider industry. Since programs which resemble those in a pre-existing category can be dealt with more quickly in the rate setting process, vendors learn that innovation does not pay - literally. Since these delays subject vendors to cash flow problems, larger vendors with their larger reserves are more likely to survive than small vendors (Buckle & Buckle, 1977). Further, though this system is formalized, there appears to be a tendency for it to be easier for vendors to get rates for new facilities established if they have a good rapport with the rate-setters (Buckle & Buckle, 1977). Since the rate increase mechanism is locked in by administrative law and is often tied to the Consumer Price Index, this type of rate negotiation increases costs very quickly (Barile, 1981). The major problem with tying rate increases to inflation is that the mechanism does nothing to improve hospital operating efficiency - rather it perpetuates existing inefficiencies (Bauer, 1978).

> "Do you think that the literature from health care is applicable to our department?" questioned Rhea Alty.
> "It's terribly basic stuff," commented Mr. Pretend Admin, "I can't think of anything that would make it any less applicable to any residential human services."

"Mr. Pretend Admin," suggested Rhea Alty, "I think you forgot to mention the two-way effects effects between rate negotiation and the provider market."

"You're right," admitted Mr. Pretend Admin, "I'll get right on it."

The less flexible the negotiation the more likely that the negotiation process will diminish competition by making it more difficult to enter and to stay in the provider market. As competition decreases it is necessary for the state to make negotiations more flexible so that state agencies can ensure that they are getting what they want at a reasonable price. However, having a large number of providers might make it difficult for a small state agency staff to adequately negotiate with any provider.

2. Method of Pricing

This axis of rate setting reflects an increasingly required efficiency of resource use as one moves from left to right (See Graph 3b). There are seven methods of pricing: delivering capability, delivering inputs, resources consumed, improvements to services, level of quality, and relative efficiency. The first method of pricing is based on the capability to do a service. This would include delivering a service capacity in facilities, i.e., a certain percentage of full occupancy. One major problem in delivering occupancy is that the larger the facility is, or the larger its potential occupancy, the higher the occupancy rate ought to be when it is compared to what would be considered full capacity, as a result of queueing and reasonable waiting lists (Maryland Purchase of Care Study, 1976). The use of block grants with utilization quotas, so that full payment is received only when the quota is filled, is particularly a problem when a private

agency determines client eligibility for its services. This method sets up an incentive for private agencies to insure that they can find enough occupants/clients to meet the quota (Childrens Services Task Force, 1977).

Occupancy minimums are usually not effective controls, because those facilities in which there is a volume shortfall eventually may obtain an upward adjustment (Bauer, 1978). Occupancy rate has a small negative effect on average costs in nursing homes (Bishop, 1980). Where penalties are imposed for under-utilization, the incentive is to keep beds filled. The penalty may work where demand can not be artificially inflated by providers (Bauer, 1978). As occupancy goes up in a for-profit nursing home, the price charged increases, with each successive bed being treated as a rarer commodity (Koetting, 1980).

The state agency uses a rate based on delivering capability when the state wants to be guaranteed that the capacity will be present when needed (Sellinger, 1979). To reduce costs when using the percentage capacity pricing method, removing a complete facility has more impact than simply removing parts of the facility due to the fixed costs associated with facilities. Consequently, reducing the variable costs (direct staff, for example) does not have a large cost impact (Denver Regional Council of Governments, 1978).

The second method of pricing is delivering inputs for a service. The state agency pays for the delivery of a certain set of inputs. This is particularly important where it would appear that differences in expenditures are related to, or can be accounted for, by differences in the type of care. In general it has been found that costs for residential services vary according to the intensity of care and

supervision required (Piasecki and Pittinger, 1977). Research on residential foster care in New York City indicated that differences in expenditures could not be accounted for by differences in the type of client, when type referred to the severity of client problems (Finch, 1979).

One study looked at "best practice" facilities and found that nearly half of the variation in client contact time could be explained by differences in patient characteristics. This was not true for facilities in general (McCaffree, Winn and Bennett, 1980). Butler (1980) found no relationship between expenditures and quality after the physical facility requirements and an initial basic service had been adequately reimbursed.

> "I'm all confused," Rhea Alty told Mr. Pretend Admin.
> "Me too," said Pretend. "I think it's time for another coffee."
> "Before you go," said Rhea, "you ought to write a bit more so that I can help you clean up your act."

No standards exist for inputs to services which compare facilities and/or service providers and comparable costs for group homes for the psycho-socially disabled (Piasecki and Pittinger, 1977). There is, however, a linear, positive relationship between facility size and per diem costs for each of these cost elements: non-nursing labor, nursing labor, and the group of operating, fixed and miscellaneous costs, singularly and in total in nursing homes (Piasecki and Pittinger, 1977). This suggests diseconomies of scale.

> "Don't I remember reading that there really weren't diseconomies of scale, Rhea? I think that larger homes had more staff and paid their staff more, if I recall correctly. Don't you think so?" Pretend Admin asked. "Rhea? where are you when I need you?"

Resources consumed reflect a third method of pricing. Payments based on resources consumed include: paying for the delivery of a certain number of hours worked. While this discourages efficiency by inducing providers to consume more resources, it provides considerable flexibility since the state agency pays only for those resources actually consumed (Fisk, Kiesling and Muller, 1978).

The fourth method is unit pricing in which a vendor is paid for each unit of service it delivers. The unintended inducement is to maximize the number of units of service delivered, without consideration of quality. If vendors are financially marginal, there is an incentive to reduce quality as a means of reducing cost.

The fifth type of pricing is based on changes in services. A vendor is paid a bonus, or given a penalty for non-compliance, for: 1) changing the service provided; 2) improving the service; 3) reducing services; or 4) changing the quality of service; or 5) changing the inputs used to deliver services. The relationship of costs to the care provided is ambiguous (Vladeck, 1980).

The sixth method of pricing is determined by the quality of services rendered. Vendor services are rated according to quality and investment in the improvement of quality. Higher quality is rewarded by higher payment. One deciding factor of quality, according to some studies of nursing homes and group homes for the psycho-socially disabled, is the auspices under which a provider operates, e.g., proprietary, non-profit, government or religious (Piasecki and Pittinger, 1977; Gottesman, 1974). In a nationwide study of mental health half-way houses operated by governmental units, non-profit organizations and proprietary organizations (Piasecki and Pittinger,

1977), auspices of those organizations were related closely to operating costs. Governmental units operated homes with the highest cost per client day, the smallest number of clients, and the lowest occupancy rate. Proprietary homes were at the other end of the coninuum on all three factors. Non-profit homes were at the median point on all three factors. However, this pattern was only significant for the number of residents because of the small number of homes operated by governmental units and proprietary organizations. Auspices is an environmental variable, which is not malleable in the short term by the control system (unless profit-making facilities are completely excluded as a vendor).

Non-profit and hospital-based nursing homes have higher costs than for-profit homes, even after controlling for patient mix and quality of care (Bishop, 1980). Another study of nursing homes found that non-profit nursing homes were more likely to be of high quality, but that all things being equal, including quality, non-profits are more expensive than for-profit nursing homes even after including a reasonable profit level for proprietary homes (Koetting, 1980).

A program adopted by the Massachusetts Rate-Setting Commision for nursing homes rewarded "quality" nursing homes with an incentive payment. Quality was defined as a high score on an accreditation survey, low to average costs, and a high percentage of Medicaid patients. The inclusion of a high proportion of Medicaid clients as a criterion was to reward nursing homes for accepting state patients and incurring the ensuing cash flow problems state patients generate due to slow payment by the state (Massachusetts Federation of Nursing Homes, 1979).

One state chose to adopt a rate setting mechanism which established

financial sanctions for not meeting minimum quality levels; providers then refused to admit clients with complicating conditions (Pollak, 1981).

Two further issues in tieing quality and rate-setting together were addressed by Vladeck (1980). First, because no one knows with certainty what "quality" is, no one knows what "high quality" services should cost. Second, suppliers of health or nursing homes services may not be able to improve services without additional expenditures. "But there is no guarantee that those additional expenditures will improve quality." Thus creating a chicken and egg (which came first?) problem.

The seventh method of pricing rates the relative efficiency of providers when compared to each other. The rate-setting agency might group providers into pairs or larger groups to determine which provider or set of providers is most cost effective (quality versus cost) resulting in a reward of additional financial resources (Willemain, 1979). Another version of this method of pricing is the "prudent buyer" approach suggested by Medicaid where reimbursement is limited to the prices charged by the most efficient providers in given types of care (Mead, 1977).

The method of pricing includes relationships with inputs, quality, outputs, or relative efficiency, so the monitoring system must capture this information. There is also a link to the method of negotiation, because the higher-level methods of pricing may require considerable negotiation.

> "Pretend Admin," Rhea Alty called, "you had better come see me. I think that the method of pricing has some relationship with standards."
>
> "How's that?" responded Pretend Admin.

RATE SETTING: METHOD OF PRICING

Graph 3b

Delivering Capability	Delivering Inputs	Resources Consumed	Unit Pricing	Improvements to Service	Level of Quality	Relative Efficiency, Compared to Other Providers

"You see," Rhea Alty continued, "it doesn't make sense to pay for something if it's not needed, and if its not needed it doesn't make sense to pay for it."

"Well, that makes sense to me!" asserted Pretend Admin. But then he thought a little more about it. "Rhea Alty," Pretend asked, "can you explain that again, but this time at sub-light speed?"

"Of course, boss," Rhea responded, "I'll even write it down for you."

If a state agency requires a set of inputs from the provider, then the state agency ought to pay for these inputs through the method of pricing. If the method of pricing singles out certain inputs to be reimbursed, then the standards ought to suggest that these specified inputs are necessary to the service delivery system.

The risk averseness that higher level (right side of the axis) pricing mechanisms may generate among providers will push providers to take a more active role in client placement decisions.

"Aha," said Pretend Admin, "I can tell this is going to take quite some time. I'd better go down with the boys for a coffee break."

"But we're done with the method of pricing for now," Rhea Alty called after him.

Pretend Admin heard but chose to ignore her comment, and continued walking toward the elevator.

3. Method of Reimbursement

The third axis of rate setting, the method of reimbursement, has six options which range from a basis on the facility's overall costs to that of the costs incurred for each specific client. It indicates an increasing recognition of the differences among clients (see Graph 3c).

The first method of reimbursement is one in which the facility is paid for the overall services that are provided. When the method of reimbursement is by facility or by level of care, then the method or pricing will most likely be determined by the provider's delivery of the capability to perform a service, delivery of a set of inputs, or by the

resources consumed in the facility. The method of reimbursement and the method of pricing are more closely related when reimbursement is linked to a facility rather than to a client. As the reimbursement method moves to the right it becomes less dependent on the provision of resources.

> "Ahem! Pretend Admin, I thought we agreed to put all this linkages and relationships business at the end of each section?" queried Rhea Alty.
>
> "You're right, as usual, Rhea Alty, but this set of relationships appears to exist only at one end of the axis, so I included it where it was appropriate," answered Pretend.
>
> "Well, of all people, you should know better than to try to confuse me by breaking a pattern!" Rhea Alty snapped.

The second method of reimbursement is by level of care where all clients are grouped into general classes with pre-established reimbursements. A general tedency of providers is to push clients into higher levels of care than their needs indicate. Consequently, providers garner more resources than necessary to keep a client healthy or stable.

Level of care does appear to have an effect on costs in nursing homes. Intensive care nursing facilities have slightly higher costs than intermediate care facilities (Bishop, 1980). However, the presumption is that level of care determines cost. Skilled nursing facilities have been paid at a higher rate which gives them more money to spend, which in turn increases costs (Bishop, 1980). It is open to question whether there are measurable differences in costs in skilled versus intermediate care nursing facilities, yet skilled care homes have been reimbursed at a higher rate.

One level of care reimbursement method is "class" rates for all vendors having similar programs. This has created a great deal of anxiety among providers who believe that it will be a homogenizing

process: 1) reducing more highly reimbursed, high quality programs into lower reimbursed, mediocre programs; and 2)upgrading the reimbursement of low quality programs (Massachusetts Taks Force on Social Service Rate-Setting, 1978).

The difficulty experienced by hospital staff in placing intensive need Medicare residents in nursing homes relates to the preception among vendors that reimbursement is linked too closely to average levels of need, and does not respond well to increases in need or to clients at the high demand end of the need scale (Willemain, 1979).

The third method of reimbursement is per case (capitation). Capitation removes financial incentives and disincentives to the use of particular services. However, it requires agreement on the components and modality of treatment. This may be complicated by the multiplicity of funding sources for different components of treatment (Richardson, 1981). For example, the development of ICF-MRs (i.e., the classification of community facilities for the mentally retarded as "Intermediate Care Facilities - for the Mentally Retarded") has resulted in funding for residential costs from medicaid, for rehabilitation costs from federal vocational rehabilitation funds, and for education costs from state sources and local school systems. Capitation payment in health maintenance organizations (H M O's) may not be the most important factor that produces major reductions in hospital utilization. The fact that an HMO is an organized, multi-specialty, group practice with salaried physicians may be of greater significance (Gaus, Cooper and Hirschman, 1978).

Capping the revenue per admission, a variant of capitation, creates an incentive to reduce the length of stay in hospitals, but would also

create an incentive to limit the admission of patients needing a long stay (Congressional Budget Office, 1978), or who need more intensive services (Vladeck, 1980). The incentive to limit acceptance of patients who are more needy would remain even if the revenue per admission were set by casemix, according to the Congressional Budget Office study.

This method cannot differentiate between legitimate savings, unwise or coincidental reductions in utilization, and the shifting of costs to other providers. It is entirely possible that a provider could increase total community expenditures while reducing its own total expenditures per client under this method of reimbursement since clients could remain needy (Hitt, 1977).

The fourth method of reimbursement is based on a per diem reimbursement where the provider is paid for each day of care, for example, per patient per day reimbursement. It has been suggested that such methods of reimbursement induce providers to reduce the volume of the services they use, in order to maximize the excess resources that could be garnered over the resources that have to be used. There is also an incentive to increase the length of stay.

With per diem rates, providers may take in more clients than the occupancy level for which a rate has been established. This may result in the accumulation of captial for improvements, economies of scale and, sometimes, profits. Sometimes this results in "hot beds," that is, a bed is never kept empty (Massachusetts Task Force on Social Service Rate-Setting, 1978). High turnover of clients is associated with higher per diem costs due to fixed administrative charges per admission and because the early days of care tend to be higher cost (Bishop, 1980).

Per diem reimbursement is insensitive to changes in the severity of

the casemix, and cost reductions which might be possible by decreasing the length of stay go unrecognized (Smejda, 1977). It creates an incentive to increase both the length of stay per client and the volume of clients (Bauer, 1978).

Per diem cost variation in group homes for the psycho-socially disabled was best explained by the occupancy rate, staff-to-client ratio and the type of staff (professional/para-professional) primarily used (Piasecki and Pittinger, 1977).

The fifth type of method of reimbursement is by type of case, which is sometimes referred to as "casemix" reimbursement. Providers are reimbursed based on the specific type of problem or the specific attributes of a problem which their mix of clients displays. This method of reimbursement may set up incentives for keeping residents "ill" on paper (Butler, 1980; Vladeck, 1980).

This counter-productive incentive is established because vendors thus have reason to make it appear that their casemix is a more severe than it actually is. Consequently, vendors can earn more resources than they have to use to maintain residents at their actual level of illness.

Casemix variables are strongly related to costs per day only when placement works well - so that clients are placed in facilities that provide the care they need (Bishop, 1980). For casemix reimbursement to escape this problem, an active quality assurance program must be in place, and a state agency must perform the patient assessments of need (Willemain, 1980).

A link to standards under casemix reimbursement would be to establish minimum standards for every facility based on its casemix (Willemain, 1980). Given the current lack of knowledge about

positive relationships between input use and quality of care, this type of standard-setting would be difficult to implement.

Non-profit nursing homes make fewer distinctions among patient condictions than for-profit nursing homes in the provision of services. This seems logical, given the evidence that there is greater slack in non-profits (Koetting, 1980). This trend toward a lack of discrimination may carry over to other types of facilities and may make casemix an ineffective reimbursement mechanism for non-profit facilities. Reimbursement based on casemix promises to pay for actual resources consumed, but requires extensive research to establish the base costs. This research is expensive and lengthy, and requires the full cooperation of physicians and care-givers (Smejda, 1977).

One alternative method of case mix reimbursement uses a sample of patients to establish the casemix within any facility. The sample could be stratified to include patients which providers identify as "heavy need." This would reduce some of the risk averseness of providers to sampling. This alternative would substantially reduce the cost of establishing an appropriate rate (Willemain, 1980).

The sixth type of reimbursement is tied to the specific client and the resources that client utilizes. Sometimes this method of reimbursement is referred to as a specific charge system. It is considered expensive to administer compared to other methods of reimbursement. However it is hard to criticize a method of reimbursement which pays for exactly what a person uses. When the uncertainty in patient assessment is low, individually computed rates are an attractive method for insuring a close match between cost of needed services and reimbursement rate. However, the current

RATE SETTING: METHOD OF REIMBURSEMENT

Graph 3c

state-of-the art in assessment does not allow a low uncertainity. When uncertainty of assessment is high, individual rates perform poorly in matching cost of needed services to the reimbursement rate (Willemain, 1980).

One variant of this method is to pay based on the initial condition of an individual rather than the specific resource use of individuals (Kane and Kane, 1978).

> Though she could see his bald head through the window in his door, Rhea decided she was not ready for another face-to-face tete-a-tete with Pretend. She decided to buzz him on the phone intercom. "Pretend Admin, this is Rhea Alty calling," Rhea could see that Pretend was not finding her humorous. She continued, "Pretend Admin, it seems to me that several of these methods of reimbursement could be found coexisting, such as a per diem by level of care in a specific facility."
>
> "You're right again, Rhea Alty, I hadn't thought about that. But the different methods may exist individually, for example, all facilities might get the same per diem. I guess my types of reimbursement are not mutually exclusive," Pretend Admin admitted.
>
> "What bias to your examples does that introduce?" Rhea Alty asked.
>
> "I'm not sure," said Pretend Admin, "I really don't believe it changes things very much, but I'm not sure."
>
> "By the way," Pretend Admin asked, "what relationships do you see between the method of reimbursement and the other control mechanisms?"
>
> "To tell you the truth, Pretend Admin, I think that the relationship between the method of pricing and the method of reimbursement that you have already mentioned is the only relationship I can think of," said Rhea Alty. "And more importantly, if we hurry on to the last rate-setting axis, payment perspective, you'll be able to make your coffee break on time."

4. Payment Perspective

The fourth axis of rate setting is the payment perspective (see Graph 3d). There are two types of payment perspective: retrospective and prospective. The first type is retrospective payment. This is payment in which an actual rate is set only after the costs have been incurred by a provider. One criticism of this system is that it is

attuned primarily to accrual accounting costs while ignoring economic costs. It disregards vital elements of financial requirements such as working captial and may provide too little funding for plant capital where mortgage payments exceed depreciation payments (Hitt, 1977).

As a consequence, a state agency may end up paying for interest payments which would appear to be excessive except that they are necessary for a vendor who is forced to borrow money to meet his working capital needs. Furthermore, this type of payment perspective is often associated with excessive costs since there is no incentive for cost containment. Retrospective payment may be inherently inflationary, because it rewards inefficiency (Vladeck, 1980).

Strangely, the only constraint found in retrospective payment is that of meeting working capital needs and since one can borrow to meet such needs, albeit at currently high interest rates, there is no incentive to constrain costs. Only when the amount borrowed for working capital reaches the limit that lenders are willing to lend against accounts receivable, does retrospective payment serve to constrain costs. Larger vendors have larger accounts receivable against which to borrow. It is hard to know whether the result is the constraint of unnecessary and excessive costs, or reduction in quantity or quality of essential services. Retrospective payment may, however, provide the fiscal motivation for increasing provider participation and service quantity by assuring that all reasonable costs will be reimbursed. Retrospective payment may also foster the financial conditions under which cost-increasing quality efforts can occur (Richardson, 1981).

The second payment perspective is prospective payment through which providers are informed of their future rate. It is often argued that

this method of payment allows providers to know what they can afford to spend before they spend it and helps secure credit. Sometimes a prospective payment is made that gives providers a flat fee in proportion to their obligations, but independent of particular resources used or their costs. Providers would be motivated to economize on costs and on the use of particular resources which have implications for quality of care (Mead, 1977; Vladeck, 1980).

Prospective payments oblige providers to live within the possible revenues generated. The provider must trim expenditures if payments are limited, possibly achieving this by reducing services. Any such trimming process is difficult and complicated, but is preferable to coping with cuts after dollars are spent. A prospective payment period would, it is alleged, permit better management of necessary inadequacies. With rate decisions being made beforehand, providers would be in a better position to challenge denial decisions on specific cost items by publicizing how services would be affected (Hitt, 1977).

Prospective payment can accomplish its cost control ends simply by excluding high cost providers regardless of quality. While the method offers substantial potential for economizing, this potential may remain unrealized. Providers may not allow a surplus to exist, because this would reduce the cost base for future years. Prospective payment may have a negative impact on quality, because it focuses pressure on cost control (Richardson, 1981).

Prospective reimbursement has had mixed success. In New Jersey and Rhode Island, where the analysis used a hospital-by-hospital budget review, prospective reimbursement had an insignificant effect on costs and quality of care. In Western Pennsylvania, where the analysis

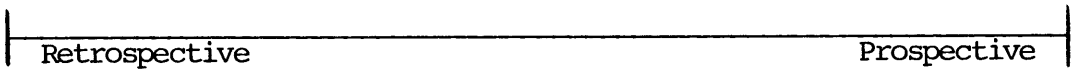
used a combination of budget reviews and a formula, there was a cost impact on services under the influence of administrators, but not on those services under the influence of physicians (pathology, radiology, surgery). There was no deterioration in care. It is possible, however, that there was a self-selection bias with participation by those hospitals who were most able to decrease costs. In New York, the analysis used only a formula without analysis of budgets or comparisons across programs. In New York costs were decreased, but possibly at the expense of hospital solvency (Hellinger, 1980). The New York hospitals were as likely to reduce costs by reducing services to patients as to cut waste or eliminate unnecessary expenditures (Vladeck, 1980).

> "Pretend Admin," Rhea Alty called out, "you forgot about the relationships that the payment perspective has with other mechanisms."
>
> "I was hoping you wouldn't notice, Rhea Alty; you see, I think I'm having symptoms of caffeine withdrawal," said Pretend Admin, knowing his protestations were falling on deaf ears.

The relationship between the method of payment and quality of service does not appear to have been supported. Retrospective payment may reduce competition by driving out small vendors. Payment perspective is also linked to contracting because of their joint effects. It is argued that reimbursement mechanisms which pay hospitals prospectively in lump sums, rather than retrospectively for expenditures, would have the effect of setting prices exogenously thereby simulating a market and giving providers a strong incentive to economize (Mead, 1977). Further, contracting mechanisms which are based on previous expenditures or are performance related are more likely to require a retrospective determination of costs.

RATE SETTING: METHOD OF PAYMENT PERSPECTIVE

Graph 3d



"Pretend Admin, can you suggest any summary of all these axes of rate-setting?" Rhea Alty asked.

"Augh!!" screamed Mr. Pretend Admin, not realizing that his office door was open. When Rhea Alty poked her head in to make sure her boss wasn't having a stroke she heard him mumbling.

"Sometimes I wish I was a bear of very little brain, then I'd know the only correct choice was honey."

"Sounds like its time for another coffee break, boss," Rhea Alty called in, "what were you mumbling about bears and honey?"

"Eeyores can't understand," Mr. Pretend Admin stated as he walked past and headed downstairs for his half-hour interlude with the boys for coffee. So it was left to Rhea Alty to attempt the summary.

Rates and standards are intertwined. One model of rate-setting is to let providers determine their cost to deliver a unit-of-service. This method assumes that the components (inputs) of a unit of service have been long established and accepted. It also assumes competition among providers. A second model is to use a system of "class rates" where the state agency defines the components (inputs) and costs of a particular delivery modality. To do this, the input standards would have to be sufficiently specific so that the fiscal impacts would be clear (Massachusetts Task Force on Social Services Rate-Setting, 1978).

F. CONTRACTING PROCESS

The second type of control mechanism is the contracting process where the axis reflects an increasing variability in the contract price (see Graph 3e). There are two types of contracts: cost-oriented and performance- oriented.

1. Cost-Oriented Contracting Processes

There are six types of cost-oriented contracting processes: fixed price, unit price, fixed price redeterminable, cost plus fixed percentage of cost, cost sharing, and cost reimbursement. The first type of cost-oriented contracting process is the fixed price contract.

It involves a fixed price, lump sum payment with the prices set beforehand by the State. It is the easiest contract to administer and is appropriate when costs can be estimated with reasonable accurancy. It places most of the risks on the provider (Wedel, 1978) and is potentially the least expensive to a state agency. Since the payment remains the same, regardless of the conditions the provider encounters, the risks for the provider can be considerable (Fisk, Kiesling and Muller, 1978).

In the version of this contracting process adopted by the Massachusetts Rate Setting Commission, a flat rate was established for each kind of service. Providers that can perform the service for less than the flat rate will keep the difference, while those that spend more will have to absorb the loss (Providence Sunday Journal, 1981). However, this plan may favor larger providers if there are economies of scale. Given economies of scale, larger providers, who can spread administrative and indirect costs over a larger direct service base, would be more likely to retain funds from this plan. Samller providers would be more likely to operate in the red. A flat rate offers no incentives to provide the effort necessary to achieve high quality, to the extent that high quality requires extra expenditures; as in nursing homes in Illinois. (Koetting, 1980).

This contracting process requires that the state agency have a very clear idea of what it needs. It is an attempt to bring market forces into the contracting process. The needed items must be sufficiently standardized to permit many firms to compete. Profit comes from holding costs as far below the estimate as possible (Dupre and Gustafson, 1974).

The second type of cost-oriented contracting process is a unit

price contract. This contract is based on a fixed price for each unit of service. A contract that is based on the units performed, carries with it the drawback that quality may be lower because it is profitable to perform each unit of service quickly, or, alternatively, to maximize the number of service units performed (Fisk, Kiesling and Muller, 1978).

The third type of cost-oriented contracting process is the fixed price redeterminable contract. This type of contract has clauses for moving prices up or down. It is appropriate when cost factors are likely to vary during the contract period and the state agencies have some flexibility in their funding arrangements (Wedel, 1978).

The fourth type of cost-oriented contracting process is based on fixed cost, plus a fixed percentage. In this type of contract the importance of establishing a target cost for the contract is vital. The target cost is the expected cost of performing the contract as negotiated between the provider and the state agency.

These negotiated contracts are appropriate where the additional resources from the percentage over target costs can be justified as profit or for program expansion (Wedel, 1978). It gives the provider significant flexibility where the service that is needed is uncertain or complex. These contracts are the result of a bargaining process in which the providers have an advantage. The providers attempt to negotiate high target costs and have an advantage over the state agency because provider personnel are likely to be more knowledgeable about cost determinants. The contractor has little risk and costs are likely to be high. Competition concentrates on aspects other than costs such as quality, timeliness, etc. (Dupre and Gustafson, 1974).

The fifth type of cost-oriented contracting process is cost

sharing. In cost sharing the provider receives a predetermined portion of costs for service delivery. Cost sharing is a time-tested way of registering individual preferences (Seidman, 1980), because it seeks to ration services through a traditional demand side variable-net price. But it is unclear whether the demand that is deflected is essential or superfluous (Schweitzer, 1978).

Cost sharing is most applicable when resources are scarce (Wedel, 1978). It can take the form of a flat fee to be paid for each service by a purchaser or of a fixed percentage to be paid for each service. Evidence suggests that cost sharing does depress the costs and the demand for services (Mead, 1977). Cost sharing in insurance plans appears to reduce new demands (resulting from the insurance) for ambulatory services if the deductible is greater than the average amount spent for care (Newhouse and Phelps, 1974). Much of the difference in utilization which occurs with cost sharing in insurance plans may be due to self-selection, with healthier people choosing plans with higher deductibles (Kaplan and Lave, 1971). However, cost sharing at least makes physicians and care-givers aware of the impacts of their decisions (Seidman, 1980).

The sixth type of cost-oriented contracting process is cost reimbursement. In cost reimbursement allowable costs are reimbursed to the extent described in the contract (Wedel, 1978). Payments may increase if care of the sicker or needier client necessitates higher costs. We rely on the high standards of the provider to prevent exploitation, but this approach has accelerated the cost increases for care (Kane and Kane, 1979). A straight cost-related system removes all disincentives to providing high quality care insofar as high quality

care is a function of expenditures, as in nursing homes in Illinois (Koetting, 1980).

A reimbursement system which pays actual costs up to a cap is indifferent below the cap to whether costs are increasing because of slack, additional quality, or special aspects of the program (Koetting, 1980; Vladeck, 1980), and above the cap penalizes a facility with high quality or special program aspects, as in nursing homes in Illinois (Koetting, 1980).

Cost reimbursement may produce perverse attitudes between payers and payees. Payers may regard providers as beneficiaries of a subsidy rather than as independent sellers entitled to full payment. Providers react to this dependency status by alternately showing subservient and demanding attitudes. Indulgence by payers is assumed by providers, so that when payers act restrictively, severe problems surface. It is unlikely that simply increasing payments would resolve those problems in health care (Hitt, 1977). Cost reimbursement was gladly accepted when hospitals were running deficits and could not collect even their costs from many patients. Cost reimbursement is unattractive now as hospitals realize they can generate surpluses and resent being told that they cannot keep surpluses (Somers, 1969; Vladeck, 1980).

In cost reimbursement contracts, when a state agency buys a whole program the answer to inadequate staffing or underfunding is solved by a provider usually by taking take in fewer clients (Massachusetts Task Force on Social Service Rate-Setting, 1978). This has led to high vancancy rates. Vendors sometimes prefer cost reimbursement contracts because it frees them from dependency on referral sources.

As one moves from a fixed cost to an entirely reimbursed cost

contract, the importance of the fiscal monitoring, i.e., auditing, linkage becomes critical. It is important to insure that the state is paying for costs that are associated with its contract and only with its particular contract, and not with all contracts in general that a provider may have.

2. Performance-Oriented Contracting Processes

There are two types of performance-oriented contracting processes: cost plus incentive and negotiated performance. Performance oriented contracts place a premium on outcomes, outputs, or processes such as quality. These contracts are appropriate where objectives are agreed upon and the criteria to measure performance can be clearly specified. The rate of actual funding is dependent on the level of provider output (Wedel, 1978). Hospitals do not attempt to realize large profits (surpluses) when there is an incentive to realize such profits. Rather, they spend up to the limit of each year's rates, because they know that their future rates will be based on current costs (Messier, 1978).

The first type of performance contract is the cost-plus incentive. In this type of contract, target costs and performance objectives are established. The provider receives funds for the costs of services at a predetermined minimum level of output. If higher output or outcome is delivered, additional funds are received by the provider up to a maximum (Wedel, 1978). The provider has three incentives: to hold actual costs below target costs, to keep target costs as high as possible (Dupre and Gustafson, 1974), and to score bonuses for valued outputs.

Incentive systems which return to providers part of the savings due to holding costs down should restrain cost increases, as demonstrated by the 1970 Medicaid experiments (Mead, 1977). However, monetary rewards

will probably find their way into additional investments and higher salaries, thus raising costs for the next rate cycle in hospitals (Somers, 1969).

The second type of performance contract is based on negotiated performance. Payment is based on an expected level of performance which is negotiated with providers. As the expected performance is achieved, an incentive payment is received by the provider. If the expected level of performance is not achieved, a significant penalty may be charged (Wedel, 1978) Hospitals have many ways to reduce costs without improving efficiency by relatively invisible reductions in quality in order to avoid a penalty (Somers, 1969). The use of incentives as motivators runs into problems when workers are unable to control all of the factors which affect the level of performance (Yorks, 1976). Under incentive payment systems, workers may view the incentive system as a control system through which management makes sure it only pays for what it gets, rather than an effort to allow workers to maximize their earnings (Yorks, 1976).

> "Now wait, Pretend Admin, I was willing to accept evidence about hospitals and nursing homes, but now you're using evidence about motivating individuals," Rhea Alty declared.
>
> "Rhea Alty, you may have something. I've been collecting evidence wherever I could find it. I think if an individual's performance is being evaluated, then specific behaviors have probably been specified. The private sector does nave the advantage that behavior can be clearly specified. Consequently, I would expect that the effects of performance contracting are more pronounced in the private sector," Pretend Admin stated.
>
> "While we're on the topic, what differences exist between health care institutions and other human service residential care programs that might be important?" Rhea asked.
>
> "I think that performance is clearer in health care, Rhea Alty, so it may be easier for other types of human service residences to cut costs and/or quality without the effects being evident," Pretend Admin suggested.

In nineteenth century England, contracts with schools were based on student attainment and attendance, which resulted in low pay for teachers and teaching which was effectively limited to the subject areas tested (Gramlich and Koshel, 1975).

In the performance contracting experiments carried out in the early 1970s in the United States, the contracts created an unintended incentive to concentrate on those children most likely to meet the average gains necessary for payment. In the three-year program in Gary, Indiana, it appears that improvement was greater among those students in the middle range where the improvement was expected based on this unintended incentive. In the one-year Office of Equal Opportunity (OEO) programs, however, this unintended incentive appeared to have little effect on the pattern of gains. Possibly, the OEO contractors might have taken greater advantage of this incentive if they had had more power to group students by potential for gain and profitability, and more time to operate. In both the OEO and the Gary, Indiana programs, those academic subjects which were not being tested suffered as part of the incentive contract. In the OEO experiment, students in the program did test slightly higher in the subjects stressed than they would have been expected to otherwise, but pupil attendance was lower than normal (Gramlich and Koshel, 1975).

One version of negotiated performance contracting is outcome reimbursement. In this type of contracting process, reimbursement is based on the initial condition of an individual. Knowing the expected course of the client's condition over time, improvements would be rewarded and deterioration punished by retrospective adjustments. Outcomes of concern would include overall physical and functional status,

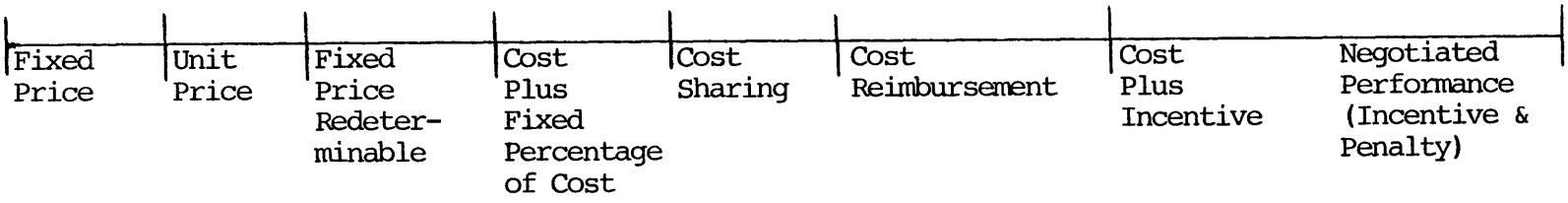
and psychological and social well-being in nursing homes (Kane and Kane, 1978). This type of reimbursement might tend to decrease innovation, as nursing home providers might feel more confident of escaping punishment for deterioration if they have followed standard patterns of care (Willemain, 1979). Possible modifications of this type of performance contracting would include ignoring minor changes in status, and limiting the liability for deterioration and the reward for improvement. Physical and functional status might be weighted heavier than other dimensions. These modifications should help insure that clients whose prognoses are poorest will still received needed services. However, the increased risks in outcome reimbursement would probably require that expenditures be increased as a compensating factor (Willemain, 1979).

As contracting processes increase the risk for all participants (rightward movement on Graph 3e), monitoring becomes a more important part of the reimbursement process. This would cause a rightward movement in the what and how of monitoring. As standards become more closely related to performance, then it is also possible for the state agency to increase the risks for vendors by moving to performance contracting or to more fixed price contracting. It is also more likely that as contracting processes increase the risks for both vendors and the state agency, standards which emphasize performance will be called for by vendors and the state, at least partly to reduce the opportunities for corruption.

As the risks within cost-oriented contracting are shifted from providers to the state (i.e., as one moves from left to right on the axis), providers would be less concerned about the clients they accept.

Graph 3e

CONTRACTING PROCESS



As the risks for providers increase (movement to the right in performance contracting), providers would want more control over the clients they accept.

> "I'll see you in a half hour," said Pretend Admin as he breezed past Rhea Alty.
> "But standards won't take long!" Rhea called after him.

G. STANDARD SETTING

The third control mechanism for influencing provider behavior is setting standards for the service to be delivered. The range of variation in standard setting runs from getting vendors to agree to a nominal set of contract terms to the specification of the desired outcome (see Graph 3f). Clear standards illuminate what is expected of providers. This is as important a concern of providers as it is of state contract managers (Rhode Island Task Force on Contracting Out, 1976). The choice of instrument must match the problem to be regulated. What works for reducing fire hazards won't work for improving the quality of nursing services (Vladeck, 1980).

The first type of standard setting mechanism is "terms of the contract." This includes such items as agreement to let state and federal agencies perform audits, non-discrimination in the hiring of staff and in the provision of client services, and bonding, as required. The agreement of a provider to these terms sometimes allows the provider to join a list of "certified" providers.

The second type of standard setting is input standards for fire and safety, as well as other facility standards such as the physical layout of a residence. Standards of this type, which constrain providers and have an arguable relationship to quality, generate ill-will with providers who may not be willing to go through the maze of details

regarding such things as the layout of rooms (Buckle and Buckle, 1977). This reduces the potential size of the provider market, increases the cost of the service, and has the effect of limiting entry to the provider market. This type of standard setting sometimes leads to "licensure" of a provider. The life safety code (licensing) requires facilities to make some unnecessary and costly changes that could be better spent on patient care (Long Term Care Task Force, DHEW, 1978).

The third type of standard setting is input standards related to institutional quality, such as the number and types of personnel, staffing ratios, record-keeping, etc. This type of standard setting is sometimes referred to as "accreditation". Despite widespread adoption as a screening mechanism, one summary of the literature in health care found that this type of input-oriented regulation appeared to make little difference in performance as evidenced by the performance of approved and non-approved providers (O'Donoghue, 1974). However, it is unclear what effect the presence of accredited providers had in possibly improving the performance of non-accredited providers.

It is very difficult, if not impossible, to relate input units and input costs to output units, and to performance. Larger expenditures do not always lead to proportionately higher quality. While overall resource expenditure may be a bigger factor, the number of employees and the organizational setting in which they work results in a variety of quality of care which can be purchased at the same price in nursing homes (Koetting, 1980). The input standards do not appear to be related to other measures of care in nursing homes unless they represent glaring inadequacies (Linn, 1974). Input standards, such as those found in accreditation requirements, are necessary but not sufficient conditions

for satisfactory care. The chief use of these standards may be to determine the boundaries and components of a service. While input standards may give indications of potential for performance, they reveal nothing of actual performance (Wiillemain, 1974).

The accreditation process assesses a facility's capacity to rendor good care, not the facility's performance. It examines structural and administrative aspects of a facility, because these aspects are highly visible. The additional inputs which accreditation requires fit well with the service orientation of providers.

Input standards are not mutually exclusive, but rather tend to cumulative. If a program has accreditation standards, then it is also likely to have licensure and certification standards.

The fourth type of standard setting is process standards and measures of the "quality" of the service being delivered. Process measures would include such items as the number and type of verbal interactions between staff and clients. Problems with this type of standard setting include the weak link between the elements of process quality, outputs and outcomes, and the general difficulty of establishing a definition of the critical elements of processes that are important components of quality. A study of the use of input and process measures in nursing homes indicated that a process measure using a peer review of quality was most closely related to assessments of the physical plant, staffing ratios and quality of meals (input variables) (Linn, 1974). Process standards relate to the dynamics of a service and are more meaningful than input standards, but are also more expensive to measure (Willemain, 1974). Process standards can degenerate into cookbooks for best care practices (Jacobs, Christoffel and Dixon, 1976).

The fifth type of standard setting is the specification of the performance of the provider. The major drawback to this type of standard-setting is the determination of what constitutes the output. The use of output performance standards may create incentives for short-term gains without proper consideration of long-term consequences, as private industry knows only too well (O'Hara and Leschem, 1977). For example, short-term profit maximization may blind an organization to long-term problems, such as client disatisfaction, facility deterioration, etc.

The sixth type of standard setting is the specification of the desired outcome, that is, the change in client condition, resulting from outputs. There is some question about the validity of this type of standard from the provider's viewpoint, because a provider may follow the best prescribed protocols for service delivery and not be effective. The ineffectiveness could result from environmental conditions beyond the control of the provider, or because the logic of the protocols is flawed, or the protocols are incomplete, as well as from an ineffective provider's program. This type of standard-setting may induce conservative strategies for service delivery, thereby reducing innovation in services (Willemain, 1979).

> "Now these last two sound like they will answer all of my questions, in fact, they sound too good to be true," stated Mr. Pretend Admin, deciding he'd bounce it off Rhea Alty.
>
> "Well," Rhea Alty said, while still formulating her answer in her head, "I like them but the vendors would kick up a fuss."
>
> "But why?" wondered Mr. Pretend Admin out loud.
>
> "You see," Rhea Alty explained, "with input standards, and maybe even process standards, you know what you have to do to pass if you're a vendor. Everything is prescribed for you and as long as you play by those rules nobody can call you a bad vendor."
>
> "Hmm," thought Admin, "are providers that risk-averse? Can Rhea Alty be right about that?"

As a state agency moves from input standards to output and outcome standards, the standards become more difficult for a state agency to specify. Hence, the absence of accepted measures. The current status of such standards is not such as to allow their use for regulatory purposes. The combination of adequately defined measures and the pressure of the legal system for standards which describe activities that are measurable and capable of being uniformly interpreted has lead to the emphasis on input and process standards (Vladeck, 1980). As a consequence, the use of monitoring information for provider compliance and change would decrease the use of standards other than input standards. Further, it would increase the detail of input standards.

The first three types of standard setting really are variations of the establishment of input standards for a service. They relate, first of all, to the method of pricing when input standards are required so that the method of pricing must have a corresponding means of including these costs as part of the established rate. They also relate to the exogenous variable, the level of competition. Input standards have costs, because as one increases the set of inputs required by a vendor, one also raises costs and reduces the potential and actual pool of providers. Providers are faced with higher costs and they must have sufficient working capital and/or start-up captial to meet the costs of input standards that are required before they can start a service. Input standards may serve to separate out a class of providers, whether it is through licensing, accreditation or certification; once a class of providers has been separated out, they are given additional power by virtue of being part of a smaller market. Their position vis-a-vis the state is one of greater power as well. Often providers

will attempt to have this determination of input standards made in such a fashion as to limit entry. This is true, for instance, in the trucking industry and many other industries, because this allows the provider market to have the government do the work for the providers of limiting entry to the market (Wilson, 1974). Similarly, as inputs become more detailed, the regionalization potential of providers may be reduced because the inputs are specific to one state purchasing agency. The relationship is not a straightline one. At either end of the standard-setting process there is sufficient latitude in the specification of the service so that competition and regionalization potential are not affected. However, as accreditation standards become more detailed, competition and regionalization potential are decreased.

Standard setting for processes, outputs, or outcome must have a similar method of pricing. If the method of pricing is based on changes or absolute levels of quality or outcome, then the criteria for quality or outcomes have to be set by standards. There is also a close relationship between standards and the contracting process, if that process includes some measure of performance. It is also important to remember that, overall, standards ought to set the stage for monitoring, i.e. monitoring should be a natural follow-through based on the standards for performance that have been established. Monitoring should simply be a verification of the extent to which the standards have been successfully implemented.

> "Rhea," said Pretend Admin, "I am thankful for your help, but many of these relationships seem obvious."
>
> "That's why you hired me," crowed Rhea Alty, "If you checked around you would find the relationships more honored in the literature and in common-sense discussions than in practice." But Pretend Admin had left long ago to join his old cronies for a cup of coffee. "No one listens to me around here, especially when I

STANDARD SETTING

Graph 3f

Standards on "Terms" of the Contract: Certification	Input Standards- Fire/Safety and Physical: Licensure	Input Standards for Institutional Quantity- Including Personnel Types & Levels: Accreditation	Process Standards- Quality of Service	Output Performance	Outcome

make my best comments," Rhea Alty said to the empty chair of Pretend Admin.

H. MONITORING

The fourth control mechanism for controlling vendor behavior is monitoring, which is the activity of determining and describing what is or is not occuring in a provider agency. Monitoring data should reflect its intended use. Critical elements in the decision of how and what to monitor are the time available for completing the monitoring, the cost of monitoring, and the number and types of staff resources available. Monitoring is difficult because of the large number of small agencies, each of which has a different approach to record-keeping. This creates a strain on the resources, costs and quality of monitoring (Buckle and Buckle, 1977). The axes of monitoring are particularly closely related: what is monitored, how it is monitored, who monitors, and the uses of the monitoring information (see Graphs 3g - 3k). Following traditional research steps, the what, how, and who of monitoring should be established after the determination of how the information is going to be used. The options on each of these axes may be cumulative. For example, if the quantity of expected services is monitored, then it is likely that fiscal procedures are monitored as well.

1. What to Monitor

The first axis of monitoring is the delineation of what is to be monitored. There are seven items that could be the object of monitoring: terms of the contract, fiscal procedures, services are delivered, quantity of expected services is delivered, all inputs expected are delivered, quality expected is delivered, and cost efficiency or cost effectiveness. The first item of monitoring is terms of the contract, including such items as personnel policy and

procedures, affirmative action policies.

The second item that could be monitored is the fiscal integrity of the provider, such as its procedures for billing, budgeting, allocation of expenses, preparation of financial reports and internal auditing.

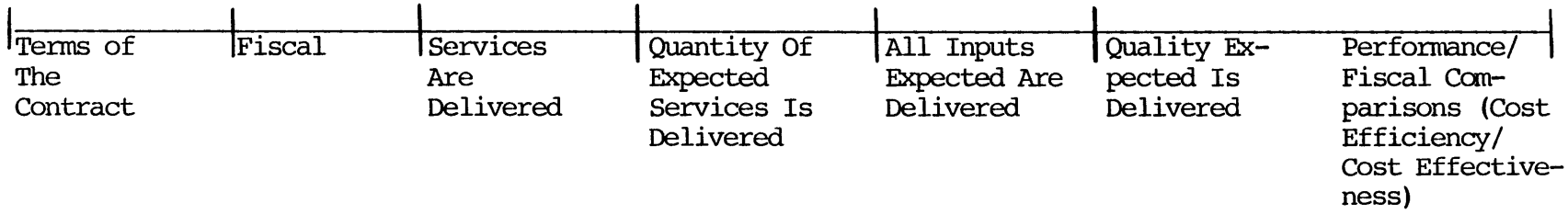
The third item that could be monitored is that services of some sort are delivered. This is simply a "yes" or "no" determination. The fourth item that could be monitored is the quantity of services that are delivered (e.g., 3,000 client bed-days). Again, this is a simple determination from the records of the agency that the provision for the expected number of units of services has been met.

The fifth item that could be monitored is that all of the expected inputs (e.g., one physical therapist three times a week for three hours each visit) are delivered. The sixth item that could be monitored is that the expected quality of the service is delivered. The seventh item that could be monitored is that the expected performance is delivered. This determination might include links with fiscal aspects of the service delivery in the determination of such things as cost efficiency and cost effectiveness.

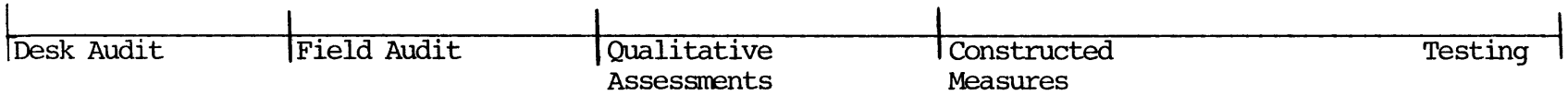
> "Do you see how quickly the monitoring mechanism is progressing, Pretend Admin?" Rhea Alty asked.
> "So far, so far," Pretend Admin responded, "but there are still four more monitoring axes and we haven't discussed the relationships that this monitoring axis has with other axes."

When contracts establish performance or the set or resources to be delivered, then obviously those factors ought to become part of the monitoring process. The same is true for the method of pricing. For example, the method of pricing may be delivering a set of inputs and that would have to be verified through monitoring. Clearly, as standards move from left to right on the standard setting axis,

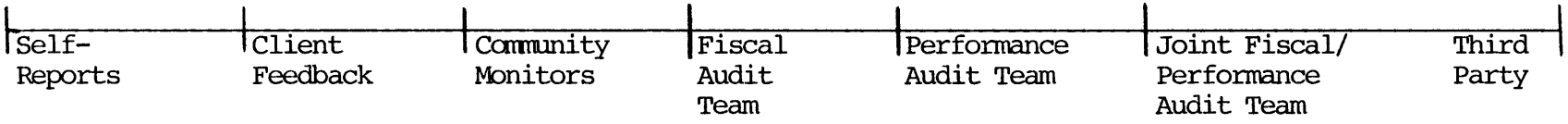
MONITORING: WHAT IS MONITORED? Graph 3g



MONITORING: HOW MONITORED? Graph 3h



MONITORING: WHO MONITORS? Graph 3i



monitoring-what would adjust accordingly.

2. How to Monitor

The second axis is how the monitoring is done. Monitoring can be done through five means: desk audit, field audit, qualitative assessments, constructed measures, and testing. As we move along this axis, the state agency resources utilized for monitoring must increase. The first method of monitoring is by desk audit, in which the state agency reviews any materials sent to it in its own offices. The second method of monitoring is by field audit, where the state agency reviews materials on file in the vendor's offices. The third method of monitoring is by qualitative assessment. This might include client feedback, client satisfaction surveys, peer reviews, etc. Client dissatisfaction may indicate the need for corrective action, but the contary may not be true (Willemain, 1979). The instructions for completion of the monitoring instrument are minimal and serve primarily as guidelines. Responses may be restricted to a choice of "yes" or "no" (present or not present). A study of implicit and explicit judgements of process and quality found that implicit judgements of process were related to care in terms of the conventional wisdoms, and not in terms of the processes likely to improve a patient's status (Brook and Appel, 1973). This suggests that since qualitative assessments are based on implicit judgments, the usefulness of the findings that these assessments generate is limited.

The fourth method of monitoring is by constructed measures. This would include reports from vendors, semi-structured interviews or

structured interviews, etc. Constructed measures use predetermined indicators of each gradation in the measure, with explicit criteria for differentiating between the gradations.

The fifth method of monitoring is by testing. This requires a determination of expected outcomes and the construction of an instrument to test for the presence of these outcomes. Specific events and changes are addressed (Wedel, 1978; Waller, et al., 1976).

The determination of how monitoring will occur is closely related to what is monitored and who monitors. For example, to verify that services are delivered there is no need for an elaborate testing mechanism; rather, a field audit would be sufficient. Consequently, as monitoring-what increases, monitoring-how would increase, thereby increasing monitoring-who.

3. Who Monitors

The third axis of monitoring is the determination of what actor will do the monitoring. The first actor would be the provider performing self-reports. The second actor would be the client, through client feedback or client satisfaction surveys. The third actor would be community monitors, either case managers or visitors, whose potential reporting of problems is apparently sufficient to improve quality. This position has been empirically supported by Barney (1974) and Gottesman and Bourestrom (1974). Barney's review of other studies found that licensing and regulation of nursing homes did not appear to be an effective tool for ensuring the quality of institutional life. However, greater community presence in a nursing home broke the traditional isolation of nursing homes and fostered greater accountability.

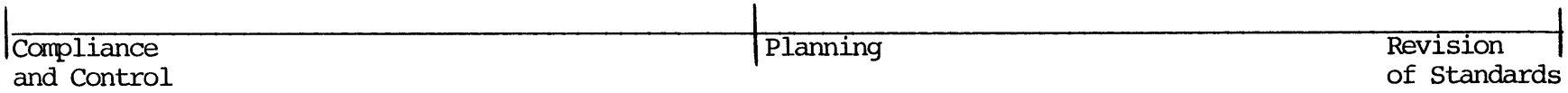
Gottesman's and Bourtestrom's review of other studies, as well as their own research, indicated that patients who have more visitors get better care.

The fourth actor would be a fiscal audit team. The fifth actor would be a performance audit team. The sixth actor would be a joint fiscal/performance audit team. The seventh actor would be a third party. As the state agency moves from self reports by vendors to third party reports, the potential objectivity and expense of monitoring increases.

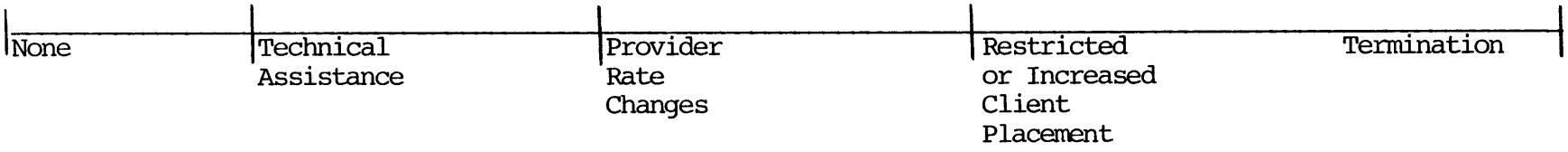
The relationship between who monitors and what is to be monitored, and how that monitoring is to be done is an obvious but critical link, both in the establishment of objectivity and in the establishment of cost. There is also a relationship to the use of the information. As the use of the information becomes more severe, that is, it is used to terminate providers, then the data must be more objective and in many cases this means more expensive, and the determination of who monitors moves towards a third party monitor. Monitoring-who also limits how monitoring can be done. Where persuasion gives way to quasi-judicial regulation and legal redress is a viable next step, then activities must be more formalized and information must be more specific and consistent, so as to survive legal evidentiary requirements (Crane, 1976).

> "At last, the what, how and who are done, that should be it for a while," decided Pretent Admin.
>
> "Not quite, Pretend Admin!" Rhea Alty called out. "You're forgetting the most important part of monitoring - the use of monitoring information."
>
> "But I just finished talking about that," said Pretend Admin resignedly.
>
> "You've only just begun," declared Rhea Alty.

USE OF MONITORING INFORMATION: LINKING PARTS OF THE CONTROL SYSTEM Graph 3j



USE OF MONITORING INFORMATION: TO CHANGE VENDOR BEHAVIOR Graph 3k



4. The Uses of Monitoring Information for Linkage

The fourth axis of monitoring is the use of monitoring information to link parts of the vendor control system. The axis reflects an increasing internalization of the focus of the change.

First, monitoring information may be used for compliance and control purposes when providers are cited for major problem areas.

Second, monitoring information may also have a significant impact on planning where it could be used to guide the choice of vendors and budget projections. The information may also be used to help managers measure their own program. This use of information appears more likely to occur when projects have been well accepted or have failed to function (Waller, et al., 1976).

Lastly, since monitoring is based on a set of standards, monitoring information may be used to revise these standards. The information would be used to evaluate the adequacy and effectiveness of existing standards and criteria that apply to processes, programs or facilities. The need for additional or more comprehensive standards could be determined.

As the characteristics of monitoring information are changed to become more appropriate for internal changes in the state agency control system, the information may become less apprpriate for severe vendor changes, such as termination.

5. Uses of Monitoring Information for Changing Vendor Behavior

The fifth axis of monitoring is the use of monitoring information to change vendor behavior. The axis reflects an increasing severity of actions against providers as one moves from left to right. Sanctions

against facilities for failing to meet standards remains a problem. Removal or diversion of clients is possible only where supply exceeds demand; reductions of future reimbursement only further reduce the possibility of improvements (Willemain, 1980).

The first use of course is to do nothing with the information. Several problems could inhibit the use of monitoring information. First, no criteria may exist for responding to the monitoring information. Second, there may be insufficient resources to respond to the information. Third, the programs, objectives, and responsibilities of the various state agencies may be too diverse to allow a particular agency to take responsibility for responding to the monitoring information. Fourth, the information may not be in a form which is usable by decision-makers. Fifth, the information may not arrive in time to allow the agencies to act on it. Sixth, often projects are funded without explicit statements of the planned results so that the monitoring information has no base for comparison (Waller, et al., 1976).

The second use of monitoring information is to negotiate changes with providers by offering technical assistance. In order for this to work, the conditions indicating when a need for technical assistance exists must be clearly specified beforehand (Waller, Kemp, Scanlon, Tolson, Wholey, 1976). Unfortunately, many states have given technical assistance a bad reputation because state agency managers have preferred to "consult with" providers who should have been recipients of more drastic measures (Butler, 1980). Surveyors regulating nursing homes in some states perceived themselves as consultants, not policemen (Vladeck, 1980).

The third use of monitoring information is to negotiate changes in the rate with the provider. This might involve changes in the number, types and costs of the units of service as part of the rate change. One method of implementing this contract change negotiation is to provide for sanctions linking performance to reimbursement (Schaffer, 1979).

The fourth use of monitoring information is to preclude or increase client placement with a provider, thereby, if allowed by the contracting mechanism, cutting off or increasing the flow of funds to a provider.

The fifth use of monitoring information is to provide for either the termination or the renewal of a contract based on performance. However, the specific criteria for motivating such a decision are rarely specified in advance. This limits the possible use of monitoring information (Waller, Kemp, Scanlon, Tolson and Wholey, 1976).

The most important relationships are the effect of the potential use on who performs the monitoring and on the standards.

> "That wasn't so bad," decided Pretend Admin.
> "There's only one mechanism left-client placement," informed Rhea Alty.
> "And then we're done?" asked Pretend Admin.
> "Not quite, Pretend Admin, we still have the exogenous variables to do," said Rhea Alty.

I. CLIENT PLACEMENT

The fifth mechanism of vendor control is client placement. The axis of client placement is the extent to which clients have a choice of providers (see Graph 31). The first type of client placement is market choice in which clients choose their own providers. This assumes that traditional market conditions are met, namely, that there are numerous competitive providers and sufficient information about these providers to allow the client to make an informed choice.

A variant of this type of client placement is the use of vouchers, which may restrict choices among providers to those certified or licensed for participation. If complete equality of care is the intent, the distribution of vouchers should be the sole determinant of the purchase of services. If, however, only a minimum quantity for each person needs to be guaranteed and not complete equality, then the purchase of services with vouchers for minimum services and money for additional services will allow a diversity of preferences to be expressed (Thurow, 1972).

Vouchers were seen as a way to increase the diversity and responsiveness of education in a competitive environment (Areen and Jencks, 1972; Arons, 1972). Despite making vouchers for more disadvantaged youth worth monetarily more, it is likely that the better private schools would limit the number and proportion of disadvantaged youth that would be admitted (Ginzberg, 1972). There must exist a sufficient provider market in which the client can use such vouchers. The notion that educational vouchers would be given to parents who, provided with information, could make an effective choice is weak

because the information about the performance of schools will be subject to disagreements about goals and it is unlikely that many parents would have the time, energy, and background to make informed judgments (Ginzberg, 1972).

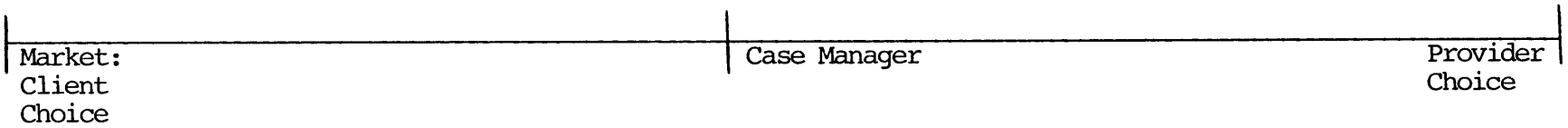
Vouchers are not immune to "distortions to measures" caused by standards for services. In housing voucher experiments, where minimum standards for dwellings where imposed as entrance requirements, the standards had only a slight impact on housing consumption. Choice and changes in housing were altered to the least extent necessary to qualify for housing vouchers. Total housing outlays (consumption) were not significantly increased.

The second type of client placement is determination by a case manager or social worker. Consumer sovereignty may not exist because of poor information or because the people are deemed poor decision-makers. This creates a need for a disinterested party to prevent exploitation (Thurow, 1972). This choice may be based on criteria such as the quality, cost, or availability of service. For this option to be most effective, information from the monitoring system about the criteria must be available to allow the intermediary to use leverage on the market.

The third type of client placement occurs when there is a local monopoly by a sole provider who is supposed to serve all qualified clients. This may occur when a provider has a guaranteed area through the bidding process, or when other factors limit the number of providers. There is evidence from a study of home health agencies in Massachusetts that providers are able to manipulate what type of client they service through their choice of a particular service delivery model

CLIENT PLACEMENT

Graph 31



(Rosenfeld, 1980).

In this type of client placement, providers usually "cream" clients with the least problems or with the easiest service requirements.

Nursing homes pursue an active policy toward rejecting and accepting different payment classes of clients (Marshall, Greenlees and Yett, 1974). In choosing clients, they will be concerned about the costs of treating individual patients and may discriminate against the most severely impaired (Scanlon, 1980). Providers also attempt to keep the census down to reduce their variable costs (Sellinger, 1979). Overall high occupancy will lead nursing home facilities, especially better facilities, to be more selective in admissions, which may mean that lower reimbursed patients will be relegated to poorer facilities. (Koetting, 1980).

As the level of competition or the regionalization potential increases, clients have more choices and market forces can operate. For the market forces to operate efficiently, the monitoring system must generate information about providers which can be used by clients in the choice.

> "At last, we're done with the endogenous variables," stated Pretend Admin. Rhea Alty sat by glumly, mourning the passing away of such a dear sounding friend.

J. EXOGENOUS VARIABLES

In order to estimate the impact on the provider market of the state's control mechanisms, an understanding must be gained of likely provider behavior. Predicting this provider behavior is difficult for several reasons. First, human service organizations traditionally have lacked feedback linkages from clients. Consequently, goals and performance criteria are determined on the basis of professional rather consumer value judgements (Baker, 1974). Human service organizations lack reliable and valid measures of effectiveness because there are no clear operative definitions of desired outcomes, there is inadequate knowledge of cause and effect relationships, or because they rarely control enough attributes of their clients in order to measure the specific consequences of their intervention procedures. As a consequence, the definitions of goals that are used in human service organizations tend to be commitments to certain values, norms and ideologies, rather than specific performance outcomes (Hasenfeld and English, 1974).

Further, it appears that non-profit organizations, particularly in the health sector, are motivated by prestige, not profit. As a consequence, any increase in demand results in a profit (surplus) in the short run and in the long run services will increase in quantity (which would be expected in profit motivated organizations) and in quality and complexity. This, in turn, increases the costs of service. If the non-profit organization's clients do not have to pay for the service, then services will not be priced out of the market and the upward spiral of costs will continue (Berry, 1974). Competition in the non-profit sector

may then serve to increase costs instead of constraining them. Non-profit nursing homes attempt to maximize their size without incurring a budget deficit and without reducing the quality of services in the facility (Scanlon, 1980).

Indeed, among the reasons that regulation has displaced the market as the controlling force are: the client is not a consumer, government is the primary consumer, there are barriers to entry to the market, and the market may be controlled by a few providers. Since the clients do not pay for the service, demand may be insatiable, providers have few restraints on price increases, and concern for quality may become secondary. Consequently, price changes may have no relationship to changes in quality (Richardson, 1981).

A study of human services contracting in Massachusetts found that the state was subsidizing providers service objectives rather than achieving its own objectives. In part this problem could be traced to the lack of usable objectives (Massachusetts Taxpayers Foundation, 1980).

In predicting provider behavior, at least two variables may significantly affect the responsiveness of providers to the state's control mechanisms: the level of competition in the provider market and the degree of regionalization of the provider market.

1. Level of Competition

The first exogenous variable, level of competition, ranges from sole source to multiple source (see Graph 3m). The first level of competition is sole-source contracting. This may be the result of the high level of expertise and resources needed to perform a particular service, or because bidding has given a provider a guaranteed

service area. One immediate problem with this type of sole-source contracting is what is termed the "capture" problem, i.e., the sponsoring agency becomes overly dependent on the sole-source provider and as a consequence, the sole source provider is in a relatively good position to dictate its terms for cost and quality (Wedel, 1978). The state agency is caught in a bind because the uniqueness of the service, or the frequency with which it is needed, may dictate that either a sole source or limited sources ought to be used for contracting.

The state must make a decision as to whether or not it is willing to pay for a multiplicity of small programs as a method of gaining independence from a sole contractor (Fisk, Kiesling and Muller, 1978). A large number of suppliers may result in greater competition and, presumably, lower service costs. But several other factors are just as important. First, there is no guarantee of competition. Second, one efficient firm and a knowledgeable public official could reach an agreement at a price no higher than if multiple competitive suppliers were present. The problem is in writing the contract and in insuring that there are sufficient opportunities for renegotiation (Fisk, Kiesling and Muller, 1978). Otherwise, providers will overestimate the costs of service to cover their risks.

When competition is sole source because vendors are chosen by a bidding process, vendors may tend to be large organizations if there are economies of scale. Since administrative expenses are either fixed, or increase in steps, there are at least some economies of scale (Koetting, 1980). It may be possible for larger vendors to provide the same service at a lower price. When competition is limited by a local monopoly, it is interesting to note that perhaps one of the best

which can compete grows smaller and smaller (Dupre and Gustafson, 1974). State agencies must recognize that in oligopolistic markets vendors tend toward a conservative competition which may not consider a variety of quality in services offered (Buckle and Buckle, 1977). There may not only be reduced choices for service, but little difference in the cost and quality among the providers (Harris, 1981). The immediate impact of limits is usually to raise costs as this involves entry to the market.

Among the reasons there were a few large vendors in each area in one state were: the impacts of financial constraints in setting up and running expensive programs; the lack of expertise available in the community; the limited ability of state agencies to monitor vendors given restricted funds for this purpose (consequently, state agencies use vendors they assume are satisfactory); the potential for economies of scale; the administrative ease of dealing with only a few vendors, and the hardship of slow state payments. This led to a provider-dominated purchase system. State agencies felt there was little they could do and had no alternative vendors to turn to if they were dissatisfied with a provider's service. One consequence of this situation is that providers feel safe in rejecting clients who they think will require too much work (Massachusetts Taxpayers Foundation, 1980).

The third level of competition is where there are many providers. If clients are primarily from one state, providers may be subject to the regulatory objectives of that particular state. The evidence from health care indicates that quality (as measured by input use) competition among providers may increase costs, because cost does not serve its usual role as a constraint. The competitiveness which results

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revolves around increased use of inputs (particularly technological inputs) with an increasing cost per bed.

Hospitals compete with each other in the adoption of technical innovations. In a competitive environment they tend to adopt new technologies sooner and to acquire more expensive equipment than other hospitals in less competitive environments (Rapoport, 1976). Competition could also drive down the cost of services by inducing providers to use fewer, lower priced, or lower quality inputs in a manner similar to the private sector.

> "Rhea Alty," sighed Pretend Admin, "this seems awfully dry."
> "I know," sighed Rhea back. "Perhaps a discussion of the relationships might help."
> "Very well," said Pretend Admin, "but I don't have to like it."

Standards have an impact on the provider market to the extent that standards, particularly input standards, may limit entry by singling out a class of providers through licensing, accreditation, or certification or by increasing costs to such an extent that only large vendors or those with a substantial amount of working capital can stay in the market. Similarly, flexibility in rate negotiation can increase competition, and as competition moves from many providers to one provider it is necessary for negotiation to increase to maintain the state's position.

Client placement also links with the provider market, i.e. the size of the provider market and the level of competition in the market has an important determining value on how clients are placed. Conversely, how clients are placed will increase or decrease the level of competition.

EXOGENOUS VARIABLE: LEVEL OF COMPETITION Graph 3m

Sole Source - Due to Expertise and Resources Needed or Guaranteed Areas	Limited Sources Due to Expertise and Resources Needed or Government Design	Multiple Sources

Graph 3n

EXOGENOUS VARIABLE: DEGREE OF REGIONALIZATION POTENTIAL OF PROVIDER MARKET Graph 14

Single Service, One State Only	Multiple Services, One State Only	Single Service, Multiple States	Multiple Services, Multiple States

2. Regionalization Potential

The second important exogenous variable is the degree of regionalization of the provider market where the range is from a single-service, single-state provider market to a multiple-service, multiple-state provider market (see Graph 3n). In this range the single-service single-state provider market is the most vulnerable to influence by the state agency. If there is a single buyer of services, it may be to the buyer's advantage to have excess capacity among providers to provide a motivation for competition even if the excess capacity increases costs (Vladeck, 1980). As the provider market begins to offer additional services (single-state, multiple-service) it increases the degree to which it can change its case mix to capture better reimbursement rates or preferred types of clients.

A study of nursing homes found that they adapted their patient mix or adjusted the way they served patients in response to different levels of reimbursement (Marshall, Greenlees and Yett, 1974). Nursing homes in this study persisted in providing more services to clients in certain payment classes even when there were no differences in debility.

Alternatively, the provider market could expand to become a single-service, multiple-state provider market. It is possible for the providers in this market to select not only the possible reimbursement level but the regulatory environment. For example, if a market includes Massachusetts, Connecticut, and Rhode Island, providers would have the option of modifying the extent to which they want to take Massachusetts residents versus Rhode Island residents versus Connecticut residents based on where they thought the best reimbursement could be obtained and the least regulation would be required. As the provider market becomes

a multiple-service, multiple-state provider market, providers are less vulnerable to the influence of one particular agency in one particular state, since the providers can always opt to select the type of client they take in or the client's state origin.

Multiple-service and multiple-state providers may maximize reimbursement or perform their goals as they perceive them, and not deliver the service the state wants, because the providers have the flexibility to choose who and how they serve.

The amount of "inter-state commerce" in non-health care human services appears, however, to be declining. Pressure from the public and the state legislatures for greater accountability has resulted in the restriction of client placement to in-state facilities. There are however, a few "chains" in the Northeast, for example, Marathon House and DARE, which operate facilities in several states.

The important link for regionalization of the provider market is to standards. In particular, as input standards increase and become more specific, it is more difficult for providers to cross service and state lines.

K. Dynamic Relationships

"Now, Pretend Admin, you must use all of this information we've been gathering to convert a static picture of the relationships into a dynamic picture," stated Rhea Alty.

"What?" questioned Pretend Admin.

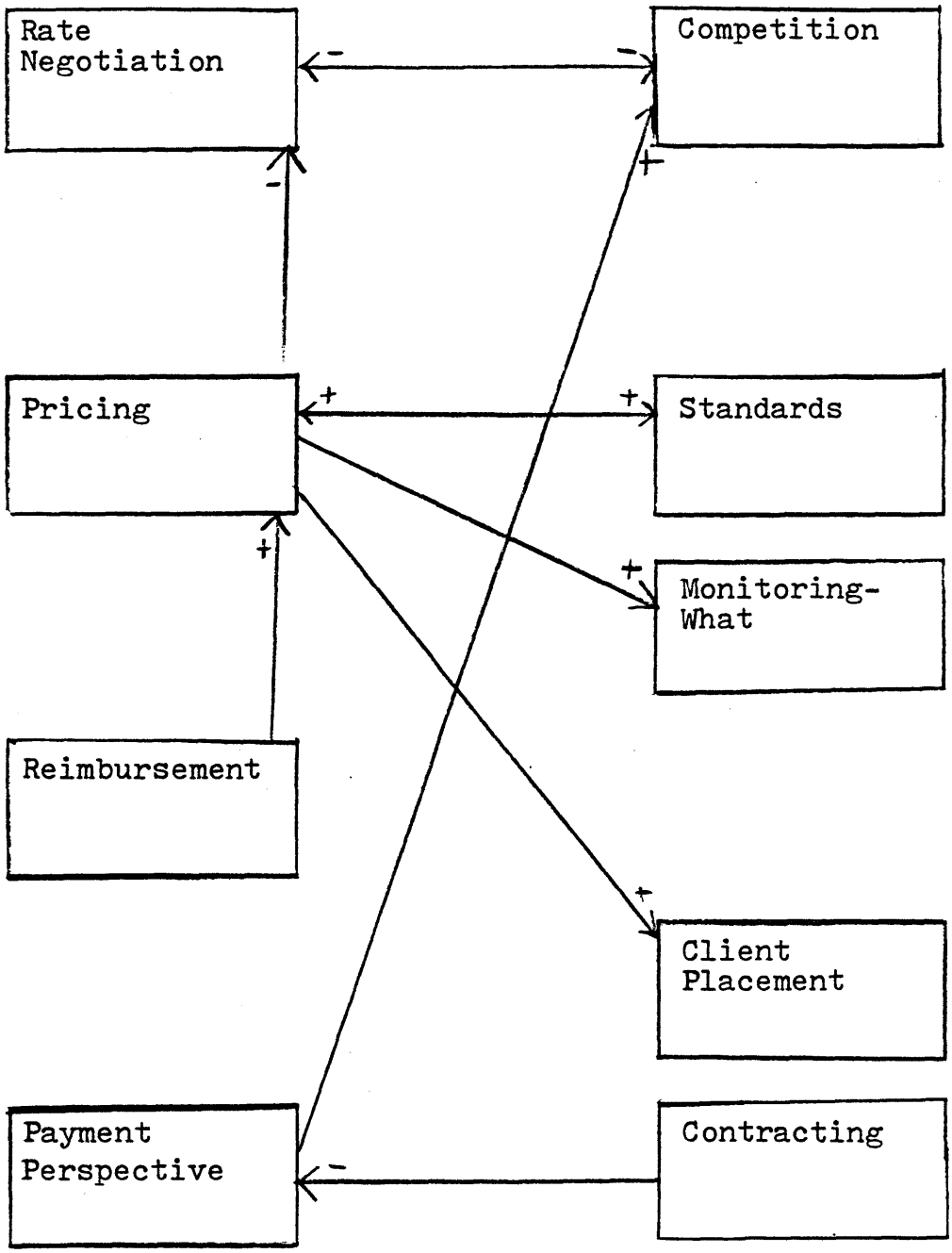
"You have to convert a snapshot into a motion picture," answered Rhea Alty.

"Oh! You mean my signed digraphs," responded Pretend Admin. "I'd better explain how to interpret them first."

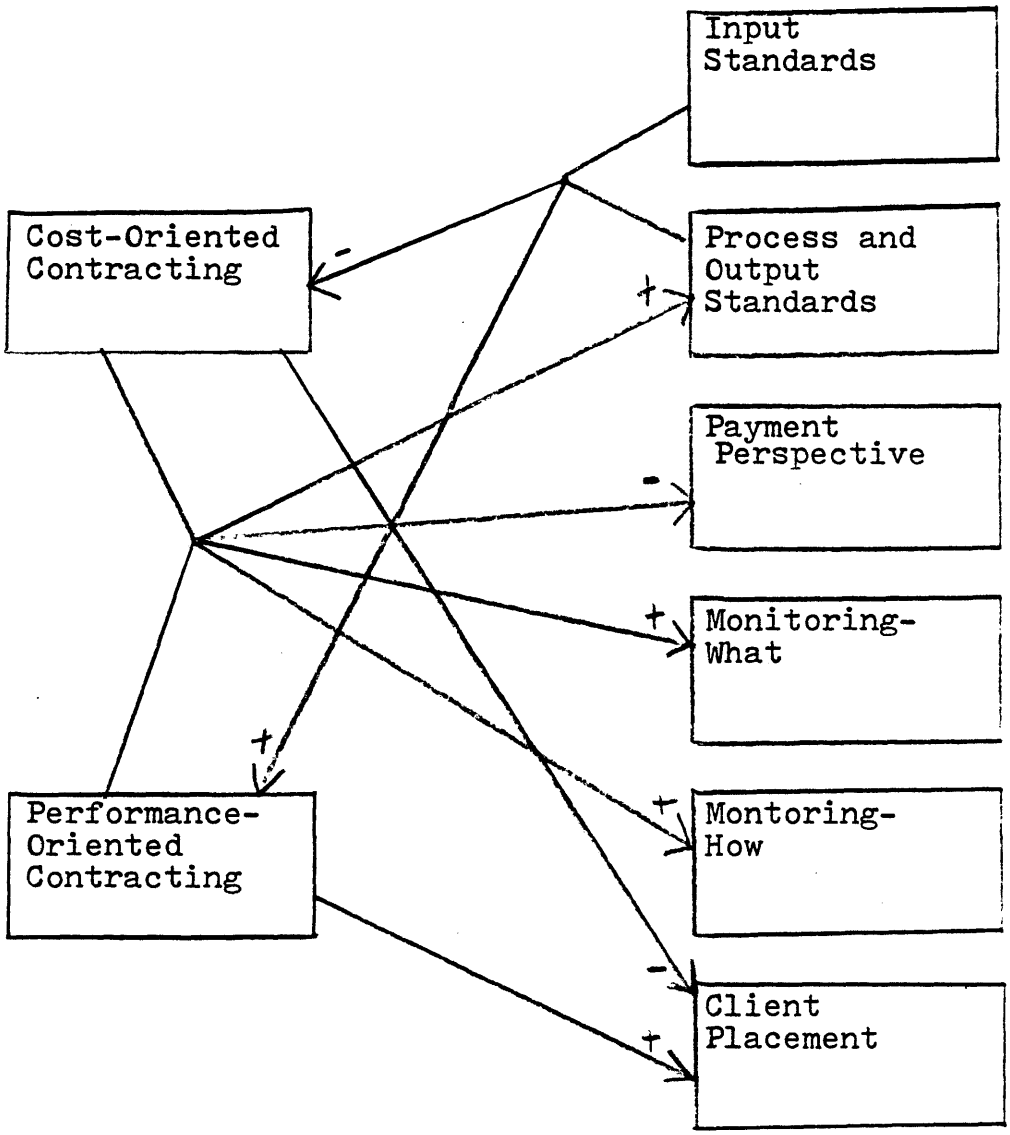
"You're catching on," Rhea Alty sniped.

The relationships between the axes in Graphs 3a - 3n are illustrated in Graphs 3o - 3s. The arrows and signs indicate the direction and type of relationship. The arrows indicate what happens to the position on the continuum at the head of the arrow as one moves from left to right on the continuum on the tail of the arrow. A positive sign (+) indicates that the position on the head of the arrow also moves from left to right, while a negative sign (-) indicates that the position moves from right to left. In the text, an "increase" on a continuum indicates a left-to-right movement, while a "decrease" indicates a right-to-left movement. The graphs include movements which cannot be fully discussed until a later axis is analyzed. No one-to-one correspondence between positions on the continuums is intended. Rather, the general direction of change is indicated.

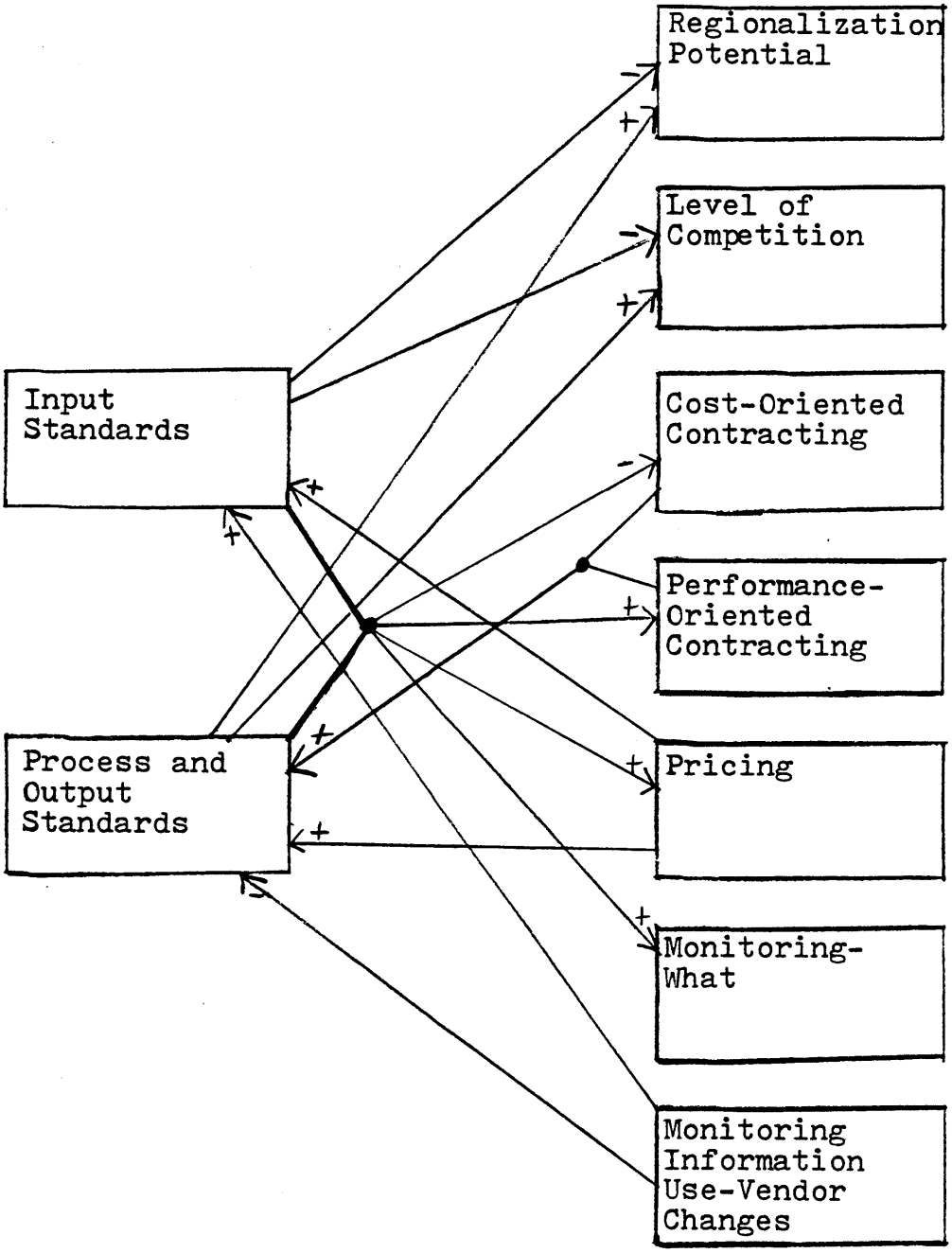
Graph 3o: Relationships of Rate Setting



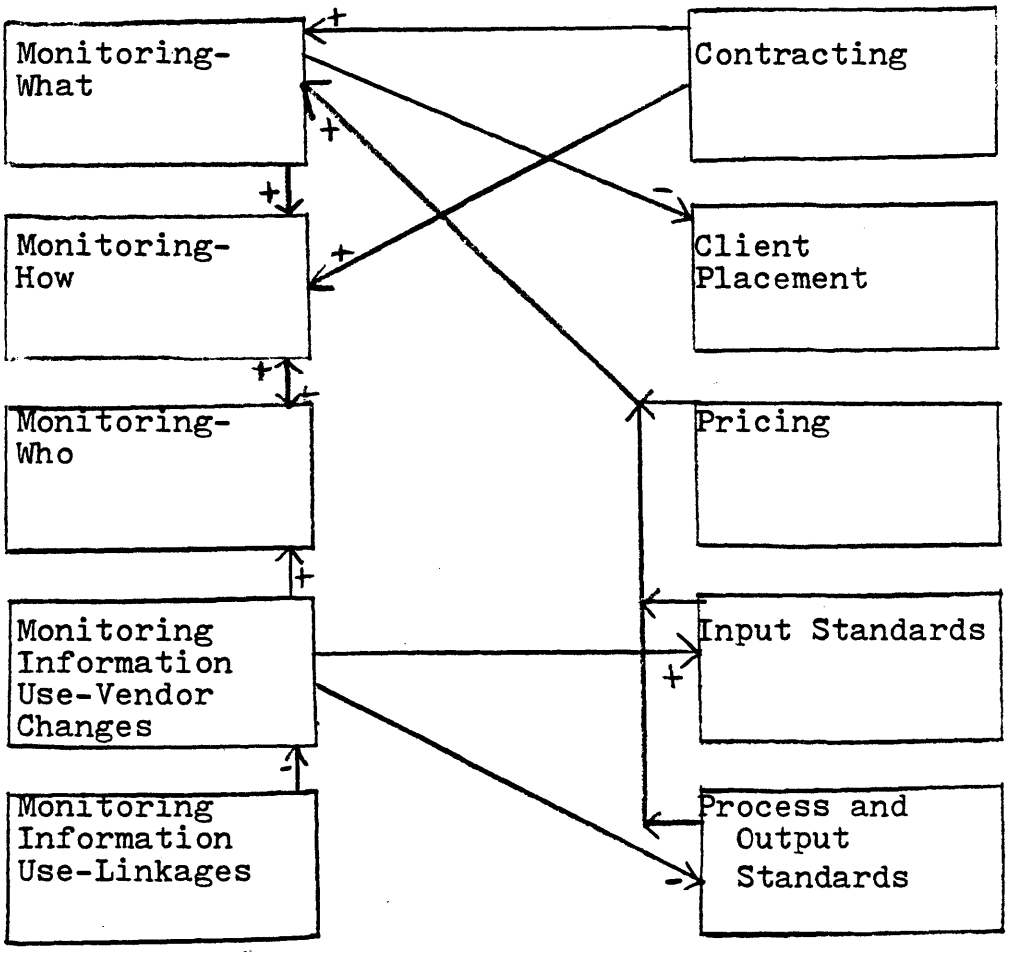
Graph 3p: Relationships of Contracting Processes



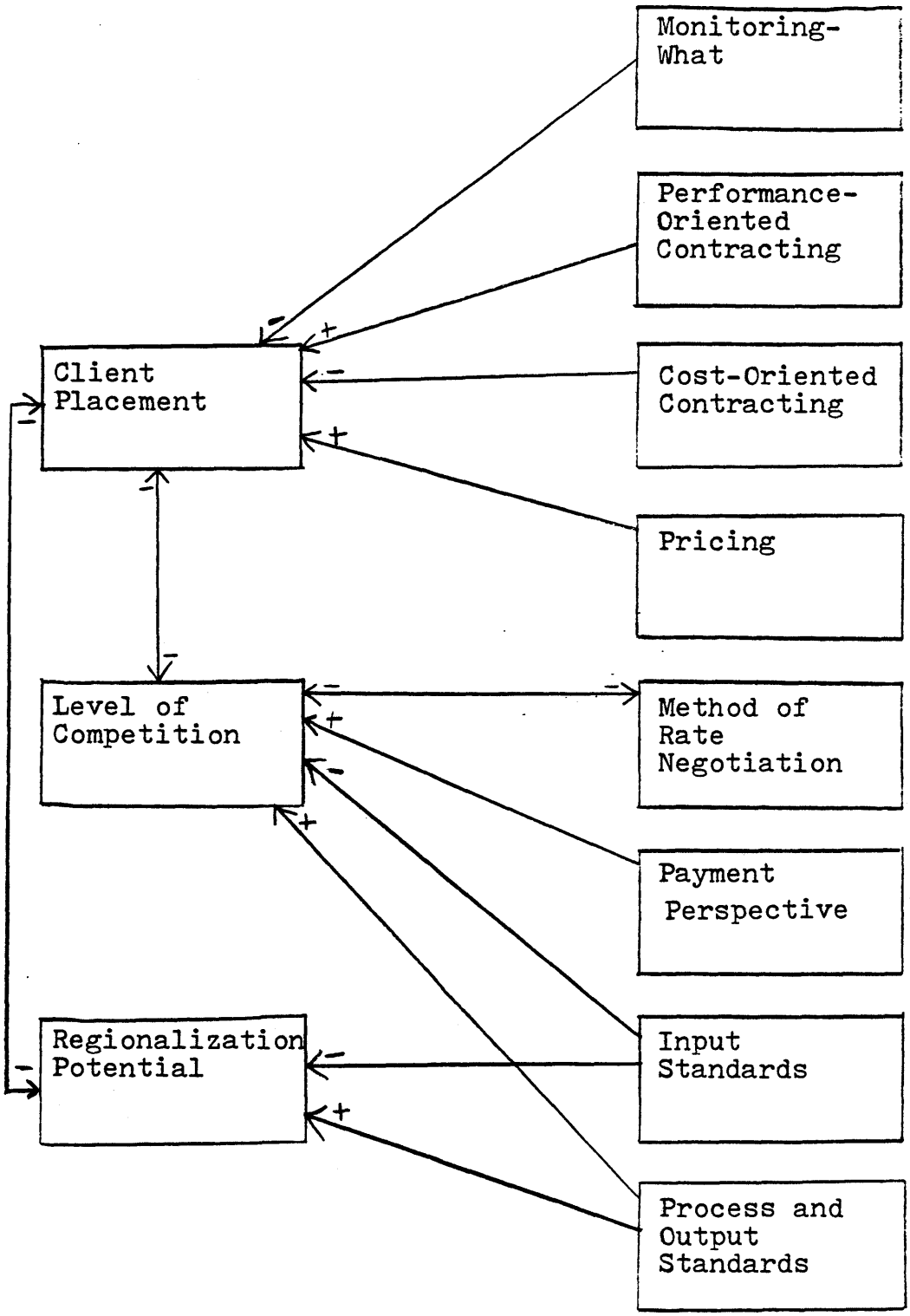
Graph 3q: Relationships of Standard Setting



Graph 3r: Relationships of Monitoring



Graph 3s: Relationships of Client Placement and the Exogenous Varibles



"Is that it for today?" asked Pretend Admin.

"To tell you the truth, Pretend Admin, I still feel uncomfortable," admitted Rhea Alty. "Why don't we see what other states do?"

"After my coffee break, of course, Rhea Alty," agreed Pretend Admin.

"Of course," agreed Rhea Alty.

L. Purchase-Of-Service Contracting In States Other Than Those In The Case Studies

A review of literature on the purchase of residential services in other states was conducted to compare the preferred relationships in the signed digraphs with actual relationships used by states. The purpose of reviewing this literature was not to validate the proposed relationships, because these relationships are the preferred associations. In reality, residential social service programs will not exhibit the range of variation found in the axes. Further, if all the relationships existed in current practices, then this dissertation would not be needed. The purpose of the review of other states is to illustrate when current practices have limited variation, and when they do not follow preferred relationships. This study was designed to further the study of the interrelationships among control mechanisms in a variety actual of provider market situations (variation in the exogenous variables). Literature about the states of Georgia, Utah, Idaho, Wisconsin, Colorado, and Maine was reviewed (see Tables 3t and 3u).

The review was based on materials sent by state agencies in response to requests and reviews undertaken by other state agencies. Most of the material reviewed was for mental health or mental retardation group homes.

Two particularly interesting studies came from the states of Utah and Georgia where the state social services department attempted to directly equate input costs to units of service. In Utah, a method of paying for services termed "Problem, Objective, Method, Evaluation" (P O M E) was adopted. For each service, the activities required to

perform that service were identified and money was appropriated to support these direct activities. Utah was attempting to relate total costs to different levels of "effort" (output units) and, ultimately, relate input costs to output units (O'Hara and Leschem, 1977). Following the nomenclature previously adopted the method of reimbursement was level of care, the method of rate negotiation was unilateral determination by the state agency, and the method of pricing was based on delivery of specified inputs. If the development of a relationship between input costs and output units is successful, it is possible to change the method of pricing to one based on relative efficiency.

The state of Georgia established costs for services based on "relative value points." These points are determined based on the time and cost of each type of activity in a service (O'Hara and Leschem, 1977). Reimbursement, rate negotiation, and pricing were determined in the same manner as in the Utah study. Contracting was based on a unit price. In both Georgia and Utah, the links among the methods of rate negotiation, reimbursement and pricing in rate-setting were recognized in order to improve the means of paying for services.

In Idaho, the Department of Health and Welfare contracts primarily with sole-source providers. Because of the low population density, there were few providers of services. The rate for services was based on a comparison of costs for similar services, state agency budget limitations, and the quality of the service (Rhode Island Task Force on Contracting Out, 1976). Rate negotiation was based on the prior rate and the state agency's projected budget. Pricing was based on the level of quality with the possible use of relative efficiency. This use of

comparisons is interesting, considering that the level of competition is chiefly sole source. The method of reimbursement was by facility.

Standards used in Idaho included certification and licensure. Certification was accomplished by including a simple statement in the contract which the provider signed. Providers were required to maintain fiscal records to substantiate payments. Licensure of providers encompassed the customary fire/safety input standards.

Monitored areas included terms of the contract, fiscal procedures, and cost effectiveness, and was done by fiscal and performance audit teams using qualitative assessments and field audits.

In Wisconsin, the terms of the contract were negotiated with a provider and included: the service to be delivered, resources to be used, the costs of these resources, the unit-of-service cost and, in some cases, standards. Providers were required to submit monthly reports detailing the number of clients served, the number of units of service delivered, the dollars expended, and the unit-of-service cost. Additionally, the state agency determined allowable expenses for cost reimbursement (Rhode Island Task Force on Contracting Out, 1976). Monitoring focused on terms of the contract, fiscal procedures and the quantity of expected services. Monitoring relied on self-reports and was evaluated by a desk audit.

In Colorado, program evaluation used an "enviornmental" checklist to assess group facilities (Yaron, 1979). The checklist was based in part on input standards for residential institutions, and assessed the quality of the service being delivered using constructed measures. The checklist was administered by a performance audit team. The information developed by the monitoring system was used to determine the need for

Table 3t: Mechanisms in Utah, Georgia and Idaho

MECHANISM	STATE		
	UTAH	GEORGIA	IDAHO
Negotiation	Unilaterally Set by State Agency	Unilaterally Set by State Agency	Prior Rate
Pricing	Delivering Inputs	Delivering Inputs	Level of Quality
Reimbursement	Level of Care	Level of Care	Facility
Contract Process	-	Unit price	-
Standards	-	-	Certification, Licensure
Monitoring-What	-	-	Terms of the Contract, Fiscal Procedures, Cost Effectiveness
Monitoring-How	-	-	Fiscal Audit, Qualitative Assessments

(Table 3t, cont'd)

MECHANISM	STATE UTAH	GEORGIA	IDAHO
Monitoring-Who	-	-	Fiscal Audit Team, Performance Audit Team
Other	-	-	Primarily Sole Source

Table 3u: Mechanism in Wisconsin, Colorado and Maine

MECHANISM	STATE WISCONSIN	COLORADO	MAINE
Negotiation	-	-	-
Pricing	-	-	-
Reimbursement	-	-	-
Contract Process	Cost Reimbursement		
Standards	-	Input Standards	Input Standards
Monitoring-What	Terms of the Contract, Fiscal Procedures, Quantity of Expected Services	Quality	Terms of the Contract, Fiscal Procedures, Quality
Monitoring-How	Desk Audit	Constructed Measures	Desk Audit, Field Audit, Constructed Measures

(Table 3u, cont'd)

MECHANISM	STATE: WISCONSIN	STATE: COLORADO	STATE: MAINE
Monitoring-Who	Self-Reports	Performance Audit Team	Joint Fiscal/ Performance Audit Team
Other	-	Information Used for Technical Assistance and Planning	Information Used for Technical Assistance

technical assistance, and for planning program expansion of providers.

In Maine, the program review methodology adopted by the state assessed compliance with the terms of the contract and input standards as well as the utilization rate (including a comparison of budgeted versus actual services rendered), expenditure rates, cost per unit of service, the number of successful closings, and staff satisfaction. These assessments were made based on desk and field audits by a joint fiscal/performance audit team. A fixed, standard review schedule was used for the field audit. An attempt was made to assess cost effectiveness. Where needed, technical assistance was arranged (Maine Department of Human Services, 1977).

The mix of control mechanisms found in this literature fits very well with the trends indicated by the signed digraphs. The exceptions to this are noted below. In Idaho, the rate negotiation by prior rate and the sole source level of competition appear to be in opposition to the direction indicated by the signed digraph. The sole source level of competition would appear to indicate a less negotiated process than the use of prior rates. However, the matching of negotiation based on the prior rate and pricing by quality and relative efficiency is indicated by the graphs. Pricing by relative efficiency and level of quality should generate higher level standards than input standards, and reimbursement by facility should have resulted in a lower level method of pricing. The input standards would appear to be mismatched with the monitoring-what that includes cost effectiveness. In Utah, Georgia, Wisconsin, Colorado, and Maine the choices of control mechanisms generally follow the trends of the signed digraphs.

"I don't know about you, Pretend Admin, but I'm rather surprised that such a small survey had such a large variation on the axes. I was quite pleasantly surprised," said Rhea Alty.

"So was I. My axes performed admirably," declared Pretend Admin boastfully.

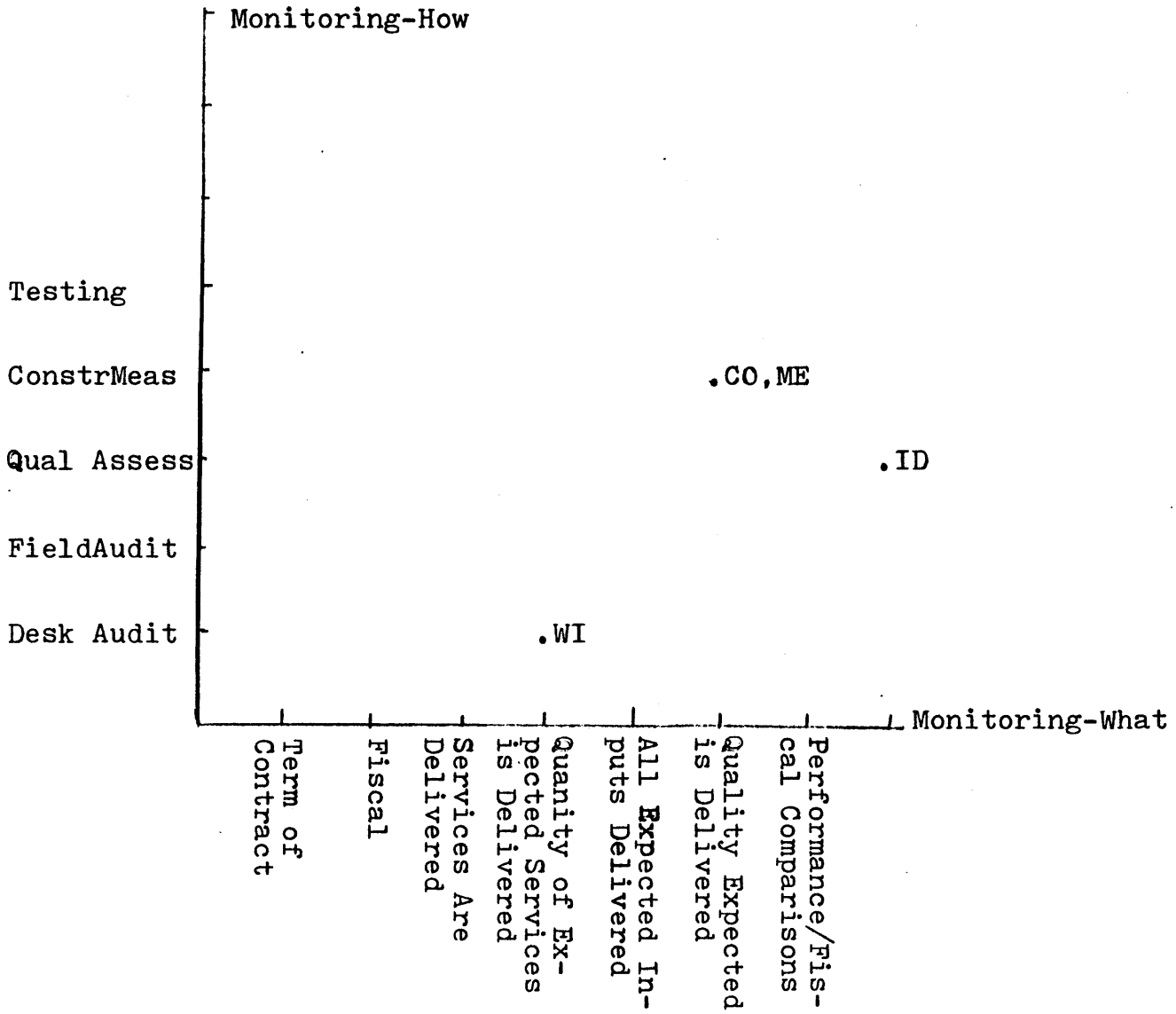
In order to assess the validity and the sign of the relationships found in this literature, the states have been put on graphs indicating the intended relationships wherever at least two states (two points establish a line) illustrate the relationship. The x-axis indicates the independent mechanism (tail of the arrow), and the y-axis indicates the dependent mechanism (head of the arrow). See graphs 3v-3aa.

Where options on an axis have not been mutually exclusive, as with monitoring mechanisms, the option farthest to the right was used. This was necessary because options on this type of axis are often cumulative. If a mechanism is cumulative, it implies that the options to the left of any other option are present as well. In other words, the presence of accreditation standards at the middle of the continuum implies that licensure and certification standards are also present.

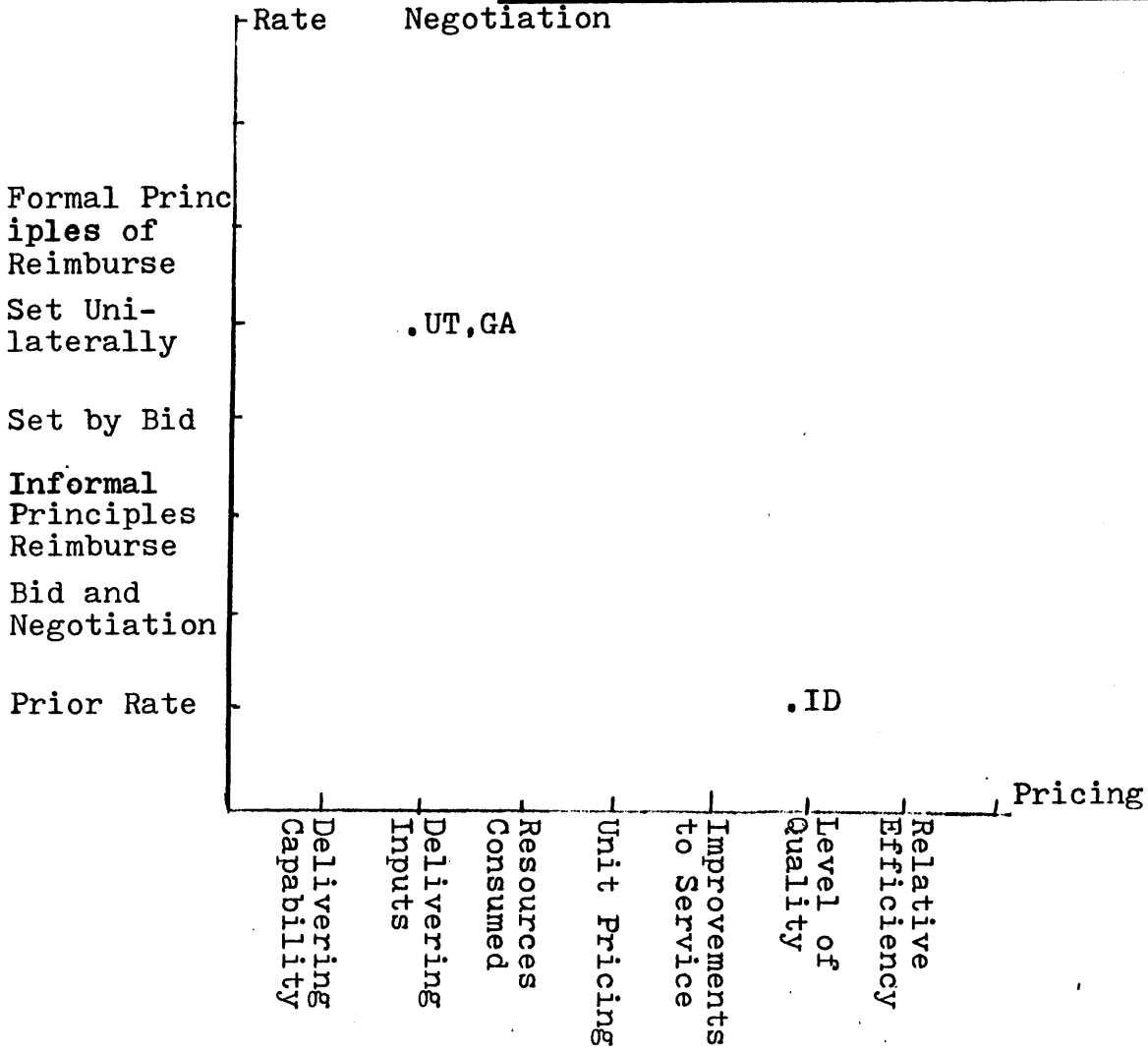
All double ended arrows have the same sign at both ends in this analysis, so only one graph is used to display the relationship. When two, three or four options for a mechanism exist, the spacing between options was adjusted to improve readability. Cost-oriented contracting and performance-oriented contracting were placed on the same axis when they affected other mechanisms or the provider market in the same way, were affected in the same manner by those variables. The same is true for input standards and process, output and outcome standards.

For Colorado and Maine, the literature did not specify the type of input standards, so a middle level option (licensure) was used.

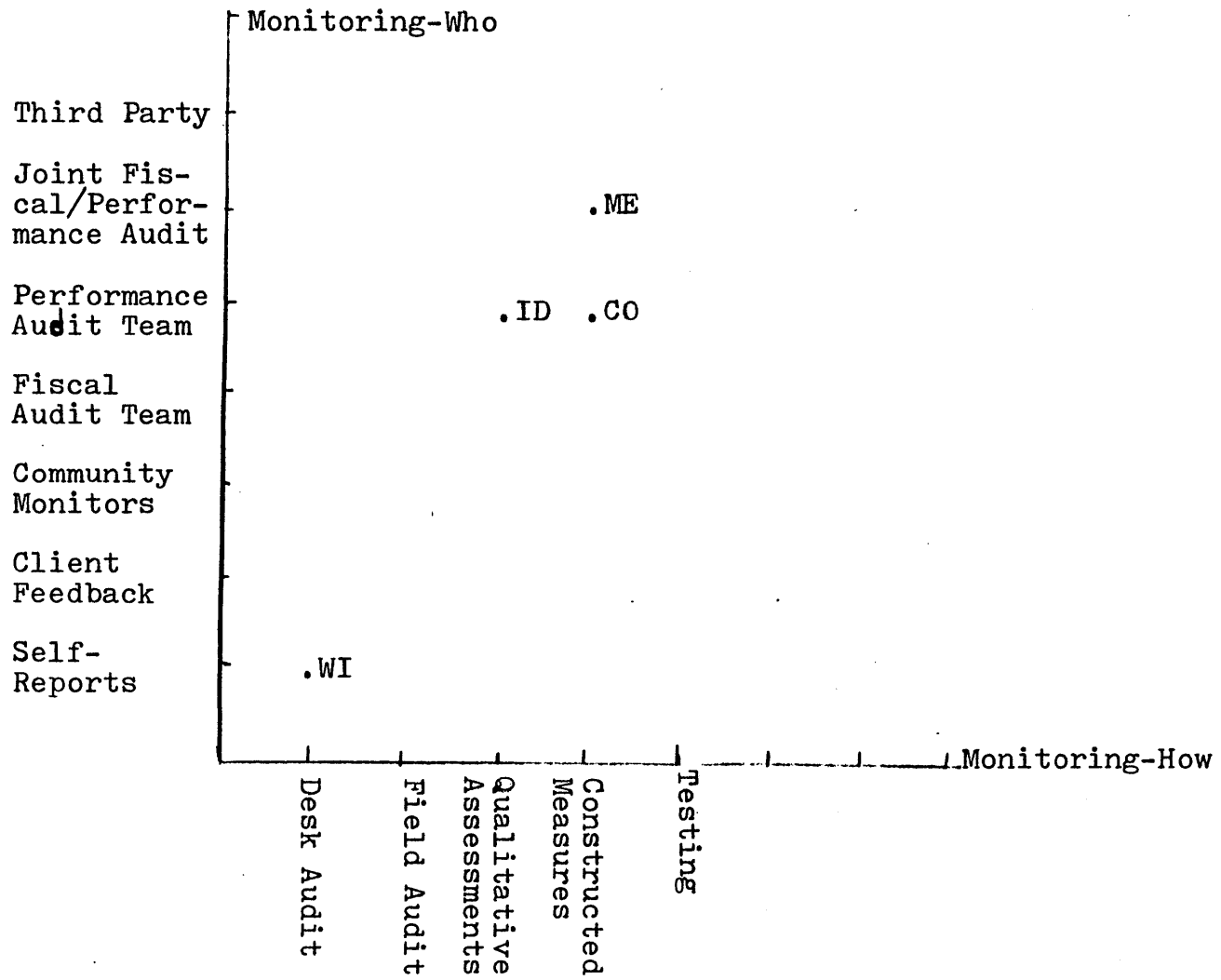
Graph 3v: Monitoring-What and Monitoring-How



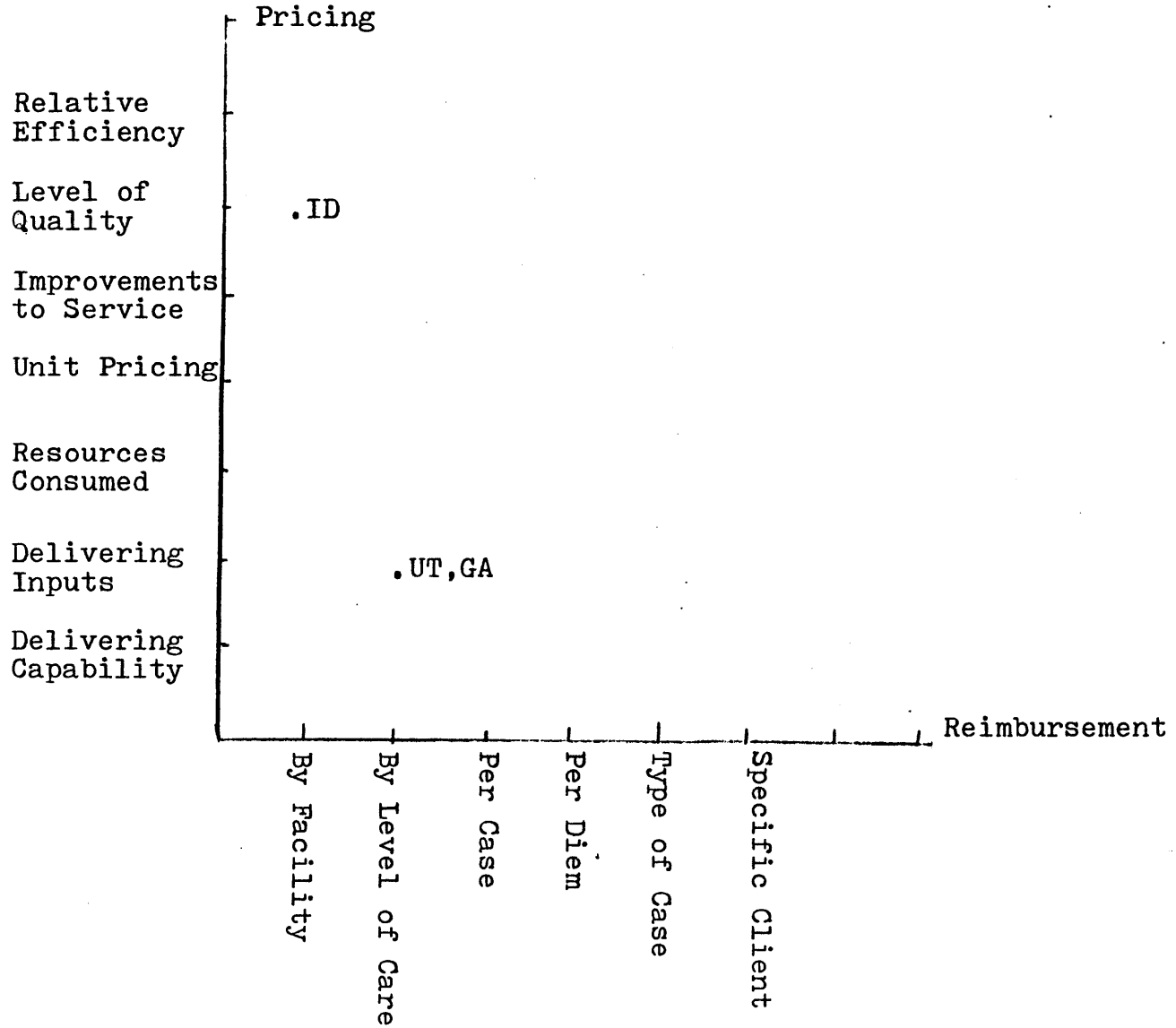
Graph 3w: Pricing and Rate Negotiation



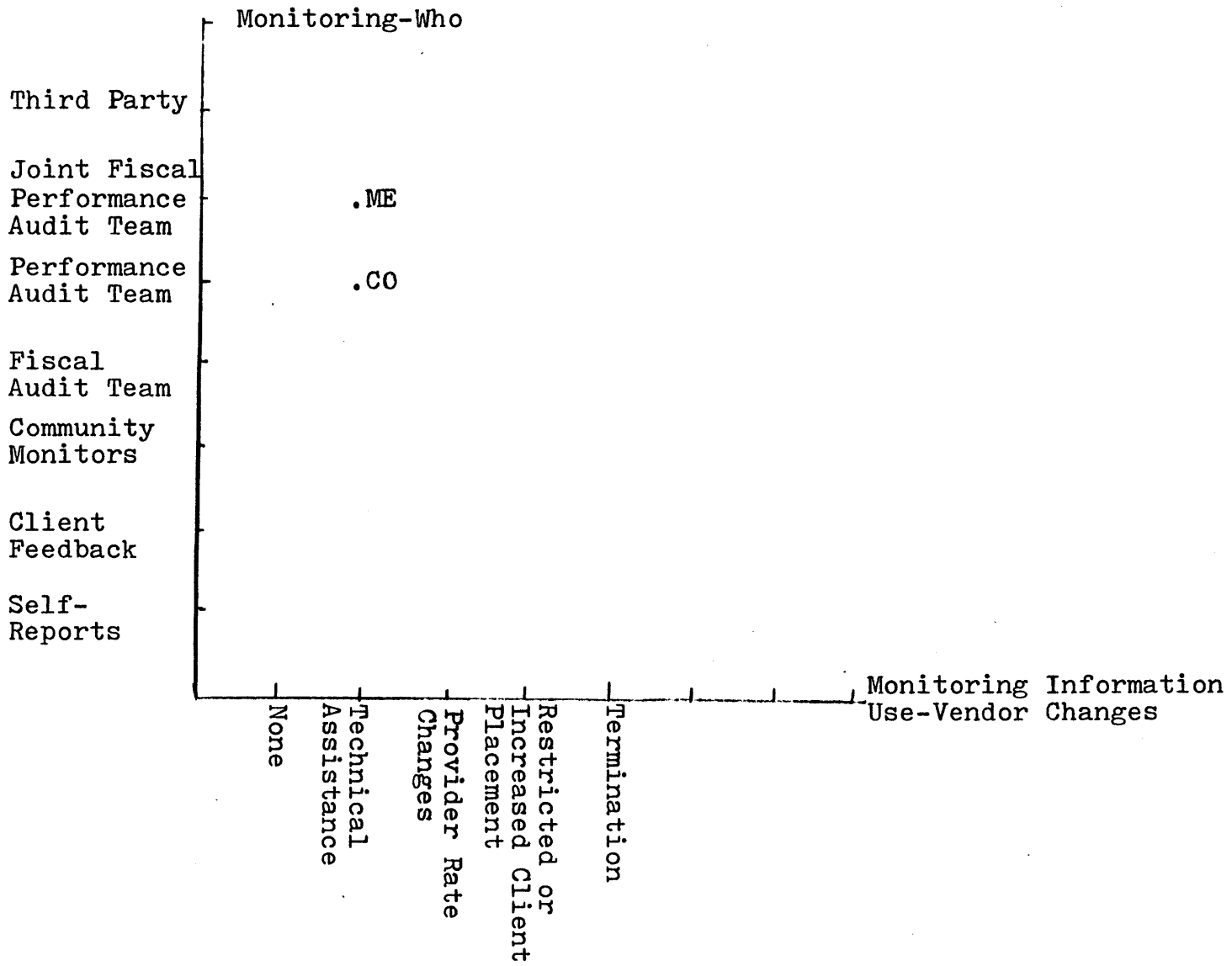
Graph 3x: Monitoring-How and Monitoring-Who



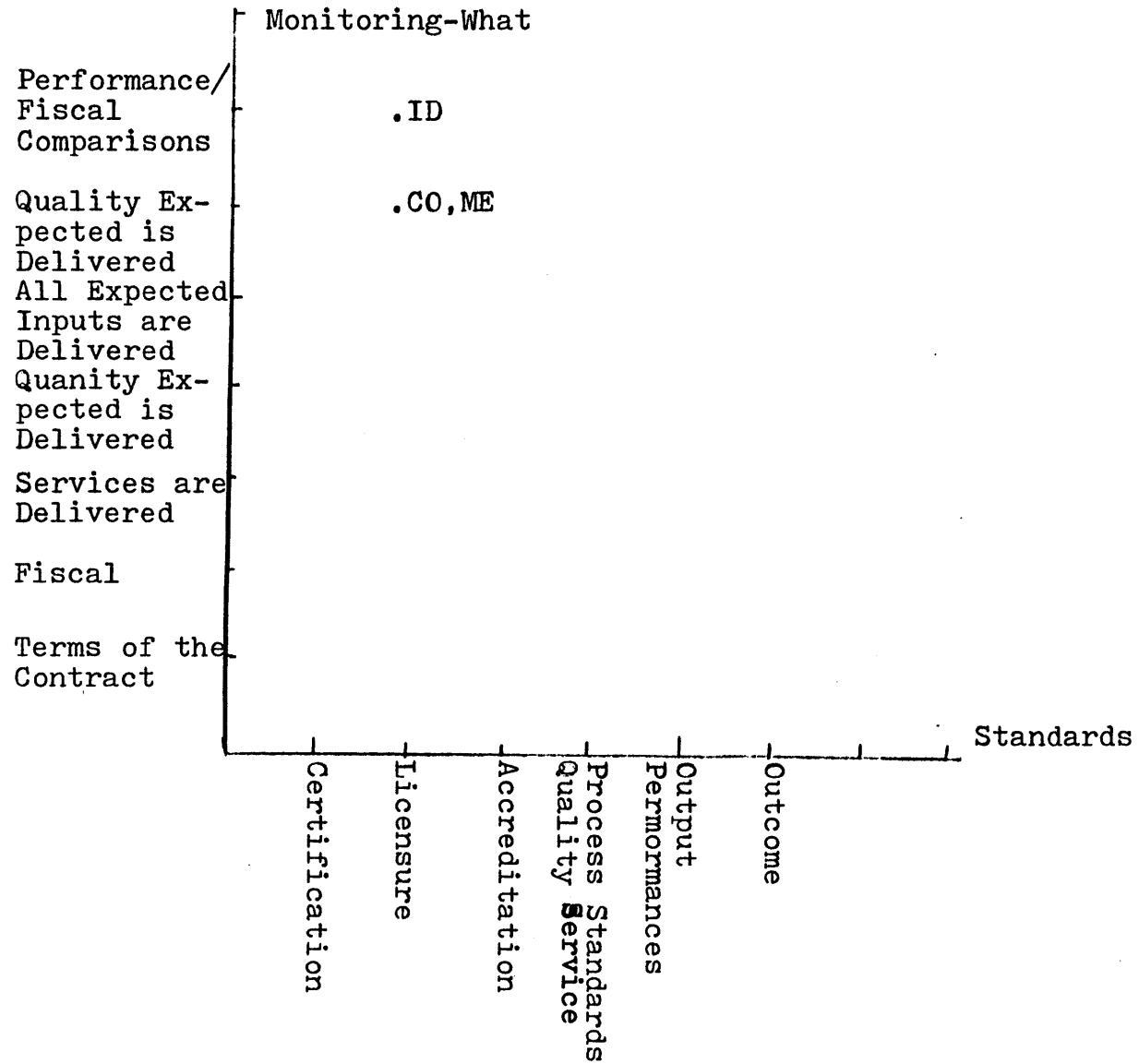
Graph 3y: Reimbursement and Pricing



Graph 3z: Monitoring Information Use-Vendor Changes and Monitoring-Who



Graph 3aa: Standards and Monitoring-What



Of the six relationships possible to depict on a graph, three followed the directional patterns indicated by the preferred relationships, and one exhibited an opposite directionality. The other two presented no positive or negative pattern. The relationships between monitoring-what and monitoring-how, pricing and rate negotiation, and monitoring-how and monitoring-who existed in the direction indicated by the signed digraphs. The reimbursement and pricing relationship was the opposite of the preferred one. For the relationships between monitoring information use-vendor changes and monitoring-who, and standards and monitoring-what, there was no variation in the independent mechanism, so no positive or negative relationship could be suggested.

M. Effective Combinations

"Pretend Admin," Rhea said, "I know I'm pushing my luck, but if you could give exemplary combinations under different conditions it would be most helpful to me."

"You aren't suggesting I do that now, are you Rhea Alty?" Pretend Admin asked. "After all, it is only an hour until quitting time and I was planning to attend a meeting with the Commissioner on my way home."

"I wouldn't think of interfering with your Space Invaders game with the Commissioner," said Rhea Alty. "Tomorrow will be soon enough."

Table 3bb exemplifies how some of the mechanisms can be combined in the least cost/most effective manner. The least cost consideration includes the cost of the mechanism and the fiscal impacts on the providers. The level of competition and the degree of regionalization in which the combination if likely to be effective are also determined.

It should be noted that the dynamics of the mechanisms may determine the level of competition and the potential for regionalization. For example, no matter how many vendors enter the bidding process, one there is client placement by guaranteed area the level of competition becomes sole source.

Table 3bb: EFFECTIVE COMBINATIONS OF MECHANISMS

CONSTRAINING MECHANISM/CONDITION	MONITORING REQUIREMENTS	MONITORING RESOURCES USED
FEW MONITORING RESOURCES	Maximize Control at Low Cost	Contract Terms, Fiscal, and Quantity of Services based on a Desk Audit of Materials from Provider Reports (Self-Reporting) (Few Resources)
NEGOTIATION BY BIDDING, CLIENT PLACEMENT BY GUARANTEED AREA	Ensure that Type of Service Delivered Reflects State Agency Objectives for Type and Cost of Services: Concern over Service Quality Will Induce Use of More Inputs Than Necessary; Which Should Lead to Contracting Mechanisms Which Constrain This Incentive	Quality Expected Based on Qualitative Assessments and Constructed Measures Dong by a Performance Audit Team (Moderate Resources)
PRICING BY RELATIVE EFFICIENCY	Cost/Output Comparisons Distortions to Measures Will Lead to Minimization of Use of Inputs Which Are Not Immediately Seen as Increasing Reimbursement: Pattern Of of Service Delivery Will Change to Reflect What Is Measured.	Fiscal/Performance Comparisons Based on Constructed Measures and Testing Done by Joint Fiscal/Performance Teams and Third Parties (Considerable Resources)

(Table 3bb, cont'd)

	ASSOCIATED MECHANISMS	RESULTING LEVEL OF COMPETITION	RESULTING REGIONALIZATION POTENTIAL
FEW MONITORING RESOURCES	Ceritifcation Standards, Pricing by Delivering Capability, Negotiation Based on Prior Rate and State Agency's Projected Budget, Unit Price Contracting Client Placement by a Market Mechanism	Multiple Sources	Multiple States/ Services
NEGOTIATION BY BIDDING, CLIENT PLACEMENT BY GUARANTEED AREA	Level of Quality Pricing, Cost Sharing or Cost Plus Incentive Contracting, Process Standards	Sole Source or Limited Sources Larger Vendors Likely	One State Only Providers
PRICING BY RELATIVE EFFICIENCY	Restrospective Payment, Negotiated Performance Contracting, Output Standards (Reimbursement Should NOT Be Too Closely Tied to a Specific Person). Reimbursement by Type of Case or Level of Care, Client Placement by a Market Mechanism, Negotiation Based on Formal Principles of Reimbursement	Multiple Sources	Multiple States/ Services

"Well, Mr. Pretend Admin, I guess that's the end of my assignment here. It certainly has been real, working with you. If we leave now, you should clear the parking lot by quitting time. Say hello to the commissioner for me, if he's still waiting."

"Thank you, Ms. Rhea Alty, thank you very much indeed. Your services have been more than human."

CHAPTER 4: RESEARCH METHODOLOGY

A. Research Focus

The focus of the research was on the use of management control mechanisms for shaping the behavior of group homes. A group home is a residential facility for five to twenty residents which includes 24-hour supervision in an environment which is as nearly "home-like" as possible. Group homes are a particularly generic service across the social services spectrum - for abused/neglected children, runaways, juvenile delinquents, corrections, mental health, mental retardation, substance abuse, and the elderly. Group homes are also cross-cutting on the federal level (HUD, Labor and several divisions of HEW). They were chosen because they have received considerable adverse publicity in Rhode Island, Massachusetts, and New York City regarding poor use of management control mechanisms. It is a priority area for change, and this has been recognized by recent efforts in Connecticut, Massachusetts, New Hampshire, New York City, and Rhode Island to improve and coordinate the use of management control mechanisms, and to use the feedback from these strategies to provide technical assistance to vendors.

The emphasis on residential facilities lends a bias to the study. Since community residential facilities are not far removed from the facilities that are regulated - nursing homes, hospitals - it was expected that the control system would be more evolved and formalized than in other types of community services.

B. Research Questions

The field research was designed to answer questions about the current and potential use of control mechanisms for shaping behavior. There were two basic questions:

1. How are the management control mechanisms used, and what effects does this use appear to have?
2. How can a state agency anticipate provider behavior, especially in response to management control mechanisms?

Current use and effects were determined through interviews. The anticipation of future behavior required an analysis of use and effects within the context of an explanatory theory.

The interviews sought answers to the questions:

1. What is the current nature of the purchase-of-service control system?
2. What do the effects of the control system appear to be from the point of view of providers and state agencies?
3. What are the apparent objectives of the control system?
4. How did providers respond to the control mechanisms?
5. What is the provider market and what influence does the provider market have on the choice and use of different control mechanisms?
6. How do providers beat the control system (minimize its effects)?
7. How actively is the legislature involved on behalf of providers? (See section on Pre-Testing.)

C. Case Studies

The survey research involved two case studies: one in a state with a small number of providers and the other in a state with a large number of providers.

The two states chosen for the case studies were both Eastern, densely populated, industrial states. However, the first case study state was one-fifth the size of the second case study state in terms of both population and physical size. State 1's budget is devoted primarily to human services and the state has a reputation for being very liberal, but is fiscally conservative (no deficits are allowed in the state budget). State 2's budget is also substantially spent on human services, and it has a long standing liberal reputation for human services; it has been a national leader in deinstitutionalization and the development of new service delivery models. Its commitment to community services has been reinforced by several court orders to speed up the development of community residential services.

These two states were chosen because purchase of services is used extensively in both states, yet they differ markedly in terms of their provider market (level of competition and regionalization potential).

D. Survey Research

1. Pre-Testing

Three levels of pre-testing occurred during the months of June and July in 1981. In the first level, an initial interview format was discussed with three dissertation advisers and with two colleagues who had substantial experience in survey research. The result of this level of pre-testing was a reduction in the time to complete the questionnaire and the use of more and simpler questions with regard to provider reaction to regulation.

The second level of pre-testing utilized five top state management officials. After reviewing the proposed format, interviews with the officials were conducted which lasted approximately two hours each. The result of these interviews was to reduce the number of questions and to reword several of the questions. These state agency officials were drawn from two states resembling the case study states.

The third level of pre-testing was conducted in two two-hour meetings with a large multiple service provider and a high level state agency official who set policy for contracting in State 1. The changes that resulted from these meetings included a reduction in the number of questions and an increase in the follow-up questions for those areas remaining in the interview format.

During the course of pre-testing, several conditions were suggested by interviewees as varying with the provider market. The conditions which were mentioned most often were: the amount of resources committed to monitoring, the number and complexity of relationships among state

agency actors involved in the control system, the providers' ability to have the legislature intervene with state agencies, and the apparent objectives of the control system.

2. Interviews

The people interviewed in the second and third rounds of pre-testing were also questioned about state agency personnel and provider staff who had a good command of the purchase of service system in the case study states. Most of these recommended people were later interviewed in the survey.

In State 1, eight state agency staff in three state agencies were interviewed. In State 2, fourteen state agency staff in seven state agencies (four line agencies and three staff agencies) were interviewed.

Providers were chosen based on the recommendations of state agency staff and other providers for their knowledge of the effects of contracting on their agencies. The provider staff interviewed were primarily executive directors or directors for management services.

In State 1, six providers were interviewed including three providers who had single-service programs and three providers who had multiple-service programs. In State 2 nine providers and the contracting expert for the human services providers' association were interviewed. This included one provider who had a single-service program, five providers who had a multiple-service program wholly within State 2 and three providers who had multiple-service and multiple-state programs.

The interviews were semi-structured using the interview format which follows this section. As each interview was conducted, the interviewee was asked to suggest names of other state agency staff and

providers who were knowledgeable about the purchase of service system. The state agency staff who were interviewed were predominantly in the upper-middle management of the state agencies, with the exception of monitoring staff, who tended to be in low to middle management positions. The decision of who to interview was made on the basis of which staff appeared to have the best command of the purchase of service system based on the suggestions of previous interviewees.

In both states, interviewing ceased when it appeared that the information being gathered was for the most part repetitive. In State 1 all interviews were conducted as scheduled. In State 2 interviews with the originally scheduled interviewees were not conducted in three cases. In two of these cases, a lower-level staff person with in-depth knowledge of contracting was interviewed. This did not affect the results. In the third case, the director of a small provider association refused to be interviewed because he/she felt their concern about providers not being able to meet new standards might be communicated by the interviewer to state agencies. A promise of confidentiality resulted in the director's agreement not to interfere in the interviews with members of the association.

In all cases, official copies of the control mechanisms being discussed were obtained and compared to the descriptions given by state agency staff and providers. There appeared to be very little difference among these descriptions of the mechanisms being used in both states.

State 1 interviews were conducted during the months of August, September and October, 1981. State 2 interviews were conducted during the months of November and December, 1981. The length of the interview was designed to be about two hours. The average length of the

interviews conducted was two to two and one-half hours. The time range of the interviews was from one hour to three and one-half hours. In each state, the majority of state agency staff were interviewed first and then the provider staff were interviewed.

3. Survey Instrument

Introduction

People whose names had been selected for interviews were contacted by telephone and told:

"I am Levi Sorrell and I am writing a dissertation at M I T about purchase of service contracting. Your name was suggested to me as someone with whom I should talk. (If asked name of referral source, then specify name.) I would like to set up an appointment with you to discuss (rate-setting/standard-setting/monitoring and the use of monitoring information/client placement/how contracting affects providers like you; (depending on what the person was recommended for)).

If a provider:

"The discussion will center around the specific mechanisms that are used, such as rate-setting, standard-setting, monitoring and client placement, and the effects of these mechanisms on your agency and the service you provide."

If a state agency:

"The discussion will center around the use of (rate-setting/standard-setting/monitoring and the use of monitoring) by your agency."

For all interviewees:

"The interview will last about two hours. Your name will not be associated with any information you provide, nor will your name appear in the dissertation. Do you have any questions about the interview?"

State Agencies

1. General

   a) Who are the key actors in the purchase of services for (name of service) in

      (1) rate-setting?

      (2) contracting?

      (3) standard-setting?

      (4) monitoring? use of monitoring information?

      (5) client placement?

   b) What activities does your unit perform in purchase-of-service contracting?

2. Specific Control Mechanisms

   a) Could you identify and describe the characteristics of each of the mechanisms your unit administers as part of its activities?

   b) What are the effects of (name of mechanism) on providers?

      (1) Mechanism 1

         (a) How did providers respond?

         (b) How did it change the service providers delivered?

         (c) How useful has (name of mechanism) been in allowing you to distinguish between providers?

(d) Were providers involved in the development of this mechanism?

(e) Would other options for this type of mechanism have required more resources or more coordination with other units? Was this an important consideration in the choice of this mechanism? (Specify other options from axes if needed.)

(2) Mechanism 2, as above

(3) Mechanism 3, as above

3. How would you describe the provider market for residential services?

a) Is the capacity of providers larger or smaller than the demand for services?

b) How does this affect your use of the (name of mechanism)?

c) Does this state agency purchase services from providers outside of the state?

If the provider market is multiple-state:

d) How does the presence of a multiple-state provider market affect your use of (name of mechanism)?

4. How does the legislature become involved in the operations of this state agency? Under what conditions? (Follow-up on intensity of involvement.)

5. Can you suggest staff in this and other state agencies, and providers with whom I should talk?

Providers

1. General and Historical
   a) Tell me about the services you deliver.
   b) How long have you been delivering these services and how have the services changed over time?
   c) What state agencies purchase residential services from you?
2. For each state agency, please describe the method of rate-setting, contracting, standard-setting, monitoring and client placement that is used. (Prompt as needed by reading alternatives from the axes.)
   a) State Agency 1:
      (1) Rate-setting
         (a) Description
         (b) What have the effects been on your agency of this method of rate setting? (Characteristics, cost, quality, quantity.)
         (c) Have you found any means of minimizing these effects? (Start off: "You have obviously been able to survive.")
      (2) Contracting
         (a) Description
         (b) What have the effects been on your agency of this method of rate-setting? (Characteristics, cost, quality, quantity.)
         (c) Have you found any means of minimizing these effects?
      (3) Standard-setting

(a) Description

(b) What have the effects been on your agency of this method of standard-setting? (Characteristics, cost, quality, quantity.)

(c) Have you found any means of minimizing these effects?

(4) Monitoring

(a) Description

(b) What have the effects been on your agency of this method of monitoring? (Characteristics, cost, quality, quantity.)

(c) Have you found any means of minimizing these effects?

(5) Client Placement

(a) Description

(b) What have the effects been on your agency of this method of client placement? (Characteristics, cost, quality quantity.)

(c) Have you found any means of minimizing these effects?

(6) Were you involved in the development of any of these mechanisms? Were other providers?

b) State Agency 2: As above

c) State Agency 3: As above

3. How would you describe the provider market for residential services for (state agency name)?

a) State Agency 1

(1) Is the capacity of providers larger or smaller than the demand for services? (If necessary, clarify the differences between "demand" and "need".)

(2) How has this affected the services you deliver?

(3) Are you able to draw clients from outside this community? Outside this part of the state? Outside this state?

(4) What evidence do you have of this?

b) State Agency 2: As above

c) State Agency 3: As above

4. Can you suggest some state agency staff and other providers with whom I should talk?

4. Coding Responses to Conditions

The set of agency actors involved in the control system was divided into three categories: simple, intermediate, and complex. A simple set of agencies existed when all mechanisms were administered by one division of a state agency. An intermediate set existed when one mechanism was administered by a second state agency. The mechanism usually administered in another agency was rate-setting. A complex set existed when at least two state agencies besides the funding agency were involved in the control system. Usually, the mechanisms administered in the other agencies were rate-setting and accreditation/licensing.

The resources committed to monitoring were divided into three categories: few, moderate, and considerable. The evidence of resources committed to monitoring was based on the importance attached to monitoring by state agency staff, and the intensity of monitoring as reported by providers. When state agency staff attached low importance to monitoring and providers reported infrequent monitoring and monitoring that did not result in changes, then the resources were considered few. When state agency staff attached high importance to monitoring, and providers reported frequent visits and monitoring-generated changes, then the resources were considered considerable. Otherwise, the resources committed to monitoring were considered moderate.

The relationship of providers with the legislature was divided into two categories: active and not active. Evidence of an active relationship was admitted if state agency staff could cite numerous examples of the intervention of the legislature on behalf of providers. To distinguish between general political activities on behalf of

constituents and political activities on behalf of service providers, the examples had to be a case of intervention on behalf of all providers, not just one specific provider. Otherwise, the relationship was considered not active.

5. Survey Inadequacies

The survey instrument proved to be inadequate for gathering information on four questions:

1) How does (the particular provider market) affect: your use of (name of the mechanism)?/the services you deliver?

For state agencies:

2) How useful has (name of mechanism) been in allowing you to distinguish between providers?

3) Would other options for this type of mechanism have required more resources or more coordination with other units? Was this an important consideration in the choice of this mechanism?

For providers:

4) Have you found any means of minimizing these effects?

Apparently, there is little variation in the use of mechanisms in different provider markets. At least, little variation could be generated by this question. State agency staff had not used the provider market as a factor in choosing mechanisms. Providers did not respond directly to the question. Rather, they responded with information about the effects of state agency decisions to buy or not buy beds and the shifting of services to state agencies that were expanding, that is, those state agencies where demand exceeded supply.

State agencies were unresponsive to the question about a mechanism's ability to offer information that allows for distinction among providers. The one notable exception was staff at the rate-setting commission in State 2.

State agencies were also unresponsive to the question of resource use and the coordination needed by different mechanism options. Interviewees tended to talk about the resource use and coordination needed by the mechanism actually used. Prompting did not elicit further comment.

Providers responded to the question of minimizing a mechanism's effects by following one of two divergent paths. One path, which I call tactics, stressed such things as end-of-the-year cost loading. The other path, which I call strategies, stressed making accreditation and licensing laws work for and not against providers. While both were appropriate responses to the question, it was impossible to pool the responses according to provider market or type of service. Interviewees in State 1 stressed tactics, while interviewees in State 2 stressed strategies.

CHAPTER 5: SURVEY RESULTS

A. Similarities Between the Case Study States

Providers and state agency staff in both states complained about the lack of clear expectations for performance even though only input standards were found. Providers and state agency staff equated higher quality with more input standards, while at the same time recognizing the difficulties cause by more and more explicit standards. This finding links organizational motivation to personal motivation. The evidence from performance appraisal and management by objectives emphasizes that only where expectations are clear will results be satisfactory. Even though providers recognized that input standards are not sufficient to clarify expectations, they indicated that they did not understand that process and output standards would be any better. The use of performance standards would also lead to cost efficiency and relative efficiency as criteria for evaluating providers. This would make the state's expectations clearer but providers' funding less certain. Providers do not recognize that the clarification of expectations could lead to both clarity and uncertainty.

In both states, state agencies relied on historical relationships with vendors. This could be expected in State 1, where there were few choices to begin with. But it was surprising to find this reliance in State 2 as well. According to one state agency officiel, reliance on known providers reduces the problem of trying to monitor the many potential providers.

B. Differences Between the Case Study States

While State 1 providers were predominantly single service with a single residential facility, State 2's providers were predominantly multiple service with multiple facilities. State 1 in general was a very uncompetitive state, while in State 2 providers appeared to be quite competitive for clients. In general, State 1 has low levels of competition and regionalization potential, while State 2 has high levels of competition and regionalization potential. One of the consequences of this, discovered during pretesting, is that in order to study the services offered by providers in State 1 it was necessary to interview considerably more state agencies in State 2, as providers in State 2 tended to have contracts for a variety of services with a variety of state agencies. In comparison to State 1, where the average provider had one to three contracts with one or two state agencies, in State 2 the average provider had over 4½ contracts for programs with a variety of state agencies. State government funding in State 2 accounted for over two-thirds of the average provider budget among human service agencies contracting with the state. In State 1 there was a central source for allocating clients among providers in each state agency. In State 2 the decentralized decision-making processes for all services was responsible for allocation of clients. The state was divided into regions and sub-regions, each with its own budget. Consequently, according to staff in State 2 there was often competition not only among state agencies for the same slots, but a competition among the regions and sub-regions for these slots. In addition, different regions and sub-regions sometimes attached different requirements to their

Table 5a: Differences Between the Case Study States

ITEM	STATE 1	STATE 2
Level Of Competition	Limited Sources (Low Level of Competition)	Limited Sources/Multiple Sources (Low and High Levels of Competition)
Regionalization Potential	Primarily Single Service, One State Only (Low Potential for Regionalization)	Primarily Multiple Services (High Potential for Regionalization)
Number of Contracts	1-3	4½
Case Allocation	Centralized	Decentralized
Community Monitors	Often Used	Seldom Used

contracts, complicating the requirements for providers. In State 2, unlike State 1, frequent community caseworker presence as a quality assurance tool was not used. The only exception was in services for juvenile delinquents which was administered by a very small state agency. Rather, in State 2 much more effort was put into formal, structured monitoring processes.

C. STATE 1

1. General

In State 1, a separate agency does fiscal audits on-site at a provider's facility. The state agency that funds the mental retardation, mental health, and substance abuse facilities also contains a licensing section. However, the director of the section stated that licensing was only a mildly effective mechanism because the agency has never denied a license. Moreover, as the small licensing staff finds it difficult to verify the activities of vendors, the head of the staff felt that it would be very easy to "beat" the licensure review. Communication about vendors among the program divisions and the licensing section is non-existent. In the words of this chief, "Licensing is the illegitimate step-child of the department."

A five-year-old state study found that 80% of the providers could and would increase their services if the state would provide clients and funding. These providers also indicated a willingness to compete for clients but only if the state would provide clear standards for comparisons among providers. Among state agency staff and providers in State 1, there was agreement that demand for residential services (group homes) exceeded the supply. However, the true constraint is the limited departmental budgets, not the restricted supply. In all programs, the current vendors are those that have always been used by the departments. The state is committed to keeping its residents at facilities within the state, even though it is recognized by staff in state agencies that this limitation reduces the number of providers and inhibits competition.

2. Substance Abuse Facilities

The substance abuse program is run by a division of the agency that also runs the mental health and mental retardation programs. The division has separate sources of funds for drug abuse and alcohol abuse, but the same staff monitors both programs. Rates are set by action of a committee for each service. While there were no comparisons of costs for different service levels, a class rate system (a single rate for similar vendors) was used in alcohol abuse services.

Proposals from providers are used for ranking vendors, but there is seldom much change in the amount each vendor receives, according to state agency staff. The entire state program has always been built around community services, with the same few providers continuing to be chosen. This non-competitive environment is probably due to a lack of effort by the state to develop new community resources. One of the providers expanded across state lines, then across program lines, and is now one of the largest providers found in either case study state.

State agency staff stressed the small size of the state and frequent contact with providers as their most effective monitoring tool. The small size allows any problems to come to the quick attention of the state. The standards used are embellishments of nationally promulgated standards. Monitoring is done by both the substance abuse division and a licensing section within the state agency. The monitoring staff within the substance abuse division indicated that communication with the licensing section was poor and that information did not flow back and forth as well as it should. This opinion was echoed by the licensing section. One state agency staff member indicated that the

Table 5b: STATE 1 Substance Abuse

RATE NEGOTIATION:	Drugs:	Prior Rate and Projected State Budget
	Achohol:	Prior Rate and Monitoring Report (agencies get essentially the same rate and same increase in rate)
PRICING:	Drugs:	Delivering Capability (at a specified occcupancy)
	Alcohol:	Delivering Capability
REIMBURSEMENT:	Drugs:	By Type of Case
	Alcohol:	By Facility
PAYMENT PERSPECTIVE:	Drugs:	Cap Set Prospectively, Rate Set Retrospectively
	Alcohol:	Prospective
CONTRACTING:	Drugs:	Cost Reimbursement (up to a cap)
	Alcohol:	Cost-Sharing
STANDARD-SETTING:	Drugs:	Certification, Licensure
	Alcohol:	Certification, Licensure
MONITORING-WHAT:	Both Services:	A. Terms of the Contract, Quantity of Expected Services Delivered
	Both Services:	B. Fiscal
MONITORING-HOW:	Both Services:	A. Field Audit, Qualitative Assessments
	Both Services:	B. Field Audit
MONITORING-WHO:	Both Services:	A. Performance Audit Team, Community Monitors
	Both Services:	B. Fiscal Audit Team
MONITORING INFORMATION USE-LINKAGES:	Both Services:	Compliance

MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	Both Services:	A. Technical Assistance
	Both Services:	B. Rate Changes
CLIENT PLACEMENT:	Both Services:	Case Manager
LEVEL OF COMPETITION:	Both Services:	Limited Sources
REGIONALIZATION POTENTIAL:	Drugs:	Mixed-Single Service, One State Only, and Multiple Services, Multiple States
	Alcohol:	Single Service, One State Only

monitoring process often gives waivers and rarely closes down a program. Another staffer felt that is is impossible for providers to "game" the rate-setting process to improve their rate. It was remarked that there was more competition in substance abuse than in mental retardation and mental health services. However, reductions in funding will leave only a few large vendors remaining.

Provider staff from drug abuse and alcohol abuse facilities indicated that the standards used by the state were too weak, and in fact, demanded less of the facilities than the internal standards of the agencies. As a consequence, the standards and monitoring did little, except to increase the paperwork of providers. Another consequence of the increasing formalization of the contracting process was that providers had to divert resources from direct services to hire more and better skilled administrative staff.

One operator of a drug abuse rehabilitation facility stated that the formalized standards were really just "common sense" ideas about running an agency. He added that the minimum utilization rate requirement never really resulted in penalties. Nonetheless, the provider could never be sure it wouldn't be, so he developed a tracking system for his clients and established a network for recruiting clients-both methods designed to keep utilization up.

3. Mental Health Facilities

Group homes for the emotionally disturbed are administered by a division of the agency also administering the mental retardation and substance abuse programs. The state is attempting to develop community facilities quickly. Each group home has a specific geographic area from

Table 5c: STATE 1 Mental Health

RATE NEGOTIATION:	Prior Rate and Projected State Budget (all group homes receive same rate and have the same number of beds)
PRICING:	Delivering Capability (at 90% occupancy with a per diem reduction per bed not filled below 90%)
REIMBURSEMENT:	By Facility
PAYMENT PERSPECTIVE:	Prospective
CONTRACTING:	Cost Sharing (becomes cost reimbursement if provider's share cannot be met)
STANDARD-SETTING:	Certification, Licensure, and Accreditation
MONITORING-WHAT:	A. Terms of Contract, Quantity of Services, All Expected Inputs Delivered B. Fiscal
MONITORING-HOW:	A. Program-Desk Audit B. Fiscal-Field Audit
MONITORING-WHO:	A. Self-Report, Community Monitors B. Fiscal Audit Team
MONITORING INFORMATION USE-LINKAGES:	Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Technical Assistance B. Rate Changes
CLIENT PLACEMENT:	Provider Choice

LEVEL OF COMPETITION: Limited Sources

REGIONALIZATION POTENTIAL: Single Service, One State Only

which its clients are drawn. The facilities are associated with either the community mental health centers, or one non-profit organization that operates several facilities.

The state agency staff interviewed place more emphasis on staff visits and the small size of the state ("everybody knows everybody else's business") as a means of monitoring than on a structured monitoring process.

It recognizes that costs are higher than the state rate, but expects providers to collect "rent" from clients. It was noted, however, that the problem with group homes is that "... they are marginal operations with money only for essentials." This leaves no money for reserves and results in low-paid staff. It would be impossible to have facilities compete for clients publicly because a town's citizens don't want ".... 'crazy people' brought in from 'outside'," according to a provider.

Providers found the rate-setting system to be "...like being on welfare..." because any money the provider brought in from outside sources was subtracted from his rate. This provided a disincentive to actively seek additional funds. However, recent cutbacks have caused at least one provider to think about innovative organizational structures, such as a holding company, that would allow the provider an opportunity to operate profitable enterprises under the non-profit umbrella.

4. Mental Retardation Facilities

Group homes for the retarded are administered by the same state agency which funds the mental health and substance abuse programs. The rate for group homes is set by another state agency which administers

the Medicaid program, because all group homes are partially funded with Medicaid funds as Intermediate Care Facilities for the Mentally Retarded (ICF-MR).

The state is attempting to deinstitutionalize and develop more group homes quickly. Each group home has a specific geographic area from which its clients are likely to come. Group homes are now primarily run by an advocacy organization, but the state is considering opening facilities staffed by workers from the state institutions as a means of increasing the number of community facilities.

Remarks by state agency staff members touched upon monitoring, costs, and politics to some extent. The role of monitoring was seen as ensuring that providers know what "...ought to be done." It was perceived that monitoring was some what easier because of a decision to seek providers who were "...service-oriented, not profit-oriented;" though some apparently service-oriented people "... ripped off the system."

Rate-setting was found difficult because "...every facility is viewed as unique." Another difficulty was that many providers had problems finding the financial backing to carry the cash flow while waiting for state payments. One offical noted that if the state ran group homes "...to compete (with the advocacy group)... the state homes would be more expensive..." because they would be staffed by higher-paid state employees. Apparently, the increased demand created by deinstitutionalization has increased the unit costs of group homes.

According to one state official, the state "...played a supplicant role..." to the advocacy organization in trying to get it to expand the group home system. The advocacy group would inform the state agency of

Table 5d: STATE 1 Mental Retardation

RATE NEGOTIATION:	Formal Principles of Reimbursement
PRICING:	Resources Consumed
REIMBURSEMENT:	Per Diem
PAYMENT PERSPECTIVE:	Prospective (with retrospective adjustment)
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Certification, Licensure, and Accreditation
MONITORING-WHAT:	A. All Expected Inputs Delivered B. Fiscal
MONITORING-HOW:	A. Desk Audit, Field-Audit, Qualitative Assessments B. Desk/Field Audit
MONITORING-WHO:	A. Joint Fiscal/Performance Contract Team B. Fiscal Audit Team
MONITORING INFORMATION USE-LINKAGES:	Compliance, Revision of Standards
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Technical Assistance B. Rate Changes
CLIENT PLACEMENT:	Provider Choice

LEVEL OF COMPETITION: Limited Sources

REGIONALIZATION POTENTIAL: Single Service, One State Only

its desired budget and if it was not granted the group would then go to the legislature.

Provider staff indicated that while accreditation standards provided a general framework for operations, they were not an effective deterrent to poor services, since most of the care provided is not visible to the public or monitors. One staff member felt that a greater presence by state staff would lead the residences to be "self-monitoring" while another felt that good relationships had been built with monitors.

Providers liked the cost reimbursement provision attached to the per diem rate determination because they need not be concerned with actual occupancy and because they are reimbursed for actual expenditures.

In general, providers stated that they usually had more referrals than they could handle.

5. Facilities for Abused and Neglected Children

Group homes for abused and neglected children are administered by a state agency for children's services. The state has switched from a state-run, large institutional program to a community-based program split between residential facilities and foster care families. It has been attempting to increase its use of foster care families and decrease its use of residential facilities, but has not been successful in recruiting a sufficient number of families. The state has not put much effort into finding or developing new residential facilities, because staff thought that it would be easier to recruit foster families than it proved to be.

Table 5e: STATE 1 Abused/Neglected Children

RATE NEGOTIATION:	Prior Rate and Projected State Budget (negotiated rate is a cap)
PRICING:	Delivering Capability (at a specified occupancy)
REIMBURSEMENT:	By Facility
PAYMENT PERSPECTIVE:	Cap Set Prospectively, Rate Set Retrospectively
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Licensure, Certification, and Accreditation
MONITORING-WHAT:	A. Terms of Contract, Delivered Services B. Fiscal
MONITORING-HOW:	A. Desk Audit, Field Audit B. Field Audit
MONITORING-WHO:	A. Self-Report, Community Monitors, Performance Audit Team (limited use) B. Fiscal Audit Team
MONITORING INFORMATION USE-LINKAGES:	Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Technical Assistance, Client Placement B. Rate Changes
CLIENT PLACEMENT:	Case Manager

LEVEL OF COMPETITION:	Limited Sources
REGIONALIZATION POTENTIAL:	Mixed: Single Service, One State Only, and Multiple Services, One State Only

Recently, State 1 has invited providers who are established in other states to open facilities within its borders. This was just beginning to occur during the study period (August - October, 1981).

Providers stressed that agency standards were lower than their own. While standards enforcement was thus often a nuisance, frequent visits by state staff and the long-standing relationships already established severed to keep providers "on their toes." One program is open to state review by choice and incorporates a self-monitoring process based on a management-by-objectives system. This program occasionally hires outside evaluators at great expense.

The rate-setting process of establishing a cap prospectively and setting an actual rate retrospectively created an incentive to spend all monies available. One provider felt that the state should allow a surplus operating cushion as well.

At least one program operator had an excess bed capacity, and believed that this was the norm for all similar providers in the state.

D. STATE 2

1. Rate-Setting Agency

State 2 has a separate quasi-judicial rate-setting agency which must approve all rates. The agency has a two-fold mission: to constrain costs and to maintain the viability of the provider market. Evidence of this dual mission can be seen in the opposition to "class rates" based on vendor comparisons which might constrain costs, because their use might be detrimental to the current provider market. Staff see their role as instituting their opinion of good management and substituting it for that of the vendors. According to one staffer at the governor's office, the mandate of the agency makes it as much an advocate for providers as an executive agency.

Rate-setting agency staff were concerned that there was insufficient funding to pay for the standards promulgated by state agencies. This problem results from the tendency for standards to be aspirational.

The rate-setting agency staff has been urging state agency staff to establish standard service elements by which contracting and rate-setting comparisons could be made. However, this standardization has not yet occurred because vendors always believe their programs are unique and they have had the power, so far, to prevent standardization.

The vendors in the state tend to be multiple-service, single-state providers. Although they may be geographically limited, the providers do overlap the regions and sub-regions of the state. This allows them, according to one rate setting agency staff member, "... to threaten to 'take our business elsewhere,'" if state agency staff are too tough.

The decentralization of services to sub-regions has resulted in "strong grass roots political support for social services," as one agency staffer analyzed it.

State agency staff responsible for contracting felt that the rate-setting agency slows down rate increases when state agency budgets are expanding and keeps rates high when state agency budgets are constricting. State agency staff felt that one effect of the rate-setting agency upon rates is that even when unit price contracts are in effect, providers get a higher or lower rate in the future based on allowed costs and actual utilization. This has the effect of changing a unit price contract into a cost reimbursement contract.

The costs of vendors related only to their contracts with one state agency are examined, even though multiple agency funding sources is the dominant mode of operation. The agency has forced de facto cost sharing upon providers, according to several providers, through selective disallowances of costs. For example, until recently capital expenditures were not an allowable cost.

State 2 has a requirement that contracts must be let out for competitive bidding. Competitive bidding assumes multiple providers and multiple consumers, but the reality is that the state is the primary consumer and that providers may only be engaging in an oligopolistic non-price competition, because the rate is independently set by the rate setting agency.

2. Governor's Office

The cabinet level agency for human services within the Governor's Office sets the terms of contracts for all contracted human services.

While this cabinet level office in State 2 might have served as a coordinating body, its functions appear to be more related to fiscal oversight and resource allocation. One staff member questioned whether the state could afford to pay for the standards for its services, given the costs of compliance which providers pass along to the state. He suggested that part of the problem that state agencies are having is that they are "...still operating in an expanding economy mode and are concentrating on contract development and not monitoring and evaluation." Further, since state agencies had to develop vendors, most human service providers are under five years old and are entirely creatures of the state. However, the state agencies are stuck with regulations that "...force competition when there really aren't any competitors."

3. Accreditation Agency

State 2 has a separate accreditation agency which sets standards for all programs with clients up to the age of sixteen. Most state agencies use these standards for programs with clients up to and including the age of twenty-two if they are also subject to the accreditation agency standards. Several of the departments also have accreditation standards for their own programs. It is unclear to providers and to some state agency staff where the dividing line of responsibility is between the departments and the separate accreditation agency. At times, the accreditation agency and the departments have promulgated conflicting standards. Providers indicated that the accreditation agency had an inconsistent enforcement pattern and the violations that were cited varied considerably between different

surveyors.

It was also believed by accreditors that a provider could meet the standards but still fail to provide quality service. The reasons for this failure were:

1) High staff turnover prevented consistency of programming
2) Agencies are effective with one type of client but sometimes not with a different type of client
3) Agencies may use ineffective modes of treatment
4) Some agencies are "closed programs" where no one will tell you the "straight scoop"; the staff and clients are either afraid or have bought into the treatment modality
5) The "tone" of a provider's facility may not seem acceptable to accreditors, but nothing objective can be found wrong
6) Providers with many clients who pay directly, are not as reactive to pressure from state agencies.

Deaccreditation or denial of accreditation is, however, rare throughout the state, and the accreditation process is usually a process of vendor improvement.

One staff member of the accreditation agency commented that if a provider is "responsive," then it would be less likely to receive a formal legal deficiency notice and, instead, would receive a month in which to correct deficiencies. Of course, as one staff member related, the lack of sufficient legal backup means that the agency is much more more likely to give providers additional time to make corrections anyway, rather than follow a formal deficiency process that might be indicated based on the number of deficiencies. Staff believed that the process works because it is "...important for providers to know they are

being watched." Good providers attempt to use the process to improve their facilities.

Staff also indicated the there is no clear contracting system; the state is not sure what it is buying, and providers are not sure what they are supposed to provide.

4. General

The process of negotiating and establishing contracts in State 2 involved considerable paper work and several levels of bureaucratic review. There had evolved a rationalization, according to state agency staff in two departments, that the multiple reviews insured accountability. This had recently been exposed as a myth by state agency staff and independent community oversight monitors. As might be expected, this compartmentalization of reviews fostered a situation in which everyone thought someone else was performing the reviews.

The allocation of clients to services in the state is apparently problematical with each service program trying to remain within budget by switching clients into other programs or getting other programs to pay part of the cost of care. The problem is most acute in children's services, where two providers indicated that some one could talk to children in their facilities and not be able to distinguish children referred from the program for mental health for children, the program for abused and neglected children, and the program for juvenile delinquents.

5. Substance Abuse

Drug abuse and alcohol abuse community facilities began as self-help programs with ex-abusers as counselors. The current emphasis on professional care staff is a response to initiatives from state agencies and insurance companies as a means of guaranteeing reimbursement. The cost of these programs rose because of this change in delivery model, and because a professional management staff also became necessary when dealing with the state and insurance bureaucracies.

a) Drug Abuse Facilities

Group homes for drug abusers are funded by a division of the state agency that also administers the mental retardation, mental health for adults, and mental health for children programs. Due to adverse community pressure, there has never been a large number of providers. According to one staff member, drug abuse facilities have always been a private enterprise. In each region of the state there may be only one or two providers. Moreover, the regions, according to central office state agency staff, are not likely to share facilities. However, according to state agency staff, while need exceeds the supply of residential services, the current demand does not. There is no ready pool of clients pressuring the community residential system for slots.

A staff member from the state social service agency indicated that the divisions of the state mental health agency attempt to renegotiate rates downward when they buy part of a program. This generates complaints about underfunding from providers who also have contracts with other state agencies.

Provider staff indicated that the state standards lagged behind the

Table 5f: STATE 2 Substance Abuse-Drugs

RATE NEGOTIATION:	Formal Principles of Reimbursement (subject to bid and negotiation based on state agency budget and components of service)
PRICING:	Vendor Choice 1. Delivering Inputs (approved line item budget) 2. Unit Pricing
REIMBURSEMENT:	Vendor Choice (depends on choice of pricing) 1. By Facility 2. Per Diem
PAYMENT PERSPECTIVE:	Prospective (with current year and retrospective adjustments)
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Certification, Licensure, and Accreditation (inside agency-primarily around components of the service)
MONITORING-WHAT:	A. Fiscal B. Terms of Contract, All Expected Inputs Delivered C. Quantity of Expected Services Delivered
MONITORING-HOW:	A. Desk Audit B. Field Audit C. Desk Audit (verified by field audit)
MONITORING-WHO:	A. Self-Reports B. Performance Audit Team C. Self-Reports and Performance Audit Team

MONITORING INFORMATION USE-LINKAGES:	A. Planning
	B. Compliance
	C. Planning
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes
	B. Nothing: Done Irregularly
	C. Rate Changes
CLIENT PLACEMENT:	Case Manager
LEVEL OF COMPETITION:	Limited Sources
REGIONALIZATION POTENTIAL:	Mixed: Multiple Services, One State Only, and Single Service, One State Only

internal standards of the providers and merely created more record-keeping. Providers proposed goals for their programs, but, according to one of the largest providers, "...no one really measured whether the goals as proposed...were achieved," Surveyors, instead, "focused in on broad things."

Guided by a desire to expand, according to a multiple state provider that started in drug abuse facilities, the vendor shifted the population to be dealt with from older to younger clients and across state lines. Eventually, the provider became a general human services agency with a diversified funding base that included contracts for services with five states and the federal government.

b) Alcohol-Abuse Facilities

Alcohol-abuse programs are administered by the state health department, many of whose other duties are regulatory. Group homes for alcohol abusers were part of an existing community network before state funding began. Many of the facilities started out as "rooming houses" where ex-abusers would provide sleeping space for alcoholics trying to recover.

State funding has been slow to increase. Initially, the welfare department provided a very small stipend to residents. The alcohol recovery homes had a great deal of trouble convincing state agencies to give them a rate. The rate-setting commission could not give them a rate unless they were licensed, so the providers went to the licensing agency and helped them develop a licensing mechanism. The providers, according to one home manager, faced adversity from every direction. According to this provider, "The only thing the state people understand

is a program which follows the models they are used to; they don't know what to do with an innovation." The new legislation to provide insurance for alcohol-related problems may create additional demand. In the meantime, supply exceeds demand from the state's point of view. Since these facilities are now considered a type of health facility, they are subject to certificates of need which may reduce the bed supply.

The providers were instrumental in the development of new standards, but there is now widespread concern among providers because they cannot meet the standards under current funding restraints. According to one provider, the standards were set high as a way of getting the state to pay for an increase in quality, even though few if any of the providers could meet the new standards. One state agency staff member stated, "There is a loss between the licensing regulations and what happens" because there is a "...real constraint not to de-license programs."

The providers, according to the largest recovery home manager, are caught in a dilemma. The state agency staff and insurers "...know the program works better than anything else they [the state and the insurers] have, but they insist on things like professional staff." The providers want to be free to choose the type of staff which their service model requires, but can not be if they are going to get the funds they need to survive. "...as times go by, recovery homes will be sucked into being just another institution."

Currently, the "competition" between homes is a non-price competition. Based on a home's units of service, the state buys a percentage of the facility at 95% capacity. The percentage of the

Table 5g: STATE 2 Substance Abuse-Alcohol

RATE NEGOTIATION:	Prior Rate and State Agency Budget (rate is essentially the same for all facilities)
PRICING:	Delivering Capability (at 95% occupancy)
REIMBURSEMENT:	By Facility
PAYMENT PERSPECTIVE:	Prospective
CONTRACTING:	Cost Sharing (state buys a fixed percentage of units)
STANDARD-SETTING:	Certification, Licensure, and Accreditation (inside agency - primarily around components of the service)
MONITORING-WHAT:	A. Fiscal
	B. Services Delivered, Terms of Contract
MONITORING-HOW:	A. Desk Audit
	B. Field Audit
MONITORING-WHO:	A. Self-Reports
	B. Performance Audit Team
MONITORING INFORMATION USE-LINKAGES:	A. Planning
	B. Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes
	B. Technical Assistance, Client Placement
CLIENT PLACEMENT:	Case Manager

LEVEL OF COMPETITION: Multiple Sources (primarily in-state)

REGIONALIZATION POTENTIAL: Single Service, One State Only

facility that the state buys is relatively uniform, except for historical differences. To encourage competition, the state is considering buying a non-uniform percentage of facilities. However, one staff member felt that a price competition is not possible, because the unit of service is not well defined.

The provider association is an important actor particularly in its role as a negotiator for the homes, according to a staff member of the state agency.

6. Mental Health Facilities for Adults

Group homes for adults with mental health problems are administered by a division of the state agency that also funds the mental retardation, drug abuse, and mental health programs for children. Demand for services exceeds the supply but due to processing delays for clients as well as the incentives for providers to keep beds empty, the group homes have a high vacancy rate. However, there are court orders forcing deinstitutionalization and thereby increasing the demand for services.

A staff member from the state social service agency indicated that the divisions of the state mental health agency attempt to renegotiate rates downward, when they buy part of a program. This generates complaints from providers. However, a staff member of the division of mental health services for adults stated that the division is "...bending over backwards to develop and keep vendors." In fact, the division is not waiting for community pressure to open facilities but instead is agressively seeking new vendors. As there is no clause in the division's contracts to force vendors to take clients, there is no

incentive for providers to fill a group home quickly.

Staff stated that sub-region state agency directors were not protected by the state agency by giving them contracting guidelines so they could avoid negotiating with providers entirely from a position of weakness.

Standards were seen by one provider as excessive, but necessary because of the high staff turnover. One criticism of standards was that they focused in too much on the physical facility and external program structure (e.g., staffing ratios). While adherence to the standards would have some indirect effect on the quality of service, they more directly raised costs, reduced flexibility, and engendered a wariness towards innovation.

The state reimbursement policy further inhibited innovation and expansion as there was constant downward negotiation of rates and recapture of excess funds. One provider stated that most operators "hedge" on their rate-setting agency reports because "... too many hours of direct service reduces your rate, but too few hours makes you look unproductive." The rate-setting policy was described as having "no impact on decisions, making administrators worry and having no impact on quality of care."

Providers had a number of comments regarding the purpose and effectivenss of deinstitutionalization. One respondent saw the role of community facilities as a way of eliminating the two class system for care; but he felt it had yet to work well. Another saw the development of purchase-of-service contracting as a way for the state to cap mental health funding, "bust" state employee unions, expedite the curtailment of services, and create competition. He felt that the state is now

Table 5h: STATE 2 Mental Health-Adults

RATE NEGOTIATION:	Formal Principles of Reimbursement, (subject to bid and negotiation based on state agency budget and components of service)
PRICING:	Vendor Choice 1. Delivering Inputs (approved line item budget) 2. Unit Pricing
REIMBURSEMENT:	Vendor Choice (depends on choice of pricing) 1. By Facility 2. Per Diem
PAYMENT PERSPECTIVE:	Prospective (with current year and retrospective adjustments)
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Certification, Licensure
MONITORING-WHAT:	A. Fiscal B. Terms of Contract C. Quantity of Expected Services Delivered
MONITORING-HOW:	A. Desk Audit B. Field Audit C. Desk Audit
MONITORING-WHO:	A. Self-Reports B. Performance Audit Team C. Self-Reports

MONITORING INFORMATION USE-LINKAGES:	A. Planning
	B. Compliance
	C. Planning
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes
	B. Nothing - Done Irregularly
	C. Rate Changes
CLIENT PLACEMENT:	Provider Choice
LEVEL OF COMPETITION:	Limited Sources
REGIONALIZATION POTENTIAL:	Multiple Services, One State Only

worried that collusion between providers will destroy a free, competitive market, and that the state is attempting to "homogenize" contracts to allow for easier monitoring.

One respondent pointed out that community residences were initially easy to establish and fill, but that growing local resistance has made it difficult to establish residences for more severely disturbed clients.

7. Mental Health Facilities for Children

Group homes for children in need of mental health services are administered by a division of the state agency that also funds the mental retardation, drug abuse, and mental health for adults programs. There has been a long history of community residential facilities, and currently, the bed supply in such facilities exceeds the demand for services.

A staff member from the state social service agency indicated that the divisions of the state mental health agency attempt to renegotiate rates downward, when they buy part of a program. This generates complaints of underfunding from providers who also contract with other state agencies. According to a member of the staff of the division of mental health services for children, if a provider comes in with a rate that is too high, the division "enters into competitive negotiation to lower the rate."

One staff member emphasized that monitoring information may not be very important, because the current vendors are so "politically entrenched" that it is very difficult to change vendors or to modify their behavior.

Table 5i: STATE 2 Mental Health-Children

RATE NEGOTIATION:	Formal Principles of Reimbursement, (subject to bid and negotiation based on state agency budget and components of service)
PRICING:	Delivering Inputs (approved line item budget)
REIMBURSEMENT:	By Facility
PAYMENT PERSPECTIVE:	Prospective (with current year and retrospective adjustments)
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Certification, Licensure, and Accreditation (outside agency)
MONITORING-WHAT:	A. Fiscal B. Terms of Contract, All Expected Inputs Delivered
MONITORING-HOW:	A. Desk Audit B. Qualitative Assessments
MONITORING-WHO:	A. Self-Reports B. Client Feedback and Performance Audit Team
MONITORING INFORMATION USE-LINKAGES:	A. Planning B. Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes B. Technical Assistance, Client Placement, Termination
CLIENT PLACEMENT:	Case Manager

LEVEL OF COMPETITION: Multiple Sources (primarily in-state)

REGIONALIZATION POTENTIAL: Multiple Services, One State Only

Providers' criticisms indicated an absence of continuity and relevance between standards and practice. There is a "tight relationship between on-going practices and formal standards," whereby sub-regional differences in standards are merely resolved by adherence to the standards of the largest contracting region or the most forceful case manager." It was noted that the state faced a problem because the "...same people who do reviews also ante up the bucks; so reviewers may be reluctant to be too forceful." In a similar vein, staffing models (ratios) were perceived as unenforceable because the state "knows it can't afford to pay for them." One provider stressed that the free-market competition notion was faulty, because the state is responsible for client referral, and thereby for demand. This provider expressed a preference for reimbursement contracts when there was a problem of low occupancy.

8. Mental Retardation Facilities

Group homes for the retarded are administered by a division of the state agency that funds the drug abuse, mental health services for adults, and mental health services for children programs. Despite a high vacancy rate, demand is considered greater than supply because there is a ready pool of clients in institutions waiting to enter community residences. This queue is backed by court orders to push people into community residences as quickly as possible.

State agency staff indicated that monitoring staff cite only those problems that the legislature might provide funds to improve, i.e., citing is done if it is politically expeditious. Further, staff felt that there is a severe drawback to aggressive enforcement: closing

facilities creates more problems than it solves because there are few open beds for the displaced clients.

In the previous year, only three licenses out of 400 licensed programs were revoked. There is a process for providers with deficiencies to be given time to improve, so most providers are licensed with deficiencies.

The state also has a monitoring program which compares the aggregated client needs within a facility to the services available to meet those needs. However, there is no link to the budget process for making corrections, as there is in licensing.

The staff also brought out the "non-price" negotiation process as a way of reducing input use, reducing costs, and getting more service time within the state agency budget. They stressed the "free form" of the negotiation process, which may even involve negotiating for or against specific people.

Fiscal evaluations are only aimed at uncovering fraud, and an audit occurs at a provider agency primarily "...in response to a situation that is about to blow up." No studies of cost effectiveness are undertaken, although the division of mental retardation has some of the best data of all state agencies about their clients and provider effectiveness.

State agency staff said that they encourage providers to "end-run" the purchase-of-service system because it does not work very well. Contracts are felt to be a game, and vendors may not deliver what the purchase order states they will deliver.

They stated that there is increasing pressure from the "overhead agencies" (presumably, the Governor's Office, the Controller, the

Table 5j: STATE 2 Mental Retardation

RATE NEGOTIATION:	Formal Principles of Reimbursement (subject to bid and negotiation based on state agency budget and components of service)
PRICING:	Delivering Inputs (approved line item budget)
REIMBURSEMENT:	By Facility
PAYMENT PERSPECTIVE:	Prospective (with current year and retrospective adjustments)
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Certification, Licensure, and Accreditation (Inside Agency for Adults; Outside Agency for Children)
MONITORING-WHAT:	A. Fiscal B. Terms of the Contract, All Expected Inputs Delivered
MONITORING-HOW:	A. Desk Audit B. Qualitative Assessments
MONITORING-WHO:	A. Self-Reports B. Client Feedback and Performance Audit Team
MONITORING INFORMATION USE-LINKAGES:	A. Planning B. Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes B. Technical Assistance, Client Placement, Termination
CLIENT PLACEMENT:	Provider Choice

LEVEL OF COMPETITION: Limited Sources

REGIONALIZATION POTENTIAL: Mixed: Multiple Service, One State Only, and Single Service, One State Only

Attorney General, etc.) to drop the purchasing of services and to have the state deliver the services directly because contracting is so troublesome.

Provider staff indicated that at least part of the reason that demand exceeded supply was that the state agency's reimbursement philosophy makes current providers reluctant to expand or innovate. The reimbursement philosophy pushes negotiations with providers to lower providers, costs, to reduce the use of inputs, and to have the state recapture any excess costs.

One provider saw the division of mental retardation in a real regulatory bind, because it has single service and multiple service providers. "The goals of single service agencies, where length of stay is most important," differ from those of multiple service agencies. "...where length of stay may not be as important, particularly if the multiple service is a range of care."

9. Facilities for Abused and Neglected Children

Group homes for abused and neglected children are administered as a part of the service program in the state social service agency. They were previously administered by a division of the state welfare agency. The state has changed its preferred treatment modality to one which is not based on group residential care. This has resulted in an excess of residential beds. Many facilities which provided this type of care also provided residential special education services. Consequently, these facilities are experiencing considerable pressure as the demand for both types of residential care decline.

State agency staff indicated that they often engage in a non-price negotiation with providers, in which the number of units of service to be purchased, the components of the service, or the job descriptions are rewritten in order to reduce the state's costs.

They stated that they can not really enforce the standards because the standards are not well developed. The state is attempting to develop standards which would be valid for residential care. According to one staff member, "Until we have standards, we cannot monitor." While the "...official policy is to monitor, ... no frequency is specified." Consequently, monitoring is usually done when there is a problem (as evidenced by newspaper stories about a facility). Case workers occasionally visit providers, but they bring no monitoring instruments and may or may not write down what they see. Primarily, they are visiting a facility only to check on a client.

When three providers said the contracting system was inflexible, I brought up the negotiation process used to modify service components and rates. They reacted as though they did not know anything about the negotiation process. One provider reacted as though he was being asked a trick question aimed at determining if something illegal was going on.

Providers stressed that they were able to use the monitoring process to get funding for improvements they wanted to make. One provider stressed the relationship between licensing standards and quality. This provider saw monitoring as a means of improving his physical plant and therby improving the environment for care.

One provider commented that the state does not tell providers what services it wants delivered. Rather, a provider tells the state what

Table 5k: STATE 2 Abused/Neglected Children

RATE NEGOTIATION:	Formal Principles of Reimbursement (agency buys marginal units of service and accepts the rates negotiated by other providers)
PRICING:	Unit Pricing
REIMBURSEMENT:	Per Diem
PAYMENT PERSPECTIVE:	Prospective (with current year and retrospective adjustments)
CONTRACTING:	Unit Price
STANDARD-SETTING:	Certification, Licensure, and Accreditation (Outside Agency)
MONITORING-WHAT:	A. Fiscal
	B. Terms of Contract, All Expected Inputs Delivered
MONITORING-HOW:	A. Desk Audit
	B. Qualitative Assessments
MONITORING-WHO:	A. Self-Reports
	B. Client Feedback and Performance Audit Team
MONITORING INFORMATION USE-LINKAGES:	A. Planning
	B. Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes
	B. Technical Assistance, Client Placement
CLIENT PLACEMENT:	Case Manager

LEVEL OF COMPETITION: Multiple Sources (primarily in-state, but crosses state regions)

REGIONALIZATION POTENTIAL: Mixed: Multiple Services, One State Only, and Multiple Services, Multiple States

type of program it has and the state decides how many units of service to buy.

There is a "...fiction of rate-setting - what it really costs is not what the department is willing to consider for costs." The provider continues to contract with the state agency, however, because of its long-standing commitment to service and its large endowment.

A multiple-service provider felt that the problem with contracting with the state is that each state agency and the regions and sub-regions want information packaged in a different way. This adds considerably to administrative costs. Another asserted that as the state agency limits the number of days of care they will pay for, the shape of the service provided will be changed. There may no longer "... be room for kids who are exceptions to the rule." If the limits are too rigid fewer clients will be served appropriately.

10. Special Education Facilities

The special education group home (residential care program) is run by the state education department. The state had been a national leader in special education. The results of legislative changes in the last decade have been to shift the treatment modality and locus of response to communities. This has created an excess supply of community residential services.

The state agency does not suspend providers as often as staff members think it should. In part, this is because disapproval is a lengthy process and the agency has too small a staff to act tough. Consequently, "... a provisional (approval) may be used when

Table 51: STATE 2 Special Education

RATE NEGOTIATION:	Formal Principles of Reimbursement (subject to bid and negotiation based on state agency budget and components of service)
PRICING:	Delivering Inputs (approved line item budget)
REIMBURSEMENT:	By Facility
PAYMENT PERSPECTIVE:	Prospective (with current year and retrospective adjustments)
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Certification, Licensure, and Accreditation (outside agency and inside agency)
MONITORING-WHAT:	A. Fiscal B. Terms of Contract, All Expected Inputs Delivered
MONITORING-HOW:	A. Desk Audit B. Qualitative Assessments
MONITORING-WHO:	A. Self-Reports B. Client Feedback and Performance Audit Team
MONITORING INFORMATION USE-LINKAGES:	A. Planning B. Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes B. Technical Assistance, Client Placement, Termination
CLIENT PLACEMENT:	Case Manager

LEVEL OF COMPETITION: Multiple Sources (primarily in-state, but crosses state regions)

REGIONALIZATION POTENTIAL: Multiple Services, One State Only

suspen(sion) might be a better option if a school has a lot of things to correct."

One large provider staff member stated that he preferred the tough compliance stance of the special edcuation division, because it forced the rate setting agency to pay for changes. He also indicated that he immediately makes changes so that he can maintain good relations with the contracting agencies. Another noted that as a result of standards, providers are a safer place for clients and the food quality has improved. It was noted that the problem with the state's standards is that they are drawn up quickly, and once written, are difficult to change. The standards are also poorer because the state did not seek input from providers. One provider thought that as the state agency encreased emphasis on keeping clients within a sub-region for service, competition would increase and many small providers would be driven out. While the state's standards require considerable paperwork of providers, providers comply because there is an oversupply of residential beds.

11. Facilities for Juvenile Delinquents

Group homes for juvenile delinquents are administered by a state agency which runs the juvenile justice program in the state. Many of the current providers for all services started contracting with the state when services for juvenile delinquents were deinstitutionalized, but have since reduced or curtailed contract services due to reduced demand, and because other clients are considered more desirable, having less severe problems. The supply of services far exceeds the demand for services and many providers are reducing the beds alloted to this service.

Several providers indicated that one of the best monitoring mechanisms is the frequent visitation strategy of the juvenile delinquency program. The providers believed that the relatively flat organizational structure of the state agency allowed information about providers to flow up and down rapidly.

Although the frequent caseworker contact with providers was often mentioned by providers, it was not by state staff, who stressed the more formal monitoring mechanisms. State staff emphasized their attempts to make monitoring a more positive mechanism to be used for provider improvement. Efforts were being made to use monitoring information as a basis for technical assistance and for sharing good information (positive program aspects) with other providers. Staff also stressed the involvement of providers in the development of evaluation instruments.

One provider suggested a concern about getting caught in contradictory expectations between the rate-setting agency, the accreditation agency, and state agency program staff. Another provider suggested that the value of standards as they exist now is that they force you to think about what it is that you do, but still felt that the standards have little effect on what providers do.

It was noted that there is considerable variation among regions regarding services requested and those that are affordable. Providers adapt to "the craziness of state agencies rather than taking less kids from one or another state agency." They agree to whatever regions and sub-regions want in order to expedite the contract process. The need for coordination in the development of standards was emphasized.

The lack of clear standards is partly attributed to the inexperience of the state negotiators. A provider felt that the negotiation process is a "joke" because the "...agency says we have X dollars .." and the providers must determine and develop the service those dollars can buy.

While purchase of service contracts seemed to be the "only way to survive," according to one provider, his agency could cover only sixty percent of its actual costs at the rate provided by the state. This provider was able to survive because it is a prestigious and well-endowed institution. The rate-setting formula contains the paradox that a provider gets a better rate if it has no endowment, but without and endowment, providers must cut corners.

Providers felt that the state sought to buy the cheapest service available, regardless of quality, as long as the facility is licensed and accredited. Budget cuts seem always to come in the more expensive program areas, which often serve the neediest clients. A related result is that at least one provider takes children on the basis of the anticipated resources to support the child, so that the most needy clients are the least likely to be accepted.

Several weaknesses in state planning for the provider market were noted. A provider who had diversified into other services felt that there was no state planning behind existing diversification. The impetus, in his view, was the initiative of individual provider staff who could foresee service extension possibilities and the state's request for the start-up of a new program. Rates and regulations did not seem to have an impact on diversification, while the ensuing multiple contracts have allowed providers to pay higher salaries to

Table 5m: STATE 2 Juvenile Delinquency

RATE NEGOTIATION:	Formal Principles of Reimbursement (subject to bid and negotiation based on state agency budget and components of service)
PRICING:	Unit Pricing
REIMBURSEMENT:	By Facility
PAYMENT PERSPECTIVE:	Prospective (with current year and retrospective adjustments)
CONTRACTING:	Cost Reimbursement
STANDARD-SETTING:	Certification, Licensure, and Accreditation (outside agency)
MONITORING-WHAT:	A. Fiscal B. Terms of Contract, All Expected Inputs Delivered
MONITORING-HOW:	A. Desk Audit B. Qualitative Assessments
MONITORING-WHO:	A. Self-Reports B. Client Feedback, Community Monitors and Performance Audit Team
MONITORING INFORMATION USE-LINKAGES:	A. Planning B. Compliance
MONITORING INFORMATION USE-CHANGES IN VENDOR BEHAVIOR:	A. Rate Changes B. Technical Assistance, Client Placement, Termination
CLIENT PLACEMENT:	Case Manager

LEVEL OF COMPETITION: Multiple Sources (primarily in-state, but crosses state regions)

REGIONALIZATION POTENTIAL: Mixed: Multiple Services, One State Only, and Multiple Services, Multiple States

administrative and supervisory staff. Some providers stated that the state agency has failed to meet its potential as a facilitator in developing services to match client need.

Finally, one provider indicated that the state agency maintains a "tight rein" by maintaining a close relationship between the central office and case managers. Case managers relay perceptions of a program upwards to central office staff. The provider staff are "always aware that first impressions are important" in their relationship with state agency staff. Public oversight, according to this provider, "provides a pressure to run an adequate program."

Chapter 6: Analysis of Survey Results

A. Typology of the Provider Market

The typology of the provider market used in this analysis is based on the level of competition and the degree of regionalization potential. Competition is a proxy measure of the ability of state agencies to choose among providers. Regionalization potential is a proxy measure of the ability of providers to choose among state programs. The level of competition is more likely to be high when there are multiple sources from which the state may choose, and the level of competition is more likely to be low when there are sole sources or limited sources of providers. There is a greater potential for regionalization where providers can draw on multiple programs for clients. This would include a single service in multiple states, multiple services in one state as well as mutliple services in multiple states. There is a low potential for regionalization where providers depend on one program in one state.

When state choice is high the state is not dependent on a few providers. However, the state will face a problem of paying for the high cost of overhead in myriad small providers. According to one state agency official in State 2, this problem has reached such substantial proportions that the state is considering operating its own community facilities. The lesson learned from health care is that competition under these conditions may actually increase the cost per slot.

When state choice is low, the state is dependent on the provider market. The provider market is in a position to dictate the terms of cost and quality.

Providers with high choice are likely to attempt to control their case mix and program content so as to capture better rates, better

TABLE 6a: Typology of the Provider Market

		PROVIDER CHOICE	
		LOW	HIGH
STATE CHOICE	LOW	Single Service/One State Only Sole Source/Limited Sources	Single Service/Multiple States Multiple Services/One State Only Multiple Services/Multiple States Sole Source/Limited Sources
	HIGH	Single Service/One State Only Multiple Sources	Single Service/Multiple States Multiple Services/One State Only Multiple Services/Multiple States Multiple Sources

clients, less regulation, and lower standards. These providers are not very susceptible to state agency control.

Providers with low choice are more vulnerable to the demands of state agencies since these providers are dependent on one state for their existence. It would be expected that providers would attempt to mitigate the state's control.

Table 6b: Competition Low/Regionalization Potential Low

	State 1 Mental Health	State 1 Mental Retardation	State 1 Drug Abuse (Partially)	State 2 Drug Abuse (Partially)
CONDITIONS				
Resources Committed to Monitoring	Few	Considerable	Moderate	Few
Set of State Agency Actors	Simple	Intermediate Set	Simple	Intermediate
Relationship with Legislature	Active Relationship	Active Relationship	Not Active	Active Relationship
Control Objective	Cost	Mixed	Mixed	Cost
MECHANISMS				
Rate Negotiation	Prior Rate and State Agency Budget	Formal Principles of Reimbursement	Prior Rate and State Agency Budget	Formal Principles of Reimbursement
Pricing	Delivering Capability	Resources Consumed	Delivering Capability	Delivering Inputs or Unit Pricing
Reimbursement	Facility	Per Diem	Type of Case	Facility or Per Diem
Payment Perspective	Prospective	Prospective	Retrospective	Prospective

Table 6b	State 1 Mental Health	State 1 Mental Retardation	State 1 Drug Abuse (Partially)	State 2 Drug Abuse (Partially)
MECHANISMS cont'd				
Contract Process	Cost Sharing	Cost Reimbursement	Cost Reimbursement	Cost Reimbursement
Standards	Certification, Licensure, Accreditation	Certification, Licensure, Accreditation	Certification, Licensure	Certification, Licensure Accreditation
Monitoring-What	Terms of the Contract, Fiscal, Quantity of Expected Services, All Expected Inputs	Fiscal, All Expected Inputs	Terms of the Contract, Fiscal, Quantity of Expected Services	Terms of the Contract, Fiscal, Quantity of Expected Services, All Expected Inputs
Monitoring-How	Desk Audit, Field Audit	Desk Audit, Field Audit, Qualitative Assessments	Field Audit, Qualitative Assessments	Desk Audit, Field Audit
Monitoring-Who	Self-Reports, Fiscal Audit Team, Community Monitors	Joint Fiscal/ Performance Audit Team, Fiscal Audit Team	Fiscal Audit Team, Performance Audit Team, Community Monitors	Self-Reports, Performance Audit Team
Client Placement	Provider Choice	Provider Choice	Case Manager	Case Manager

Table 6b	State 1 Alcohol Abuse	State 1 Abused/Neglected Children (Partially)	State 2 Mental Retardation (Partially)
CONDITIONS			
Resources Committed to monitoring	Moderate	Few	Moderate
Set of State Agency Actors	Simple	Simple	Complex
Relationship with Legislature	Not Active	Not Active	Active Relationship
Control Objective	Mixed	Cost	Mixed
MECHANISMS			
Rate Negotiation	Prior Rate and State Agency Budget	Prior Rate and State Agency Budget	Formal Principles of Reimbursement
Pricing	Delivering Capability	Delivering Capability	Delivering Inputs
Reimbursement	Facility	Facility	Facility
Payment Perspective	Prospective	Retrospective	Prospective

Table 6b	State 1 Alcohol Abuse	State 1 Abused/Neglected Children (Partially)	State 2 Mental Retardation (Partially)
MECHANISMS cont'd			
Contract Process	Cost Sharing	Cost Reimbursement	Cost Reimbursement
Standards	Certification, Licensure	Certification, Licensure, Accreditation	Certification, Licensure Accreditation
Monitoring-What	Terms of the Contract, Fiscal, Quantity of Expected Services	Terms of the Contract, Fiscal, Delivered Services	Terms of the Contract Fiscal, All Expected Inputs
Monitoring-How	Field Audit, Qualitative Assessments	Desk Audit, Field Audit	Desk Audit, Qualitative Assessments
Monitoring-Who	Fiscal Audit Team, Performance Audit Team, Team, Community Monitors	Self-Reports, Fiscal Audit Team, Performance Audit Team (Limited Use), Community Monitors	Self-Reports, Client Feedback, Performance Audit Team
Client Placement	Case Manager	Case Manager	Provider Choice

Table 6c: Competition Low/Regionalization Potential High

	State 1 Drug Abuse (Partially)	State 2 Mental Health Adults	State 1 Abused/Neglected Children (Partially)
CONDITIONS			
Resources Committed to monitoring	Moderate	Few	Few
Set of State Agency Actors	Simple	Intermediate Set	Simple
Relationship with Legislature	Not Active	Active Relationship	Not Active
Control Objective	Mixed	Cost	Cost
MECHANISMS			
Rate Negotiation	Prior Rate and State Agency Budget	Formal Principles of Reimbursement	Prior Rate and State Agency Budget
Pricing	Delivering Capability	Delivering Inputs or Unit Pricing	Delivering Capability
Reimbursement	Type of Case	Facility or Per Diem	Facility
Payment Perspective	Retrospective	Prospective	Retrospective

Table 6c	State 1 Drug Abuse (Partially)	State 2 Mental Health Adults	State 1 Abused/Neglected Children (Partially)
MECHANISMS cont'd			
Contract Process	Cost Reimbursement	Cost Reimbursement	Cost Reimbursement
Standards	Certification, Licensure	Certification, Licensure	Certification, Licensure, and Accreditation
Monitoring-What	Fiscal, Quantity of Expected Services	Terms of the Contract, Fiscal, Quantity of Expected Services	Terms of the Contract, Fiscal, Delivered Services
Monitoring-How	Field Audit, Qualitative Assessments	Desk Audit, Field Audit	Desk Audit, Field Audit
Monitoring-Who	Fiscal Audit Team, Performance Audit Team, Community Monitors	Self-Reports, Performance Audit Team	Self-Reports, Fiscal Audit Team, Performance Audit Team (Limited Use), Community Monitors
Client Placement	Case Manager	Provider Choice	Case Manager

Table 6c	State 2 Drug Abuse (Partially)	State 2 Mental Retardation (Partially)
CONDITIONS		
Resources Committed to Monitoring	Few	Moderate
Set of State Agency Actors	Intermediate Set	Complex
Relationship with Legislature	Active Relationship	Active Relationship
Control Objective	Cost	Mixed
MECHANISMS		
Rate Negotiation	Formal Principles of Reimbursement	Formal Principles of Reimbursement
Pricing	Delivering Inputs or Unit Pricing	Delivering Inputs
Reimbursement	Facility or Per Diem	Facility
Payment Perspective	Prospective	Prospective

Table 6c	State 2 Drug Abuse (Partially)	State 2 Mental Retardation (Partially)
MECHANISMS cont'd		
Contract Process	Cost Reimbursement	Cost Reimbursement
Standards	Certification, Licensure, Accreditation	Certification, Licensure, Accreditation
Monitoring-What	Terms of the Contract, Fiscal, Quantity of Expected Services, All Expected Inputs	Terms of the Contract, Fiscal, All Expected Inputs
Monitoring-How	Desk Audit, Field Audit	Desk Audit, Qualitative Assessments
Monitoring-Who	Self-Reports, Performance Audit Team	Self-Reports, Client Feedback, Performance Audit Team
Client Placement	Case Manager	Provider Choice

Table 6d: Competition High/Regionalization Potential Low

	State 2 Alcohol Abuse
CONDITIONS	
Resources Committed to Monitoring	Few
Set of State Agency Actors	Intermediate
Relationship with Legislature	Active Relationship
Control Objective	Cost
MECHANISMS	
Rate Negotiation	Prior Rate and State Agency Budget
Pricing	Delivering Capability
Reimbursement	Facility
Payment Perspective	Prospective

Table 6d	State 2 Alcohol Abuse
MECHANISMS cont'd	
Contract Process	Cost Sharing
Standards	Certification, Licensure, Accreditation
Monitoring- What	Fiscal, Delivered Services
Monitoring- How	Desk Audit, Field Audit
Monitoring- Who	Self-Reports, Performance Audit Team
Client Placement	Provider Choice

Table 6e: Competition High/Regionalization Potential High

	State 2 Juvenile Delinquency	State 2 Abused/Neglected Children
CONDITIONS		
Resources Committed to Monitoring	Considerable	Moderate
Set of State Agency Actors	Complex	Complex
Relationship with Legislature	Not Active	Not Active
Control Objective	Mixed	Mixed
MECHANISMS		
Rate Negotiation	Formal Principles of Reimbursement	Formal Principles of Reimbursement
Pricing	Unit Pricing	Unit Pricing
Reimbursement	Facility	Per Diem
Payment Perspective	Prospective	Prospective

Table 6e	State 2 Juvenile Delinquency	State 2 Abused/Neglected Children
MECHANISMS cont'd		
Contract Process	Cost Reimbursement	Unit Price
Standards	Certification, Licensure, Accreditation	Certification Licensure, Accreditation
Monitoring- What	Fiscal, All Expected Inputs	Fiscal, All Expected Inputs
Monitoring- How	Desk Audit, Qualitative Assessments	Desk Audit, Qualitative Assessments
Monitoring- Who	Self-Reports, Client Feedback, Performance Audit Team, Community Monitors	Self Reports, Client Feedback, Performance Audit Team
Client Placement	Case Manager	Case Manager

Table 6e	State 2 Mental Health Children	State 2 Special Education
CONDITIONS		
Resources Committed to Monitoring	Moderate	Considerable
Set of State Agency Actors	Complex	Complex
Relationship with Legislature	Active	Active
Control Objective	Mixed	Program
MECHANISMS		
Rate Negotiation	Formal Principles of Reimbursement	Formal Principles of Reimbursement
Pricing	Delivering Inputs	Delivering Inputs
Reimbursement	Facility	Per Diem
Payment Perspective	Prospective	Prospective

Table 6e	State 2 Mental Health Children	State 2 Special Education
MECHANISMS cont'd		
Contract Process	Cost Reimbursement	Cost Reimbursement
Standards	Certification, Licensure, Accreditation	Certification, Licensure, Accreditation
Monitoring-What	Fiscal, All Expected Inputs	Fiscal, All Expected Inputs
Monitoring-How	Desk Audit, Qualitative Assessments	Desk Audit, Qualitative Assessments
Monitoring-Who	Self-Reports, Client Feedback, Performance Audit Team	Self Reports, Client Feedback, Performance Audit Team
Client Placement	Case Manager	Case Manager

B. Analysis of General Trends

An analysis of the mechanisms shows several general trends. Rate negotiation based on prior rates or the use of formal principles of reimbursement were prevalent. Pricing by delivery of capability and the delivery of inputs were dominant. The use of more evolved mechanisms was virtually non-existent. Perhaps this can be tied to the dominance of prospective payment. More evolved pricing mechanisms might require a retrospective payment in order to take into consideration changes in the relative status of providers. Reimbursement by facility was also dominant. Reimbursement by type of case or specific client was essentially non-existent. Even though a prospective payment mechanism was used much more than expected the use of current year adjustments from the inflated base year rate may blunt much of the presumed effectiveness of a prospective payment mechanism. There was very little use of reimbursement by type of case or by specific person. Cost reimbursement contracting was much more prevalent than had been expected. There was very little use of process and output standards.

The lack of performance standards (that is, process/output standards) may account for the lack of performance oriented contracts and the lack of pricing by improvements to service, level of quality, or relative efficiency. As a result there was no need for monitoring which included cost/performance comparisons. The monitoring conducted was primarily concerned with fiscal aspects and expected inputs.

Consequently, there was no need to use more sophisticated methods such as constructed measures and testing as a means of gathering monitoring information. This in turn would account for the lack of use

of joint fiscal/performance audit teams and third party monitors. There was little use of market mechanisms for client placement and a much stronger use of client placement through case managers and through provider choice. This may be the result of monitoring which emphasizes fiscal aspects and inputs, resulting in few choices and little performance information available for making choices.

For the most part, the mix of particular control mechanisms found in the trends appears to follow the directions indicated by the signed digraphs. The exceptions are noted below and many can be categorized as related to contracting. The predicted effect of contracting on client placement appears to have not followed the preferred directionality in the case studies. The effects of contracting on monitoring-what and monitoring-how also appear to have not followed the preferred directionality. In addition, the high level of vendor changes based on the monitoring information should have generated a higher level of monitoring than was the case.

To assess the sign of the relationships in the case studies, each service was put on a graph. It was not expected that the relationships could be fully verified empirically because:

1) the variation in the axes was increased to find relationships, but not all of the variation was present in community social services

2) the relationships represent a logic about choosing options of a mechanism that may not be present in the way options are currently chosen.

Indeed, these two factors form a significant part of the rationale for this study, so it would be quite surprising and disappointing if the

relationships were verified empirically, and I would not have had a challenging dissertation topic.

The purpose of the case studies is to illustrate the variation and relationships of current practices. An explanation for the variance between the preferred and empirical relationships is given to suggest the means by which mechanisms are now chosen. These explanations are not intended to supplant the more logical explanations in Chapter 3.

As in the graphs constructed in Chapter 3, the x-axis indicates the independent control mechanism (tail of the arrow) and the y-axis indicates the dependent control mechanism (head of the arrow). The abbreviation at each data point indicates the state and the service.

In order to retain the typology of the provider market in the graphs, the data point's symbol will be different for each type of provider market. The key on the graphs indicates the symbol for each type of provider market. If more than one service was found at a point on the graph, the symbols were vertically aligned at the point. The symbol in the middle of this line is on the data point.

When options on an axis were not mutually exclusive, such as monitoring, the option farthest to the right on the axis is used. Many times the options on this type of axis are cumulative. This means that if the option farthest to the right is located, the options to its left exist as well. However, this cumulative effect does not always prove true. In some cases involving monitoring mechanisms, the highest option of the independent mechanism was associated with a dependent mechanism that was <u>not</u> the highest option present; and the highest option of the dependent mechanism was associated with an option of the independent mechanism which was not the highest option present. Both

sets of options are presented in the graphs.

All double headed arrows in the signed digraphs had the same sign at both ends in this analysis, so only one graph was used to display the relationship. When two, three or four options for a mechanism existed, the spacing between options was adjusted. Cost-oriented contracting and performance-oriented contracting were placed on the same axis when they affected other mechanisms or the provider market in the same way, or were affected in the same manner by those variables. The same is true for input standards and process, output and outcome standards.

The drug abuse facilities and the facilities for abused and neglected children in State 1 were considered to have a retrospective payment perspective, even though the rate cap was set prospectively, because the actual determination of the current year's rate is done in a following year and adjustments are then made in the prior year's rate. Facilities for abused and neglected children in State 1 were usually inspected by a fiscal audit team with only rare use of a performance audit team, so the highest level of monitoring-who was considered to be a fiscal audit team.

Unfortunately the pattern can not be established for thirteen relationships. For six of these, no instances of performance contracting or process, output and outcome standards were present in the case study states. The other seven relationships were not clearly postive or negative. The relationships between pricing and client placement (Graph 6a), and monitoring-what and client placement (Graph 6b) exhibited a horizontal pattern indicating insufficient variation in the dependent mechanism, client placement.

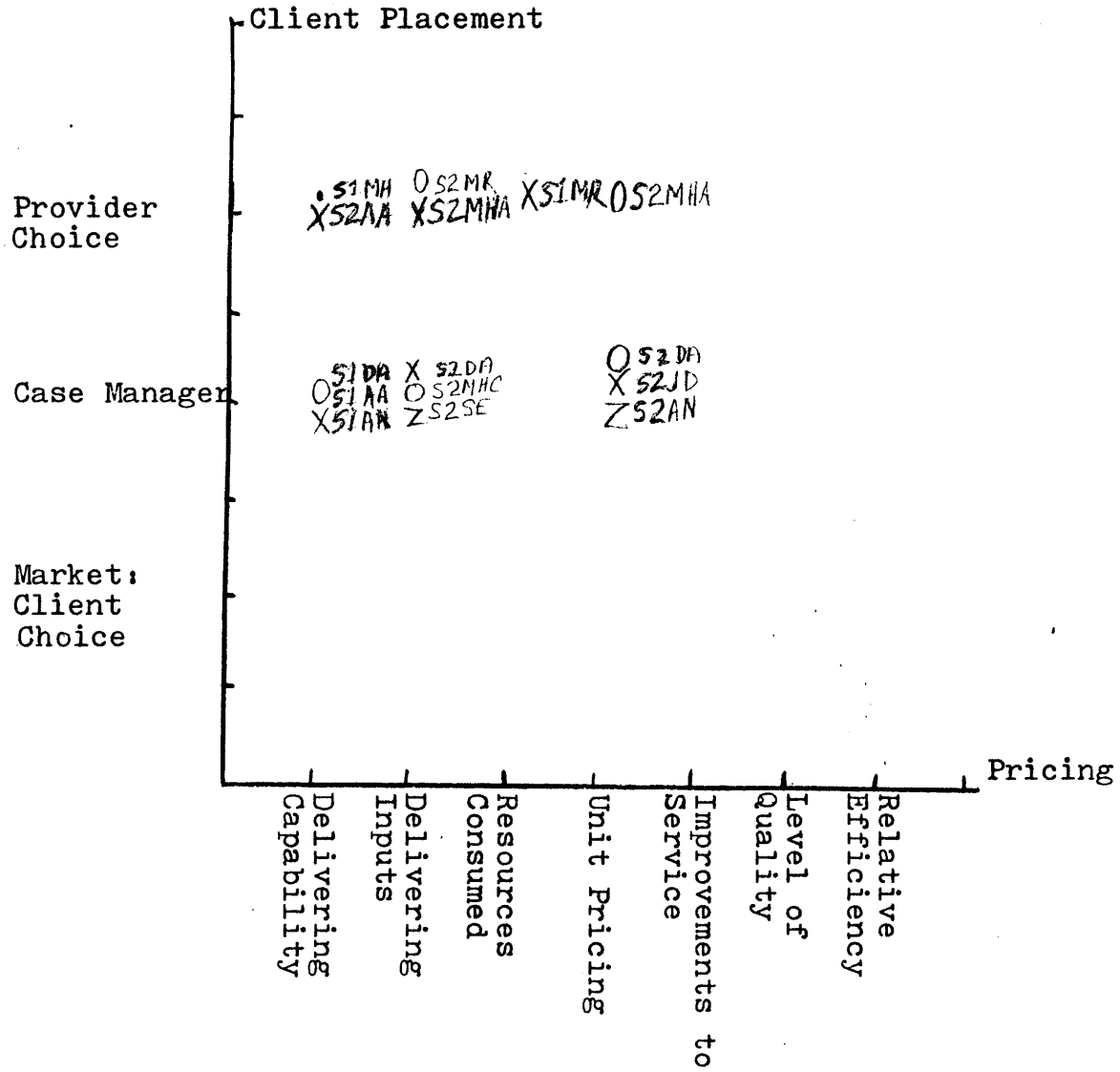
The relationships between standards and pricing (Graph 6c) and input standards and regionalization potential (Graph 6d) exhibited a vertical pattern indicating insufficient variation in the independent mechanism, input standards (all standard-setting practices used input standards).

The relationship between the level of competition and rate negotiation (Graph 6e) was also indistinguishable because there was insufficient variation in the level of those variables; the rate negotiation axis exhibted only the extremes of prior rate and formal principles of reimbursement. The relationship between standards and monitoring-what (Graph 6f) indicated that there was insufficient variation in both axes to allow a positive or negative pattern to form. Finally, the relationship between monitoring information use-vendor changes and monitoring-who (Graph 6g) exhibited significant variation, but no pattern was apparent.

This review indicated that the axes for standards, client placement, and perhaps, rate negotiation should be reviewed and adjusted so that a larger variation in the axes would be possible.

Five relationships showed opposite directionality to the preferred relationships established in Chapter 3: pricing and rate negotiation; contracting and monitoring-what; contracting and monitoring-how; cost-oriented contracting and client placement; and input standards and competition. The positive relationship between pricing and rate negotiation (Graph 6h) contradicted the pattern found in the literature from other states in Chapter 3, so it is difficult to determine how to interpret this pattern.

Graph 6a: Pricing and Client Placement



Key to Provider Market

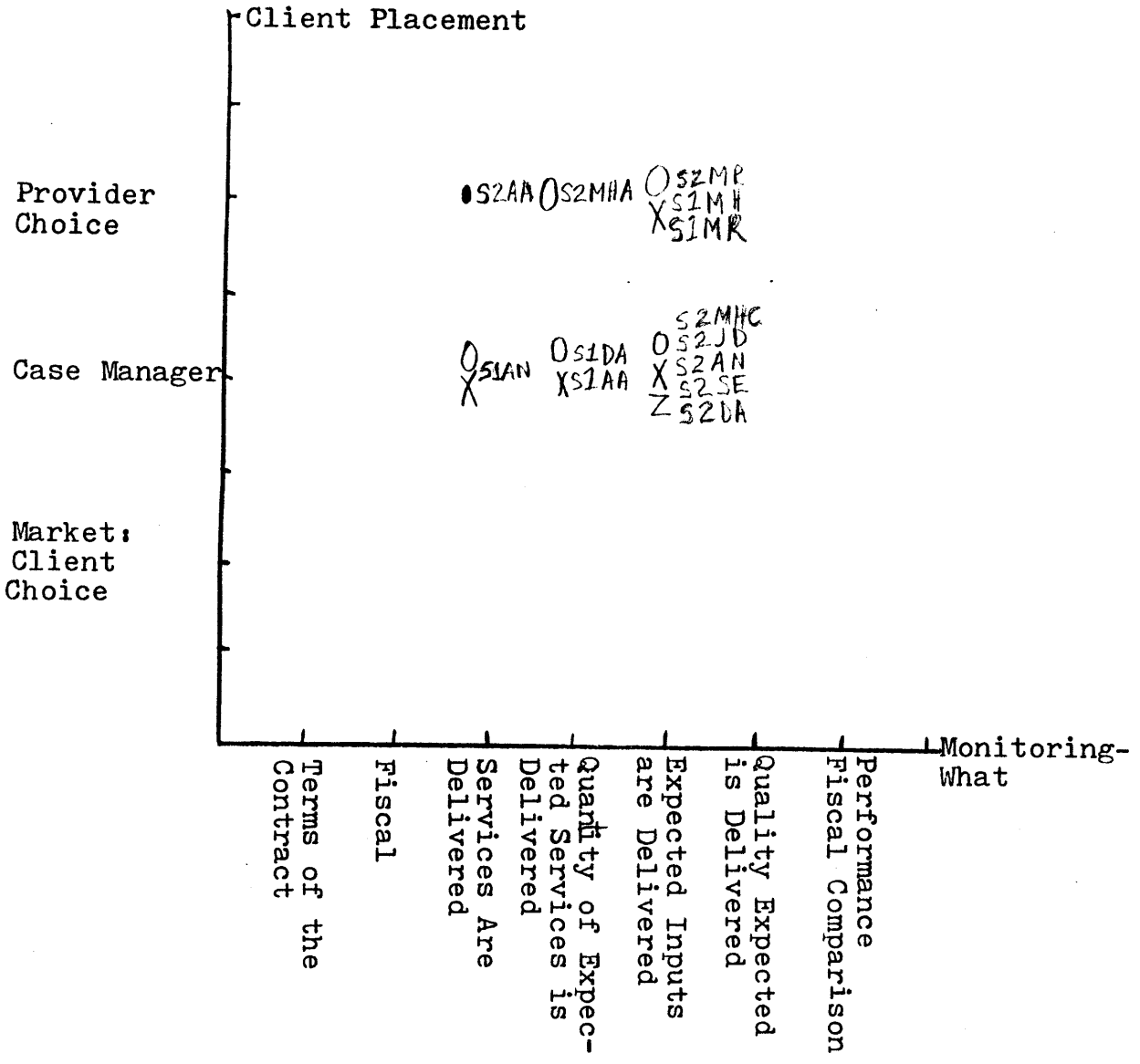
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

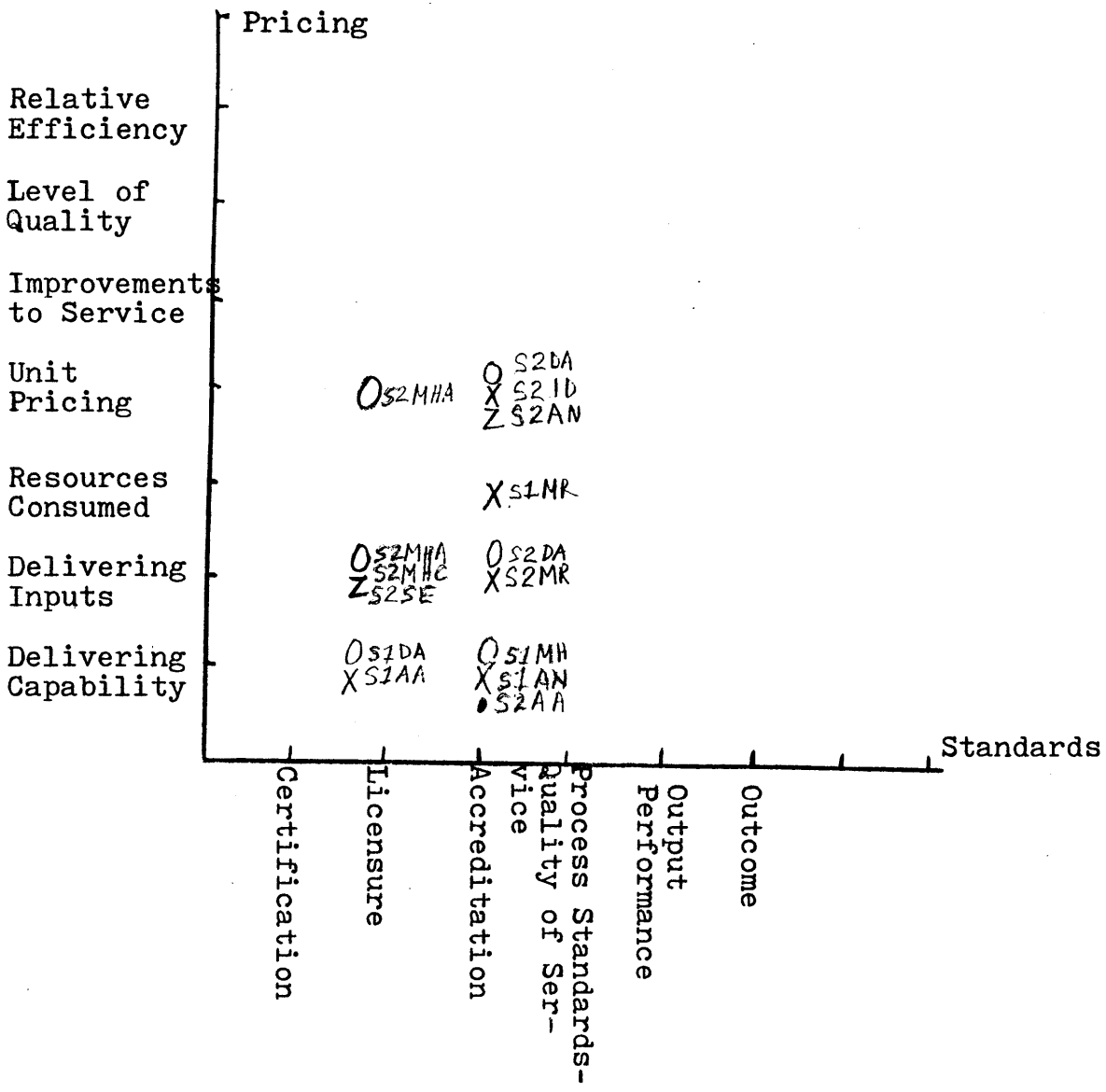
Graph 6b: Monitoring-What and Client Placement



Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- ●=competition high, regionalization potential low
- Z=competition high, regionalization potential high

Graph 6c: Standards and Pricing



Key to Provider Market

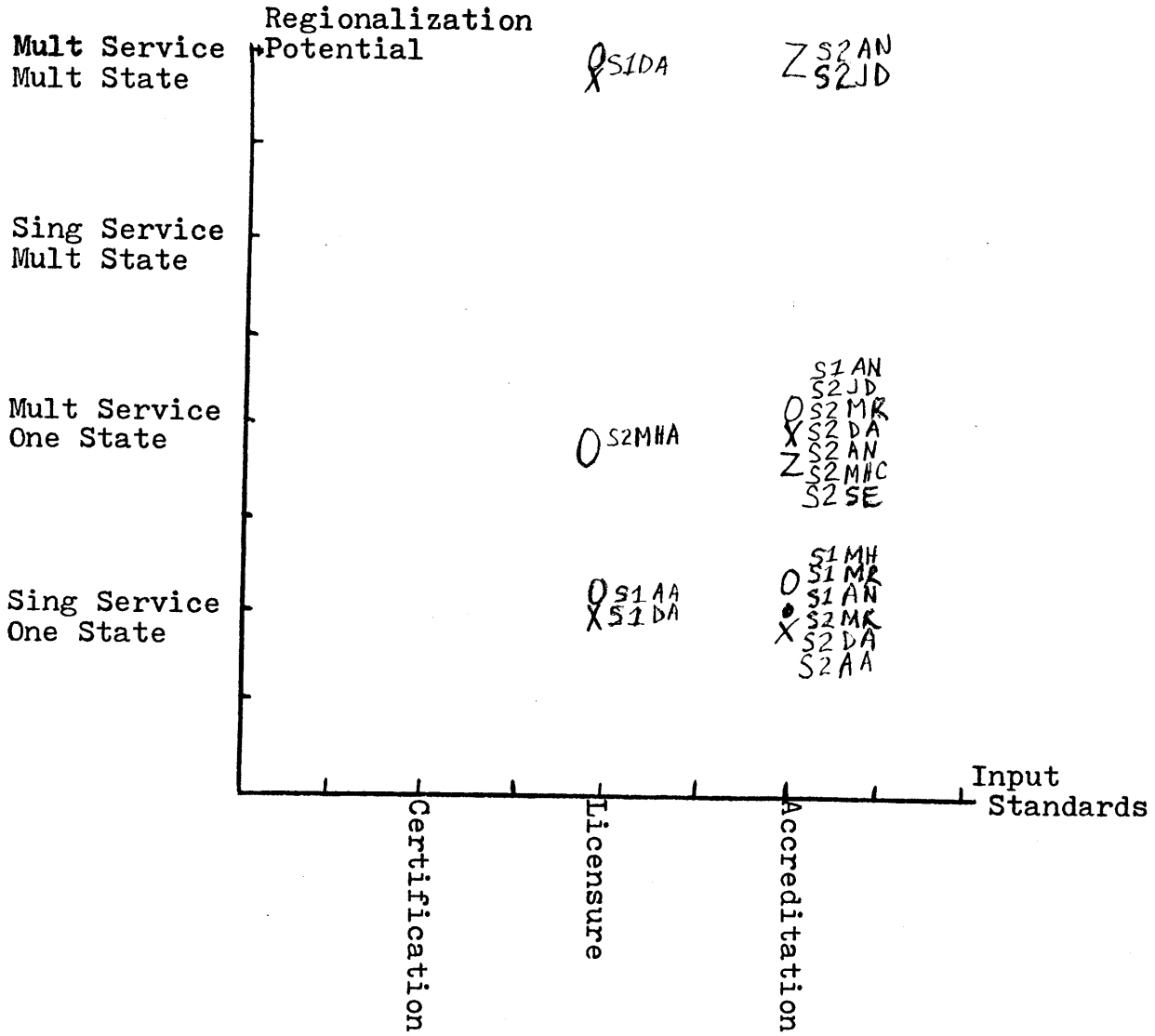
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 6d: Input Standards and Regionalization Potential



Key to Provider Market

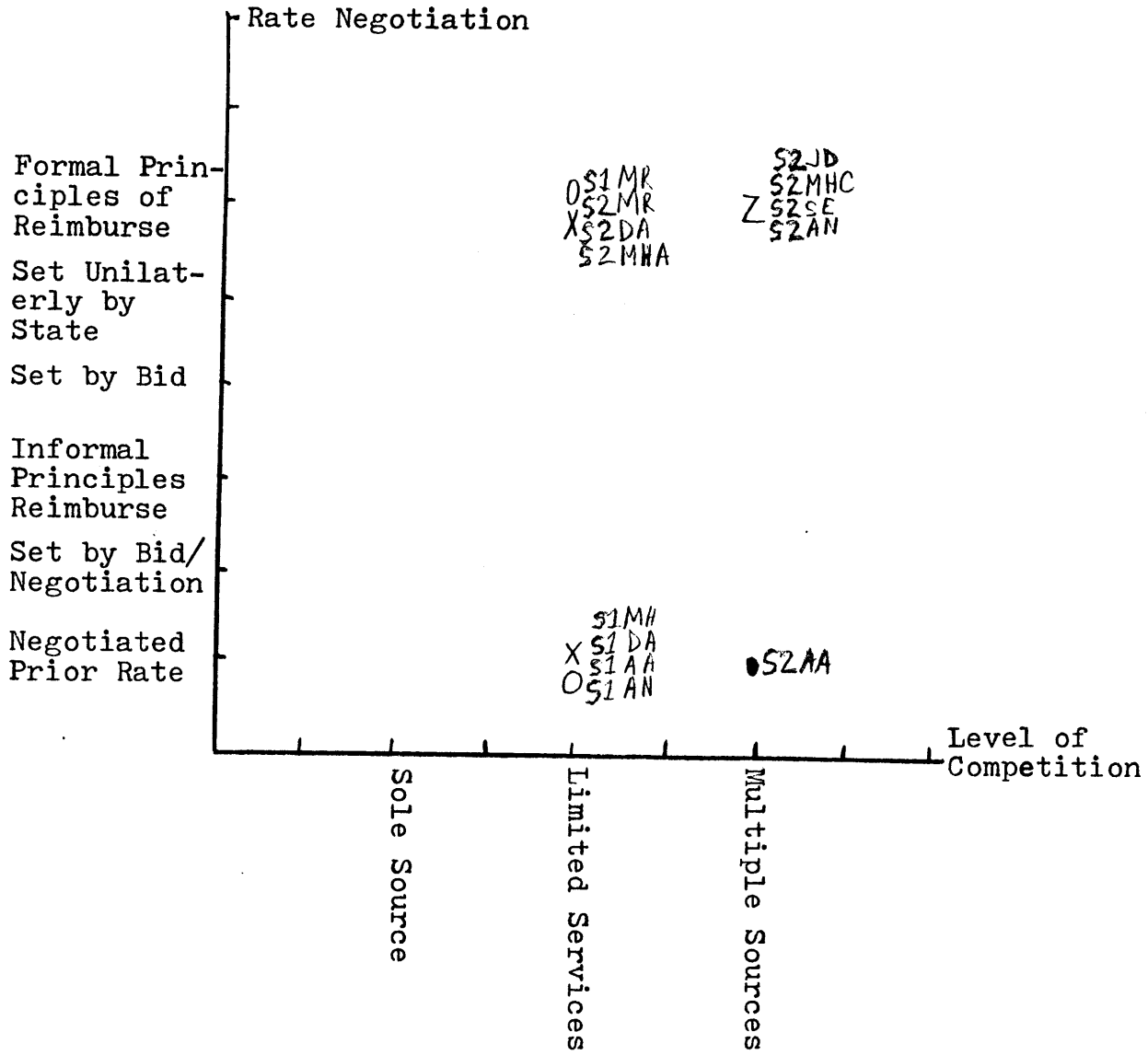
X=competition low, regionalization potential low

O=competition low, regionalization potential high

•=competition high, regionalization potential low

Z=competition high, regionalization potential high

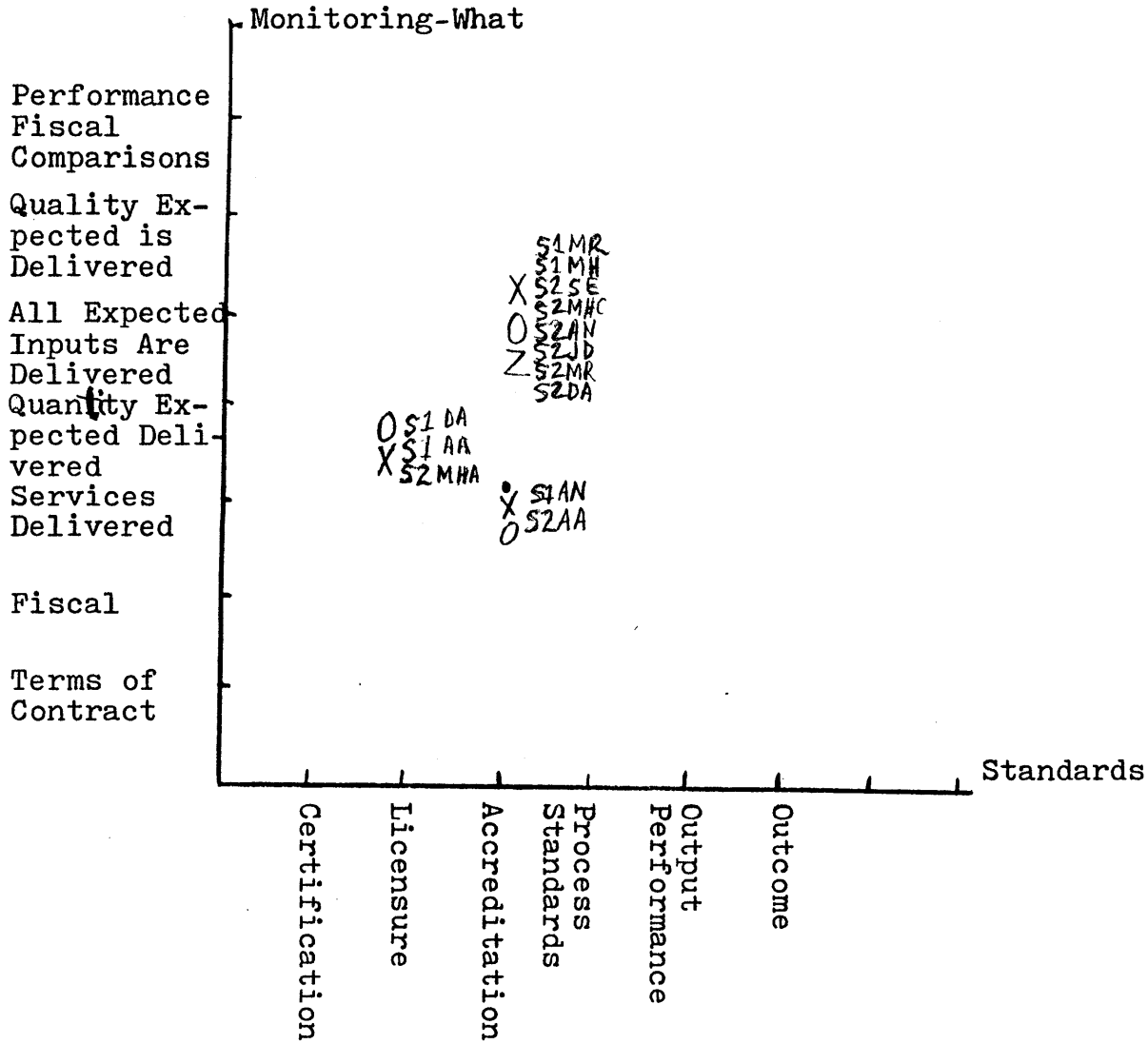
Graph 6e: Level of Competition and Rate Negotiation



Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- •=competition high, regionalization potential low
- Z=competition high, regionalization potential high

Graph 6f: Standards and Monitoring-What



Key to Provider Market

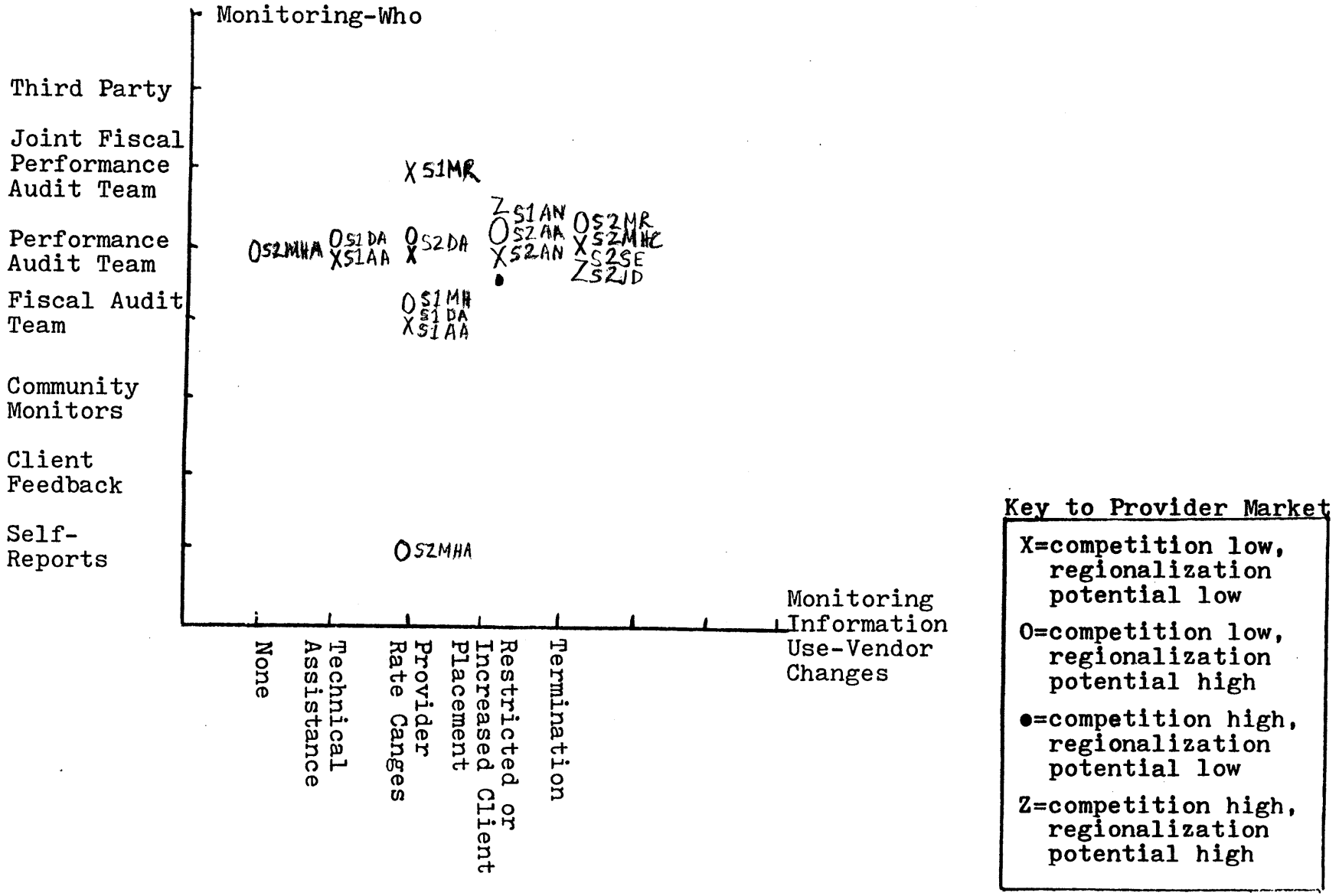
X=competition low, regionalization potential low

O=competition low, regionalization potential high

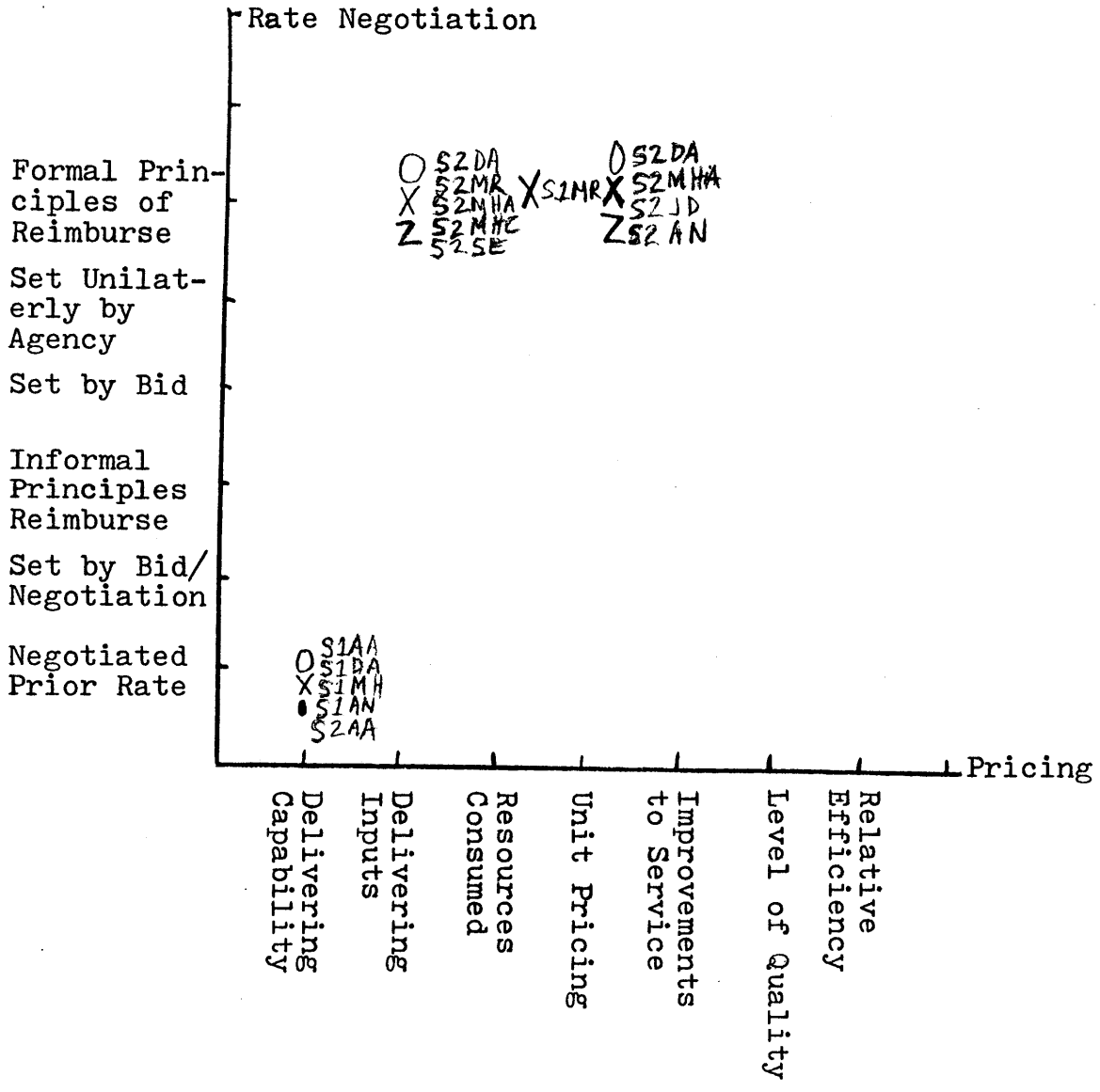
●=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 6g: Monitoring Information Use-Vendor Changes and Monitoring-Who



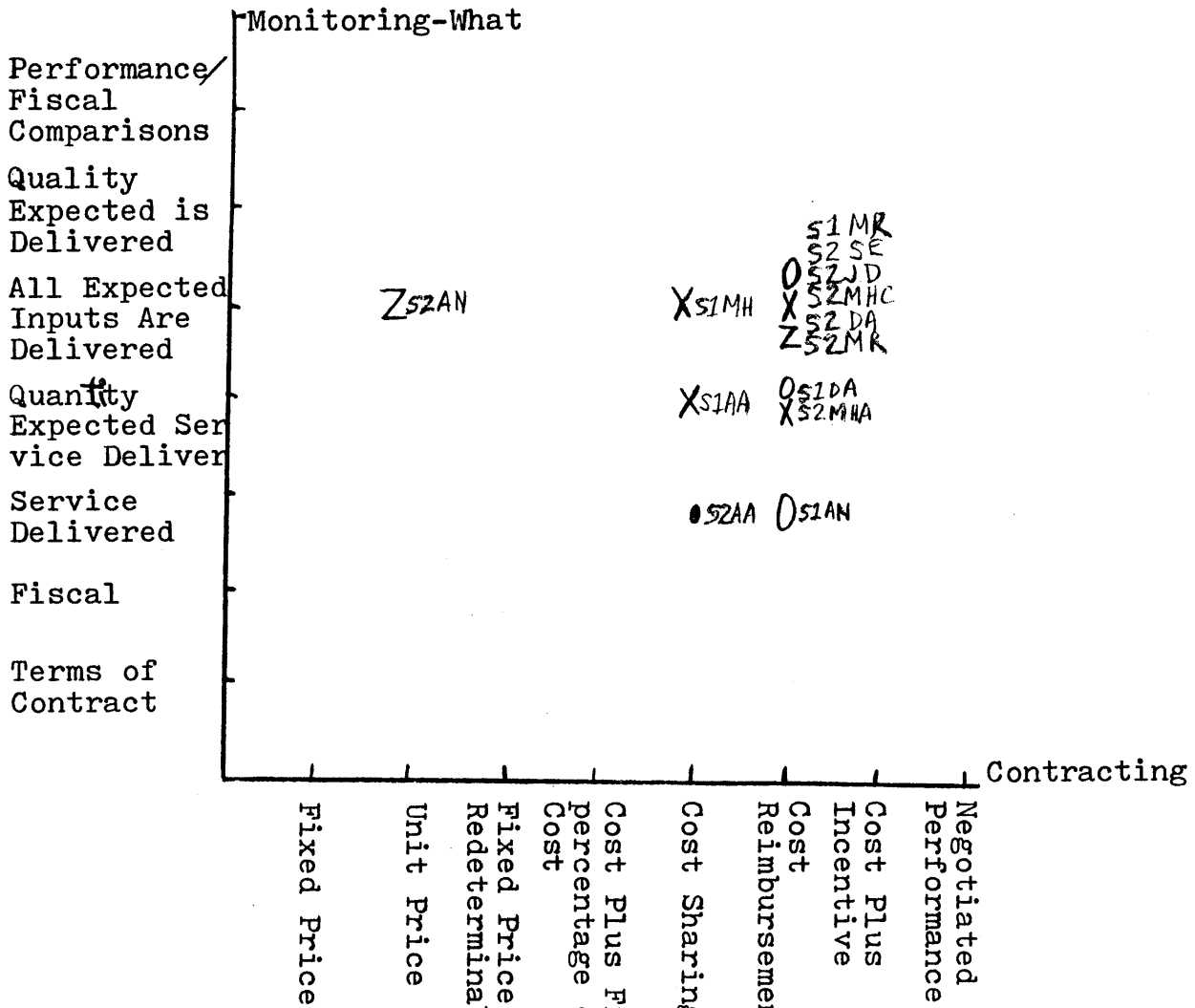
Graph 6h: Pricing and Rate Negotiation



Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- •=competition high, regionalization potential low
- Z=competition high, regionalization potential high

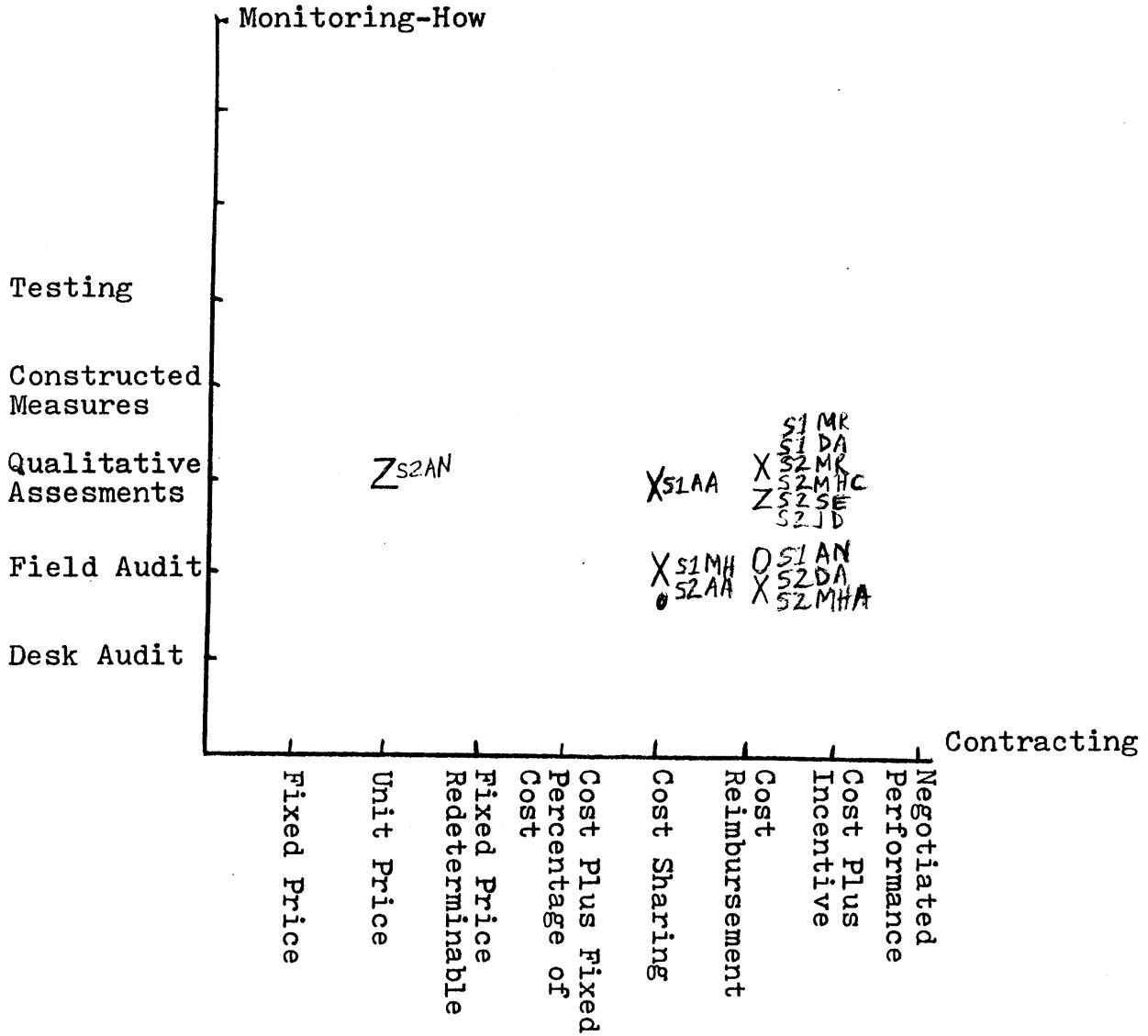
Graph 6i: Contracting and Monitoring-What



Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- ●=competition high, regionalization potential low
- Z=competition high, regionalization potential high

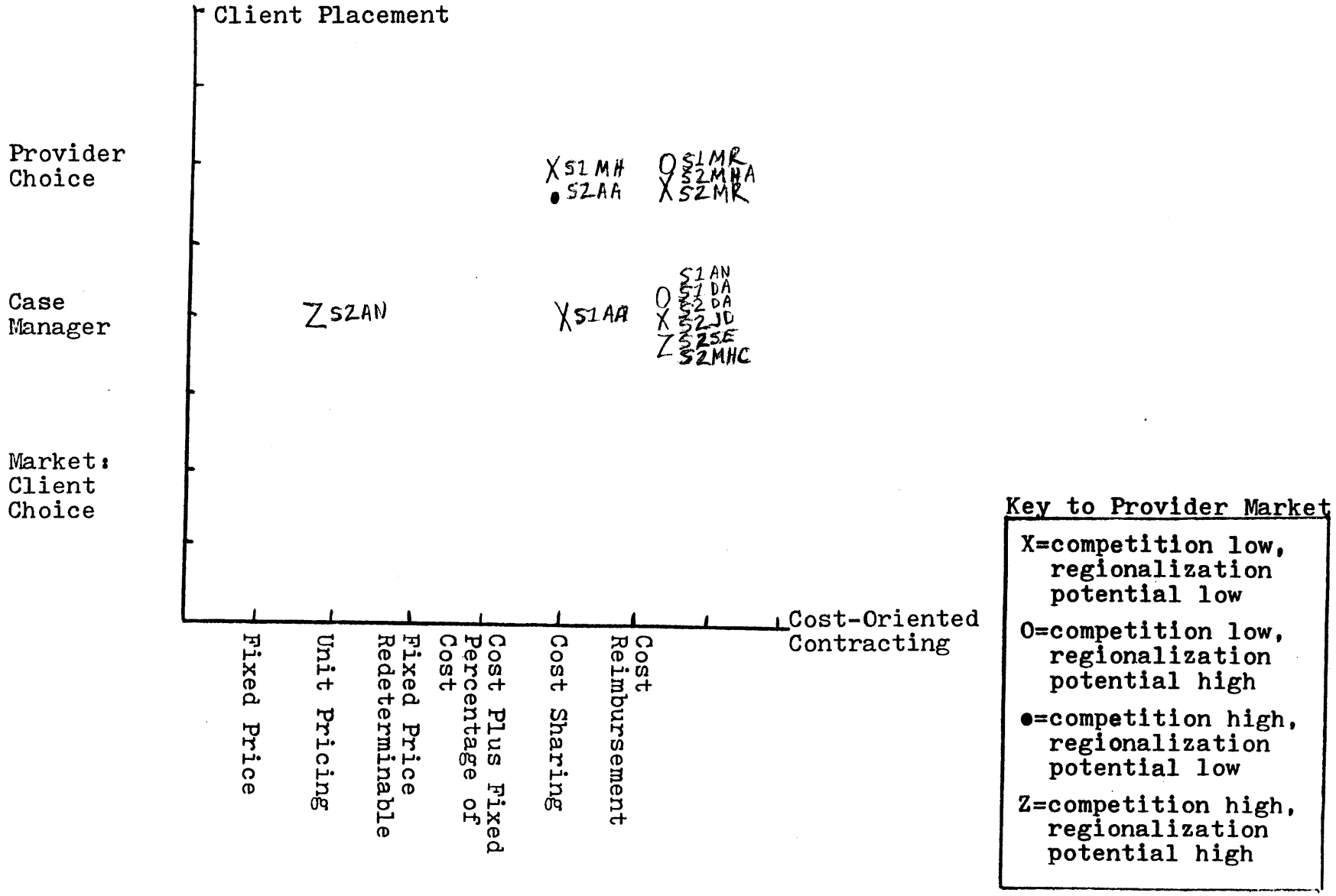
Graph 6j: Contracting and Monitoring-How



Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- ●=competition high, regionalization potential low
- Z=competition high, regionalization potential high

Graph 6k: Cost-Oriented Contracting and Client Placement



Key to Provider Market

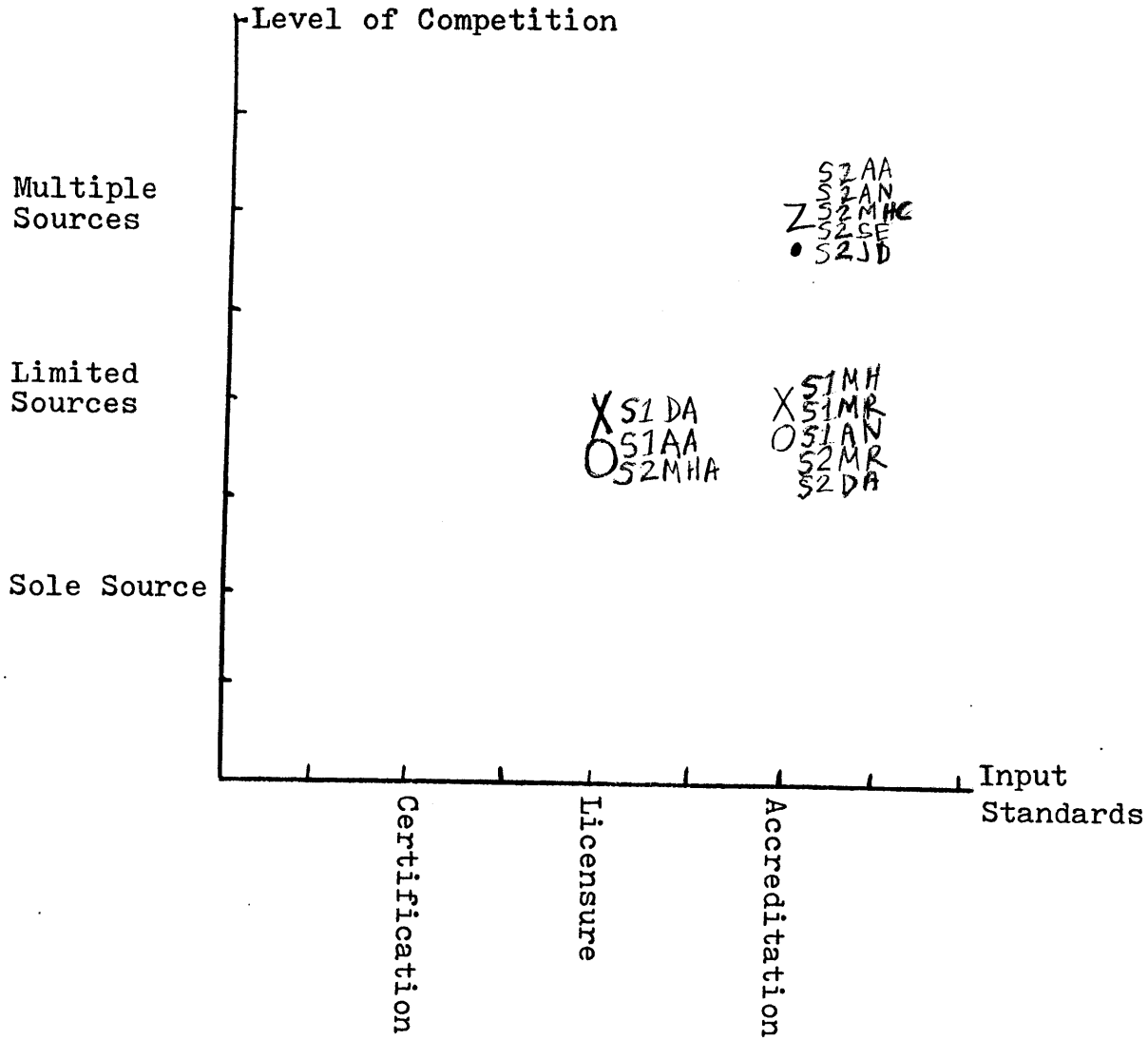
X=competition low, regionalization potential low

O=competition low, regionalization potential high

•=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 61: Input Standards and Level of Competition



Key to Provider Market

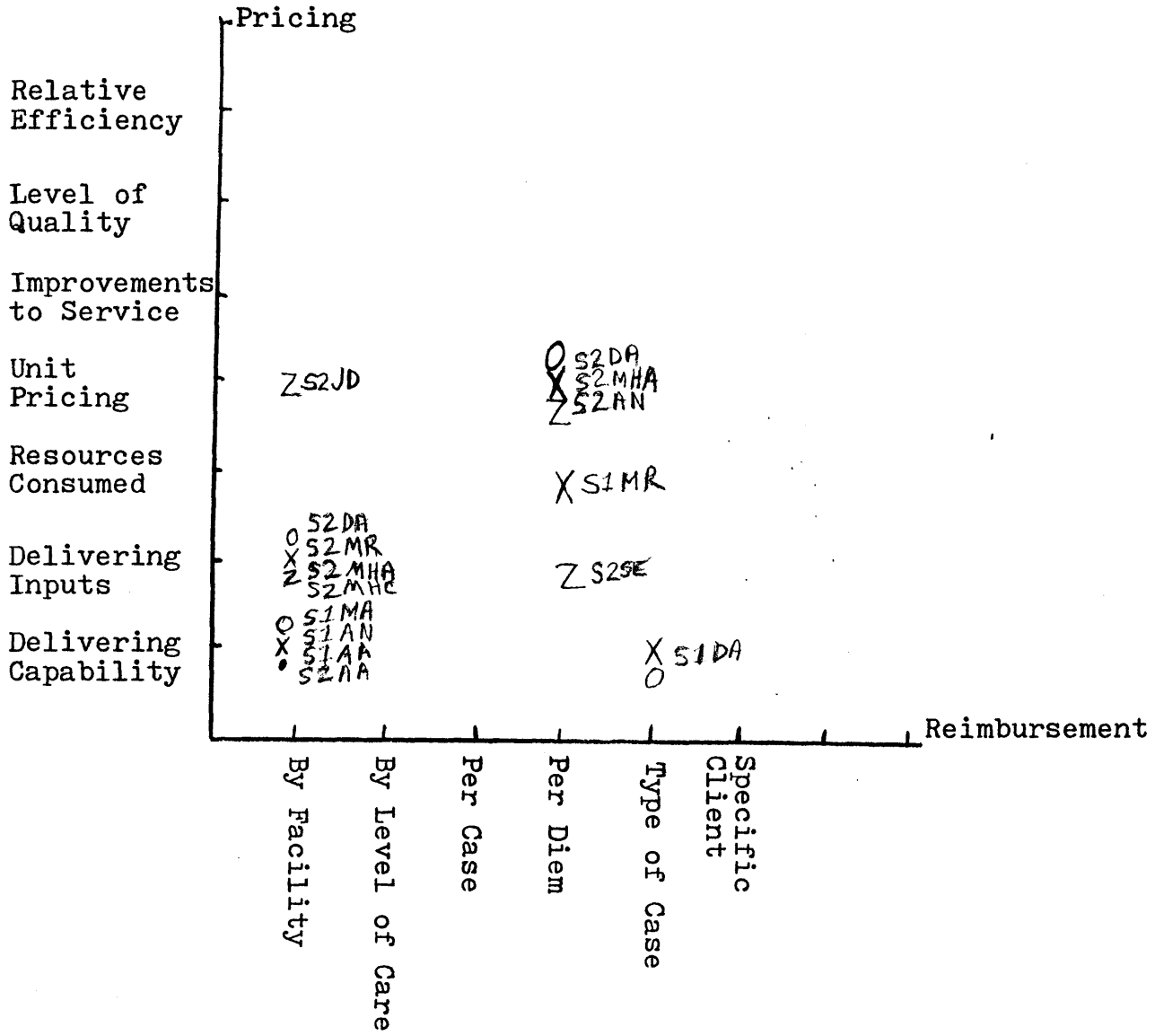
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 6m: Reimbursement and Pricing



Key to Provider Market

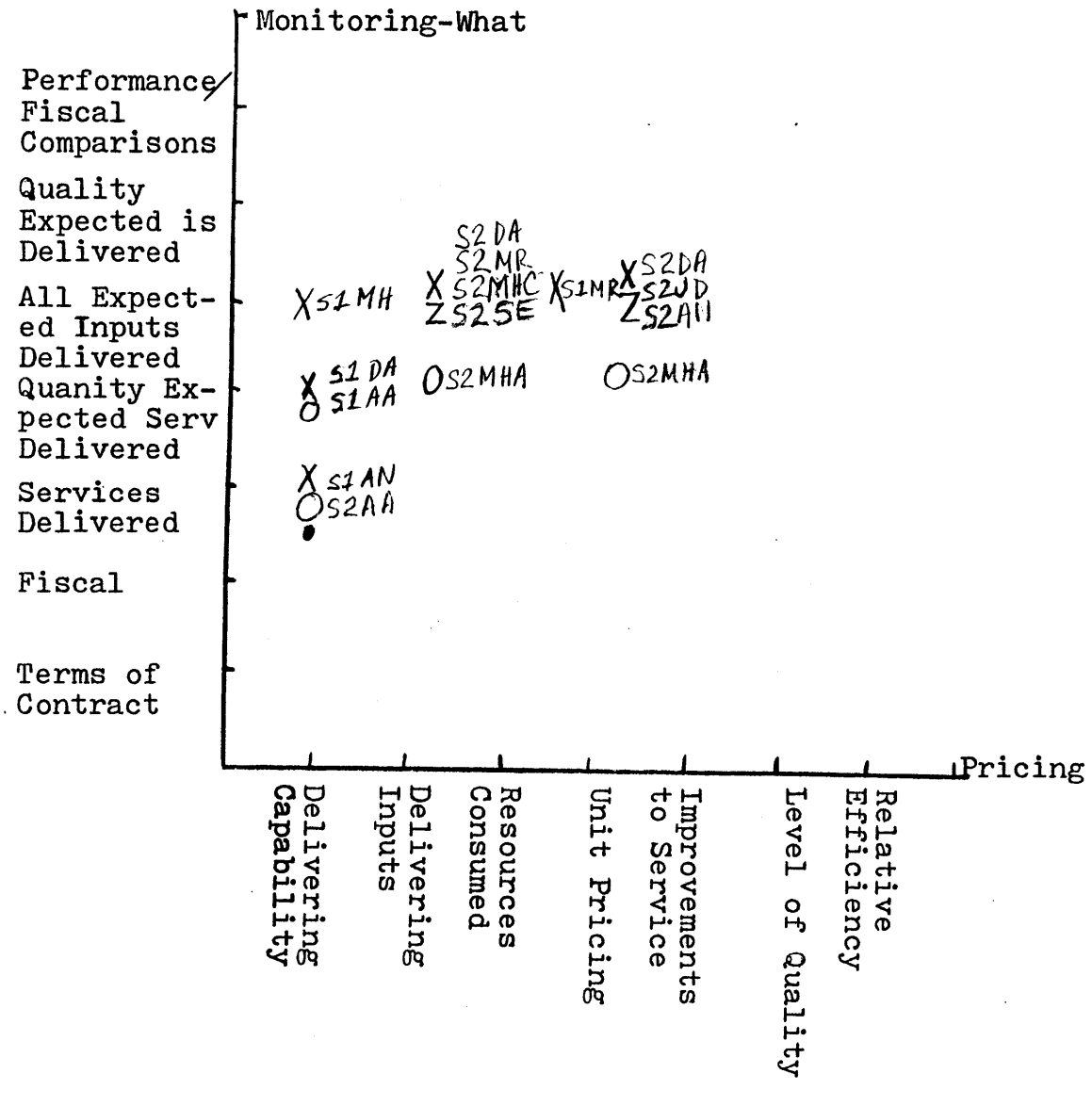
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 6n: Pricing and Monitoring-What



Key to Provider Market

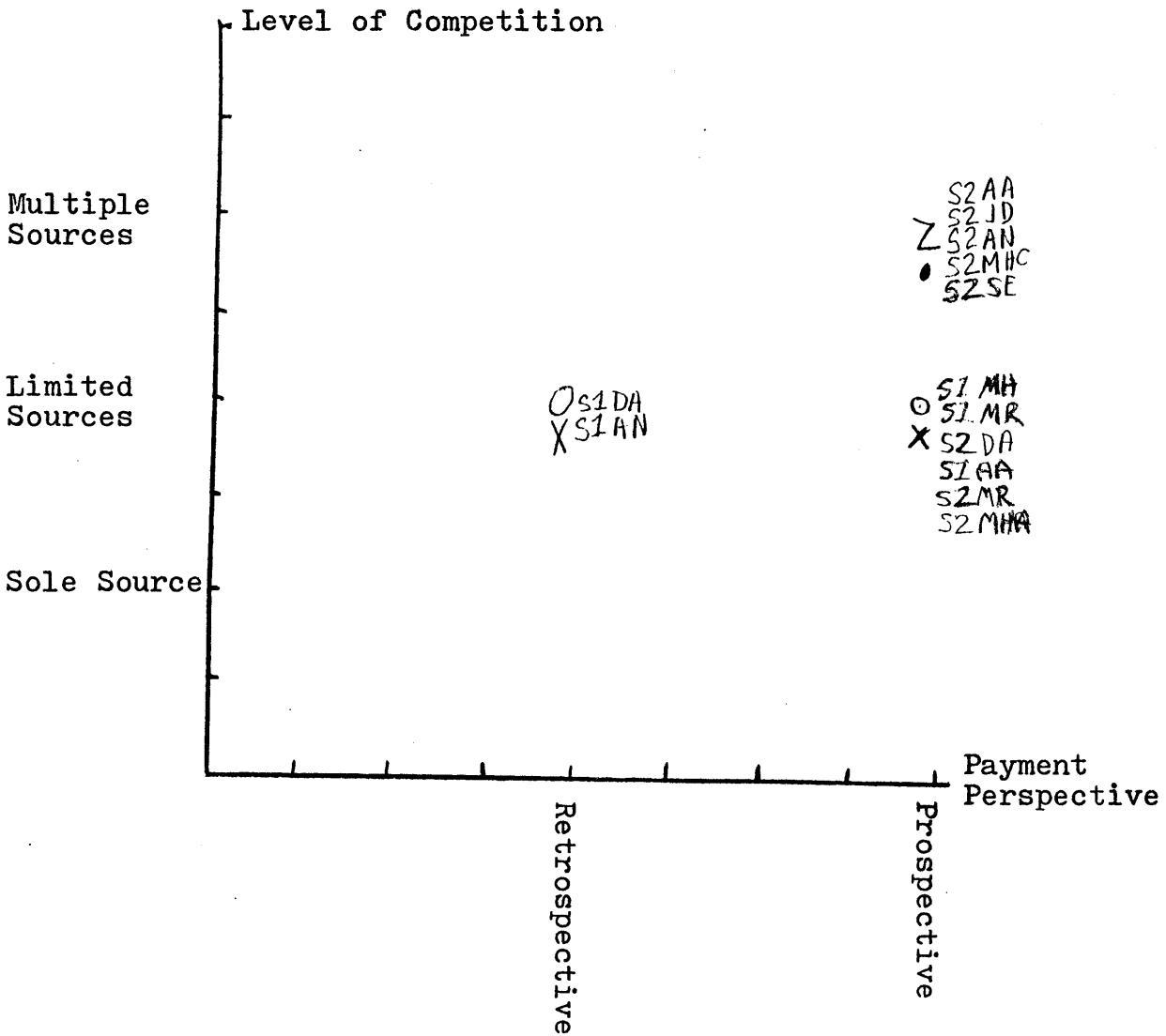
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 6o: Payment Perspective and Level of Competition



Key to Provider Market

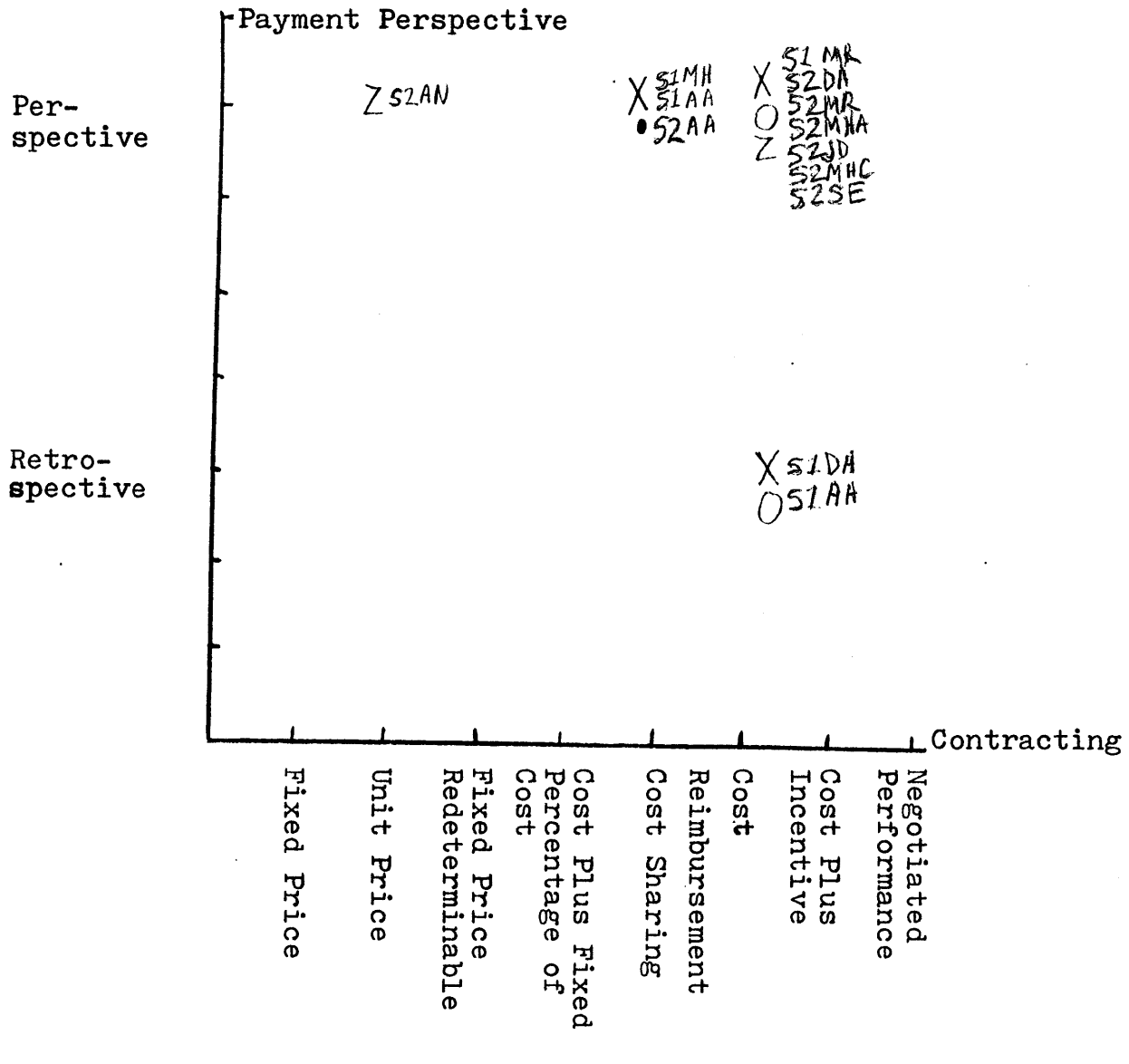
X=competition low, regionalization potential low

O=competition low, regionalization potential high

•=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 6p: Contracting and Payment Perspective



Key to Provider Market

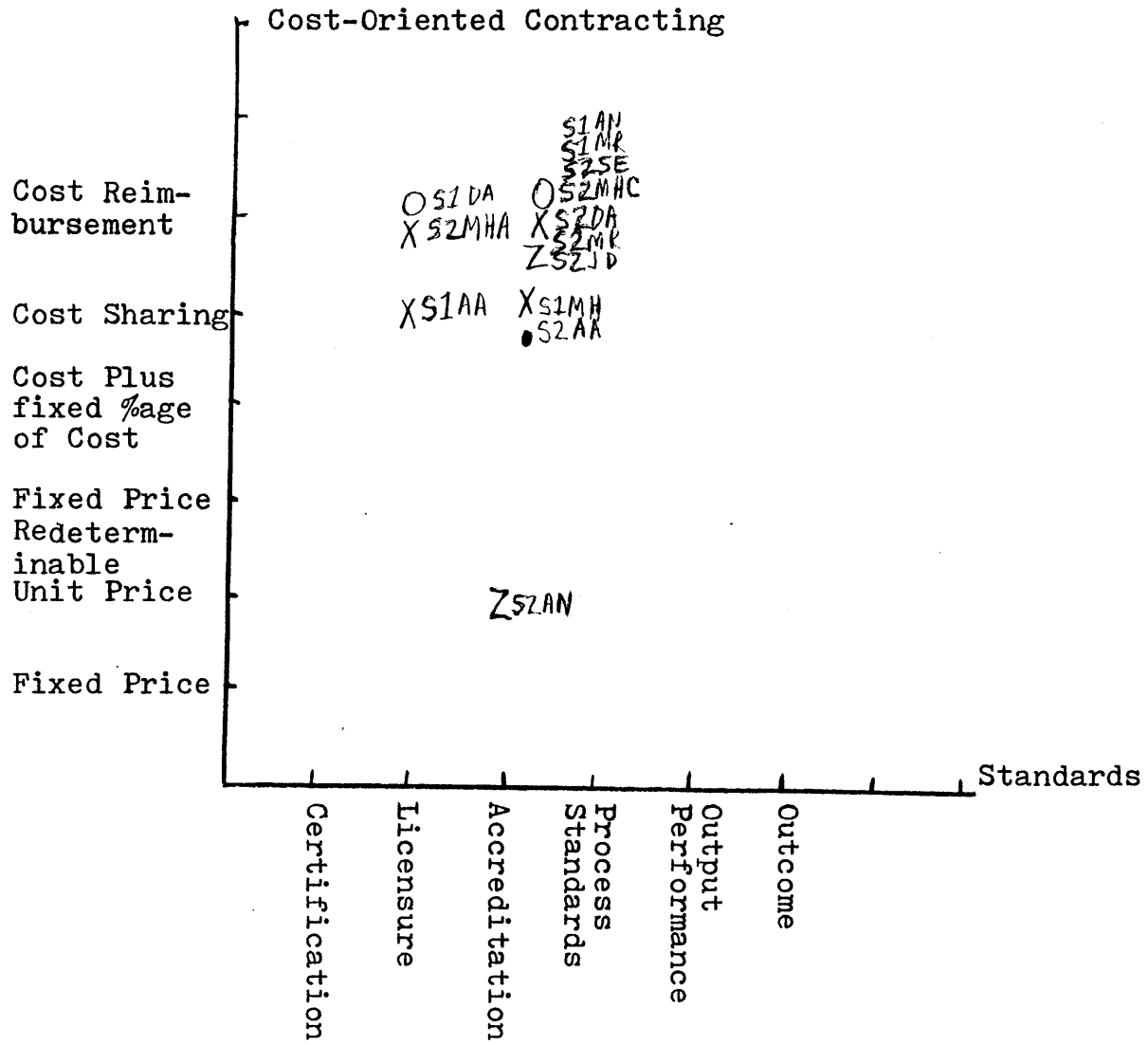
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

Graph 6q: Standards and Cost-Oriented Contracting



Key to Provider Market

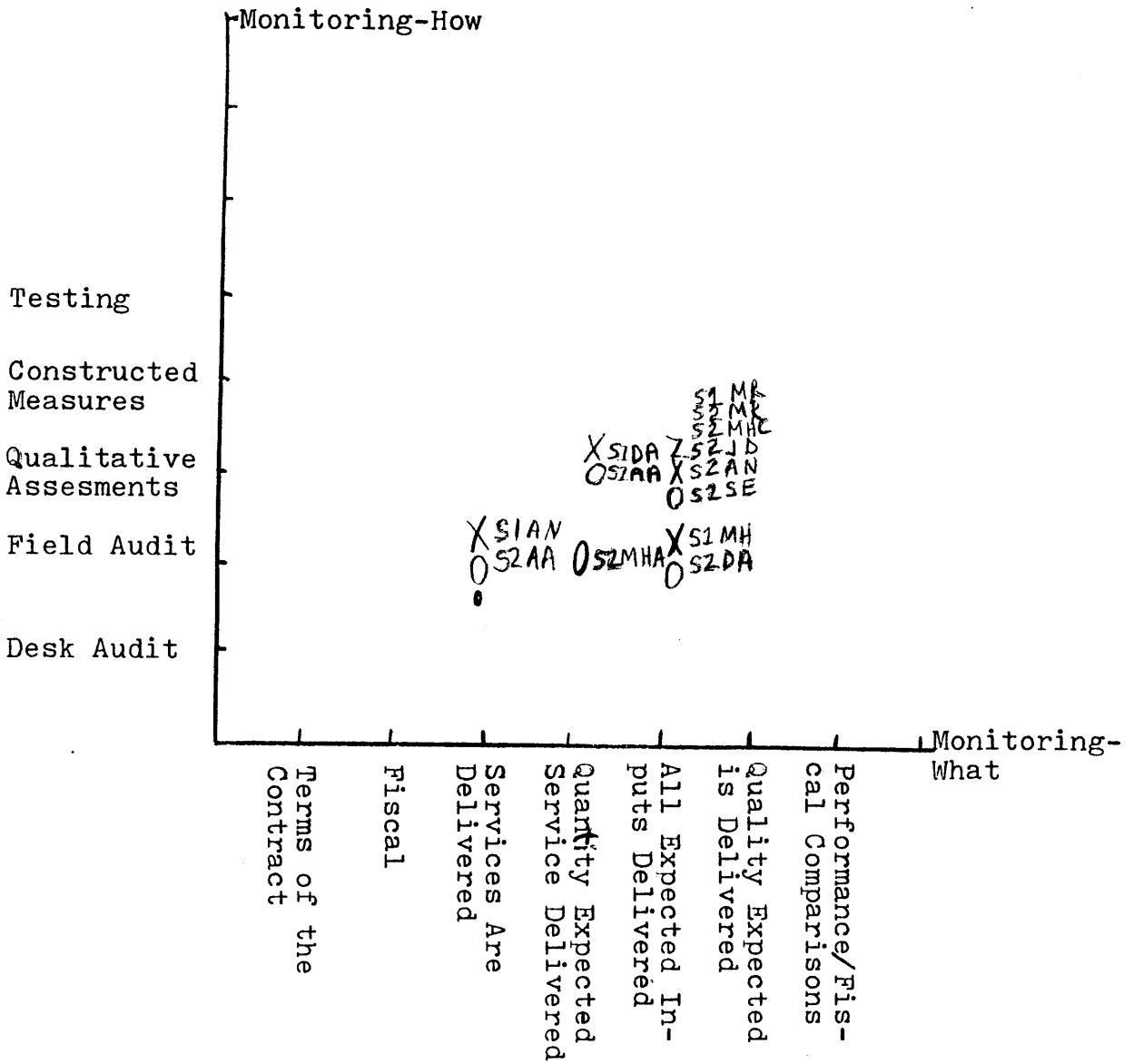
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

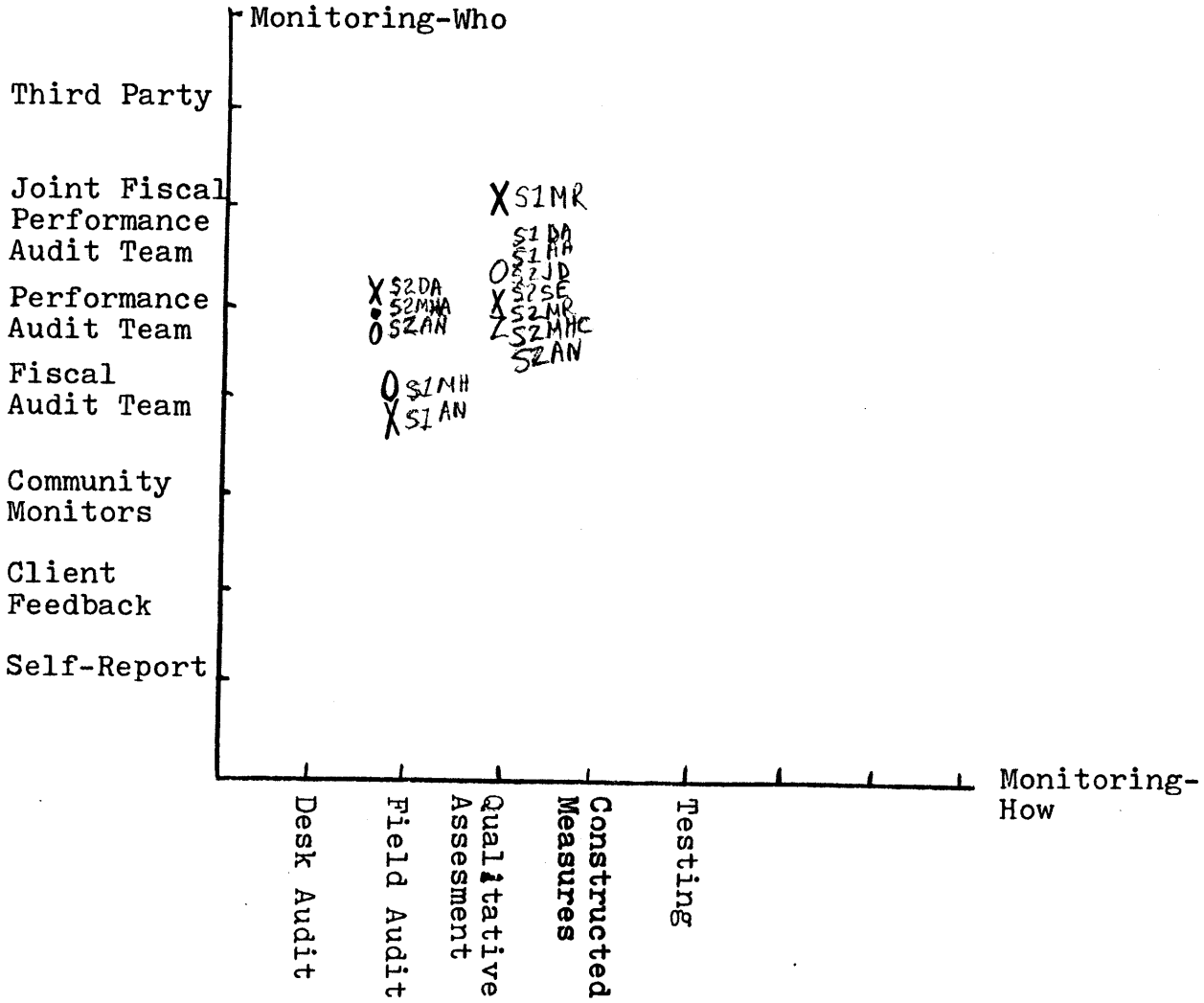
Graph 6r: Monitoring-What and Monitoring-How



Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- ●=competition high, regionalization potential low
- Z=competition high, regionalization potential high

Graph 6s: Monitoring-How and Monitoring-Who



Key to Provider Market

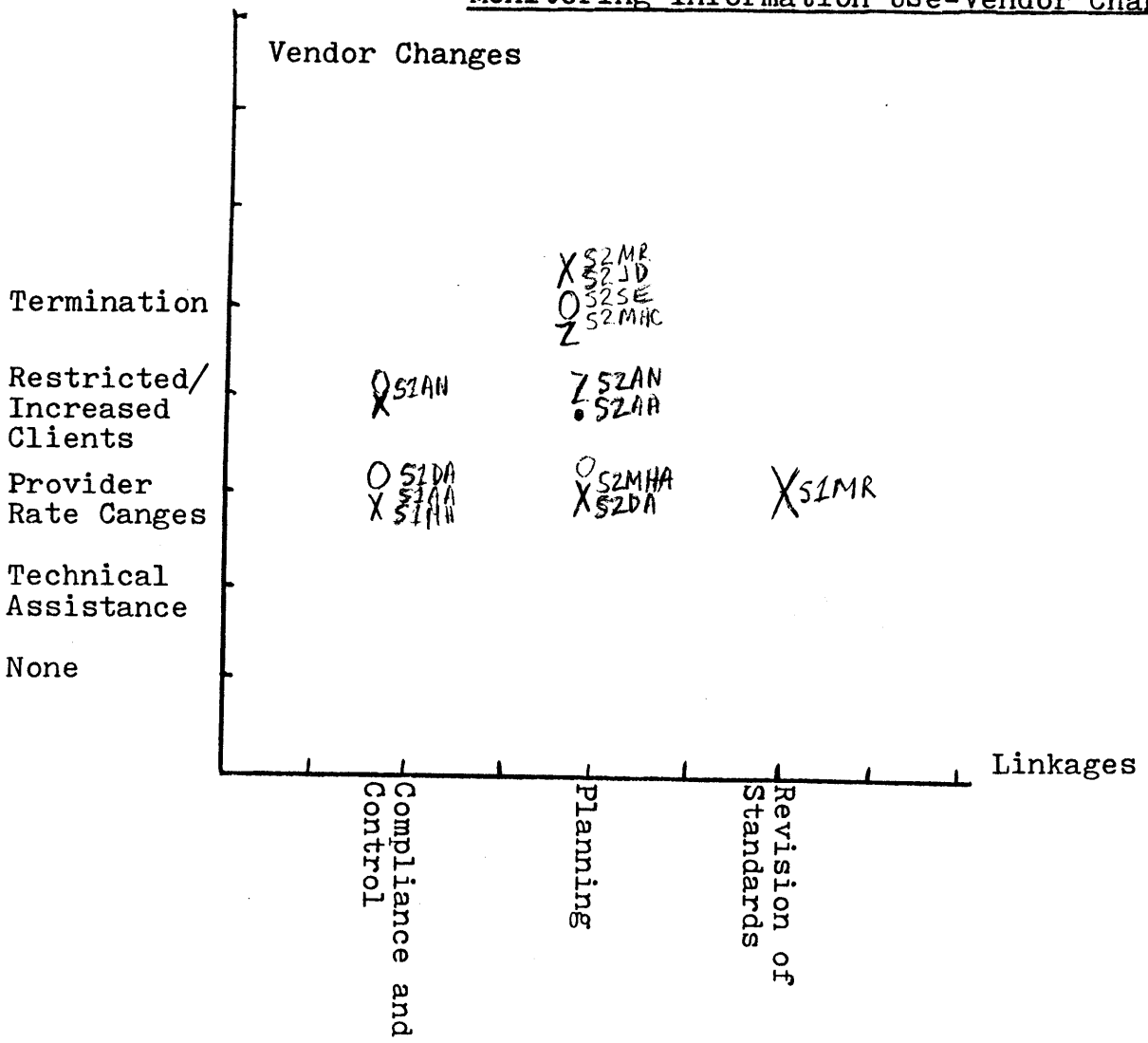
X=competition low, regionalization potential low

O=competition low, regionalization potential high

●=competition high, regionalization potential low

Z=competition high, regionalization potential high

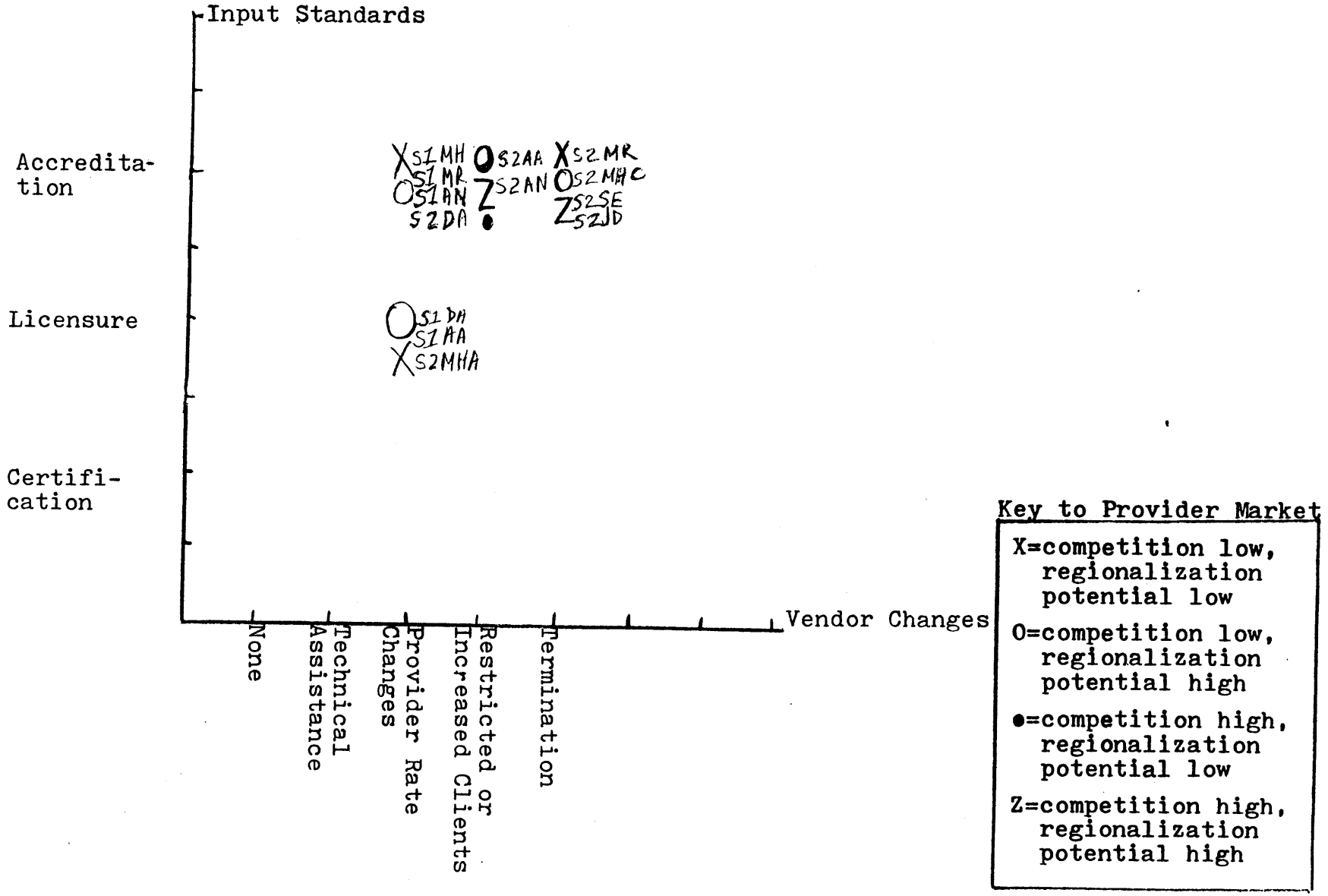
Graph 6t: Monitoring Information Use-Linkages and Monitoring Information Use-Vendor Changes



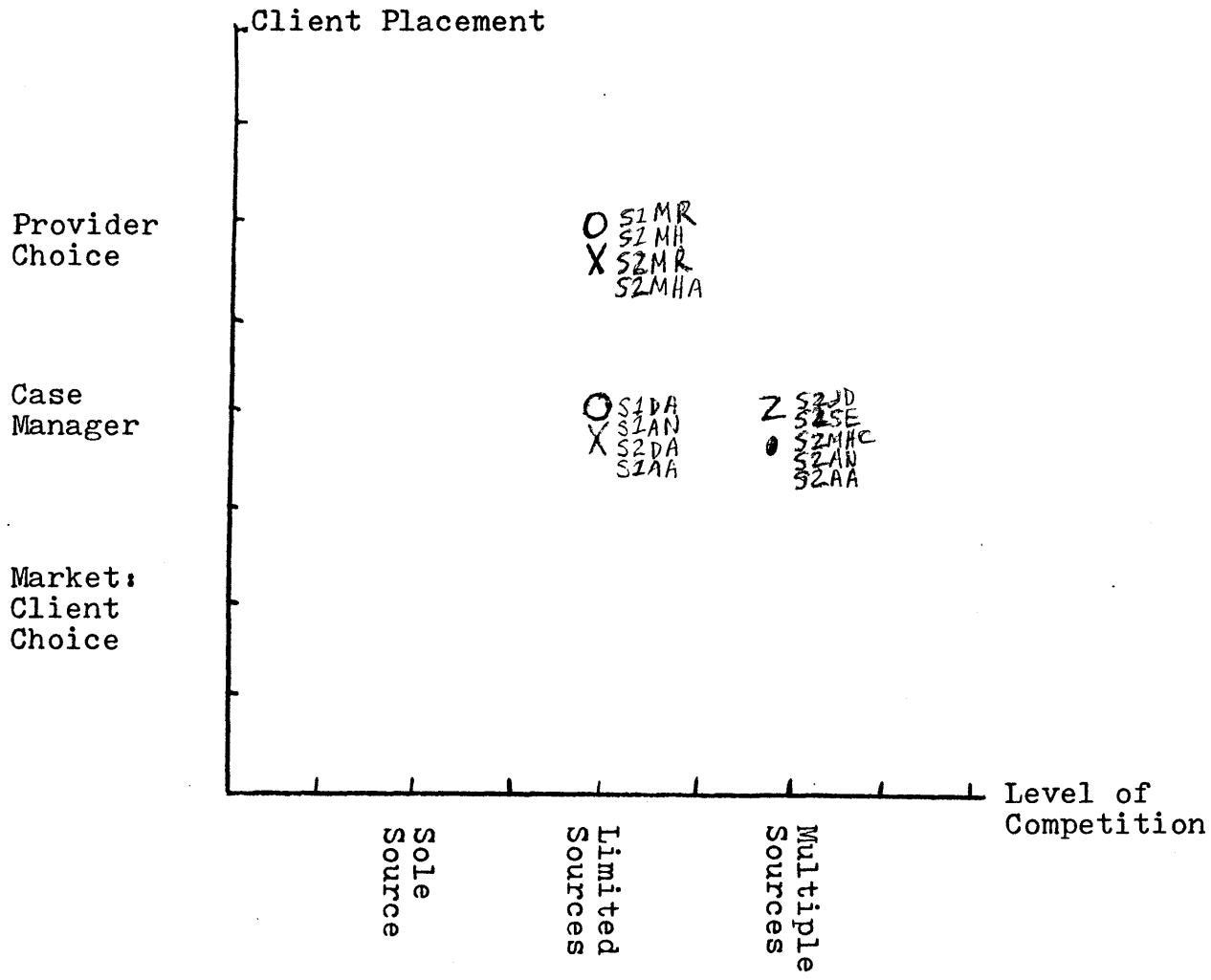
Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- ●=competition high, regionalization potential low
- Z=competition high, regionalization potential high

Graph 6u: Monitoring Information Use-Vendor Changes and Input Standards



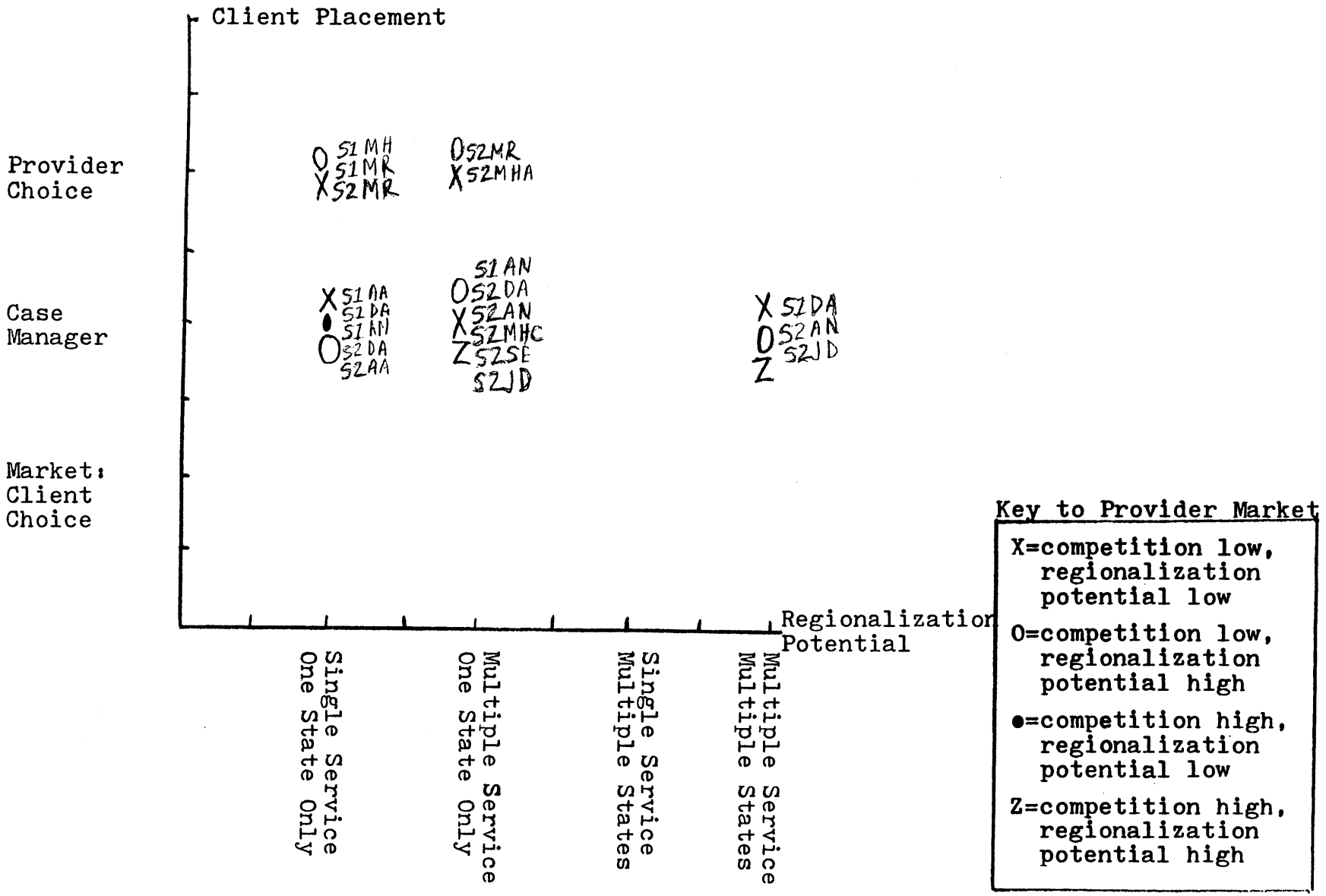
Graph 6v: Level of Competition and Client Placement



Key to Provider Market

- X=competition low, regionalization potential low
- O=competition low, regionalization potential high
- ●=competition high, regionalization potential low
- Z=competition high, regionalization potential high

Graph 6w: Regionalization Potential and Client Placement



It is tempting to dismiss the three contracting relationships due to the restricted variation of contracting in the case study states. However, the negative relationships between contracting and monitoring-what (Graph 6i) and monitoring-how (Graph 6j) may very well indicate that the emphasis on cost reimbursement and cost sharing reduced the perceived need for monitoring, which might be greater if providers were taking more risks (fixed price or performance contracts). The other contracting relationship which exhibited the opposite sign from what was expected, cost-oriented contracting and client placement (Graph 6k), suggested that providers gained more control over who they accepted when they were in a contracting system which required them to take fewer financial risks through cost reimbursement contracting. This finding suggested that a provider dominated contracting system existed for some services.

Although the relationship between input standards and competition (Graph 6l) did not match the preferred relationship in the signed digraphs, this failure may be instructive from a common sense point of view. Rather than the increasing input standards diminishing the possible competition, an increasingly competitive market may actually induce providers to cheat the contracting system which in turn causes state agencies to attempt to increase their control by increasing the number, detail and types of input standards, as the bureaucratic process model predicts.

The remaining relationships were confirmed (see Graphs 6m-6w).

Examining the relationships between conditions and mechanisms in the tables generated two findings. The first finding was that when providers had an active relationship with the legislature, rate

negotiation through formal principles of reimbursement was more likely to be present. Interestingly, the use of community presence as a monitoring mechanism was associated with the lack of an active relationship with the legislature. This suggested that when mechanisms in general are more formalized or complex, providers were more likely to seek legislative assistance. Conversely, it may suggest that when, for historical reasons, active relationships exist, providers and/or state agencies formalized their relationships. The evidence from services to the mentally retarded in State 1 was that an active relationship with the legislature caused the formalization of processes.

The second finding was that the resources committed to monitoring had a substantial impact on the "how" and "who" of monitoring. That is, where more resources were committed to monitoring there was a higher level (right side of the axis) of how monitoring was done and who did the monitoring. Where there were fewer resources committed to monitoring, there was a lower level of how monitoring was done and who did the monitoring. While this is common-sensical, what was interesting was that in both cases the variation was only between the left-side and the middle of the axis. Further, the commitment of fewer resources to monitoring was associated with a cost control objective, while committing considerable resources to monitoring was associated with a mixed objective or an emphasis on program content. In all likelihood, this was because fiscal monitoring procedures are simpler and the monitoring protocols were developed long ago. This makes fiscal monitoring easier and more precise. It is unclear, however, whether the cost control objective was adopted and consequently used fewer resources, or whether the lack of resources made a cost control objective the only possible choice.

C. Use of Monitoring Information

The primary use of information appeared to be oriented to procedural and contractual changes of such things as the rate, the units of service purchased, and problems in specific agencies. Consequently, data were sent to compliance enforcement agencies and rate-setting bodies. Nowhere, however, was the information about quality used to change the rate. Rather, information about over/under spending was used to change the rate. Monitoring information appeared to stay within

channels: fiscal information went to rate setting and other fiscal staff; program information went to program staff.

In only one state agency was monitoring information used to revise program standards and state agency practices. Apparently, the information always flows in one direction: to state agencies which then recommend changes in provider behavior, rather than analyzing the context in which providers act.

D. Multiple-State Providers

Multiple state providers were found as partial parts of the market in drug abuse services in State 1, and in services to abused and neglected children, and juvenile delinquents in State 2. After the study period, services to abused and neglected children in State 1 began using multiple state providers, although there still remained very limited sources from which the state could contract for services. It was expected that state agencies would make special provisions if they were contracting with multiple state providers and the relative freedom from state pressure these providers might enjoy. State agencies in program areas where multiple state providers were found did not appear to treat them differently. There did tend to be moderate to considerable resources committed to monitoring with an associated mixed objective control system. Client placement by a case manager was also more prevalent. All three of these factors could be attributed to general trends.

Chapter 7: Implementation Models as Models of Change

Making changes is a matter of strategies and tactics. The implementation models represent the strategies for deciding which tactics are most appropriate under different conditions. The control mechanisms represent the tactics through which any changes must be implemented.

To change the current contracting system requires an understanding of its current milieu, and a set of propositions which indicate the likely intervention areas. Elmore's summary of the models of implementation are a good place to begin if one recognizes some of the models' limiting problems. These models ignore the level of hierarchical structure and consider intra-group, inter-group, interorganizational and intergovernmental relations in similar ways. The systems management model is used to structure decision-making problems intra-organizationally. The bureaucratic process model is most often used to explain worker-versus-management problems. The organizational development model is usually used to explain intra-group and inter-group relations. The bargaining and negotiation model is often used to explain problems at every level from inter-personal relations to inter-group relations to inter-governmental relations. Since changes may be made at many hierarchical levels, the choice of the intervention point may influence the choice of an implementation model for guidance.

One problem with the four models is that they are not prescriptive to the same degree. The systems management model is primarily normative. The bureaucratic process and the bargaining the negotiation models are primarily descriptive. The organizational development model can be both descriptive and normative. Consequently, if one takes a

snapshot of a problem within an organization, there will be clearly defined elements capable of interpretation within all four models. This should not be surprising. Models are simply alternative abstracts of reality. They can not encompass all aspects of reality and remain a shorthand for it. Instead, each model has a different method of abstraction and emphasis.The goal is to choose the model which allows an agent to effect the most change with the least disruption within any specific context.

When using these four models to explain reality, it may be necessary to use more than one model. In the example below, the routines found in a bureaucratic process model were continued, because the street-level bureaucrats correctly perceived that the state had a poor bargaining position. A study of the special education reform law in Massachusetts (Weatherly, 1979) illustrates these principles. State bureaucrats were given a law which they did not have the resources to implement. Knowing this, street-level bureaucrats in local school systems were able to distort the policies to their ends. Despite an equalizing formula, rich school districts fared better monetarily under the law than poor ones, because they had the resources and sophistication to challenge funding decisions.

It is possible to project the behavior of state agencies and the responses of providers using the four implementation models. State agencies, according to the systems management model, attempt to clarify and objectify goals and standards and to develop a reward and punishment system for effecting change, relying on feedback about provider standards or other parts of the control system while emphasizing the coordination of the tasks of all actors within the control system.

State agencies and providers would review contract objectives and standards so that both sides would be sure that they are attainable. State agency staff would review the feedback loop to insure that the information suggests specific actions. State agencies would insure that the reward/punishment incentives were sufficient to change provider behavior. This might be implemented through the use of the options on the right side of the axes for pricing, standard-setting, monitoring-what, and the use of performance contracting. Providers would demand more discretionary control over resource use as a means of improving performance.

Providers, according to the the bureaucratic process model, are determined to maintain the service they have traditionally provided, even though the state requires a different service. State agency personnel would respond with increased monitoring and auditing, more detailed standards, and more frequent involvement of state agency personnel in the internal policies of providers. Providers would react by becoming procedure oriented and would work "by the book," or would actively subvert the system.

Providers, according to the organizational development model, must own the program, agree to the standards, and be an integral part of the work group that develops the standards. Standards and monitoring that emphasize only the state's point of view will have a detrimental effect on provider performance. State agencies' allocation to providers should cover not only basic costs, but offer some excess funds which may facilitate innovation by the providers. State agencies would give direct feedback to providers and allow them the opportunity to resolve negative feedback themselves.

In the bargaining and negotiation model, state agencies develop more detailed and complex standards than they can expect to be able to enforce. Monitoring and the use of monitoring information is designed only for superficial purposes as a threat. Providers attempt to minimize the threat of state agencies imposing standards by appealing to the legislature and by contending that they have superior program knowledge. State agencies use resource allocation as a threat. Providers may attempt to neutralize this threat by political pressure and by lobbying to formalize the way in which resources are allocated.

There is to at least partial evidence to support all four implementation models. In the systems management model it appears that the states have not allowed providers to become responsibility centers accountable for their output but instead have concentrated on internal provider operations. As might be expected, the providers have demanded more discretion and greater internal control over what resources they use to accomplish any given ends. There are no clearly specified objectives as evidenced by performance standards, and there seems to be no objective means of measuring actual performance in use in the control system. Since providers indicate that their own standards exceed those of the state, it could be argued that the state's controls are not sufficient to hold providers accountable. Lastly, the feedback in the system does not appear to provide state agencies with the information required to allow the control system to be self-correcting.

The bureaucratic process model also appears to be supported by the responses of providers. Providers are able to turn the states' attempts to enforce new routines through the use of monitoring into a means for paying for changes that providers want, thereby reinforcing the provider

service orientation. There is little evidence that providers are unable to deliver a service that is the same service that they have always delivered (or a preferred more expensive version) with the exception of substance abuse services in both states. The bureaucratic process model also appears to describe state agencies aptly, particularly State 2. State 2 appears to have become procedure-oriented. This is evidenced by concentration on layers of bureaucracy and increased paperwork as a means of control.

The organizational development model stresses consensus building and accommodation which has not occurred in the control system. For example, the non-price negotiations which state agencies carry on with providers appear to be one way---the state agency's. Providers do not "own the standards" which mitigates the potential effectiveness of the control system.

The bargaining and negotiation model gets substantial support from the study. For example, State 2 appears to have developed a more detailed set of standards than it can truly enforce. What is cited in some services during the monitoring process becomes a mental game where providers attempt to get improvements paid for and state agencies only cite improvements that they think the state legislature will fund. State agency staff acknowledge that they cannot really de-accredit providers despite tough licensing and accreditation laws. The non-price negotiations can, in fact, change not only the components of the service but the rate for the service so that the state attempts to get a lower rate for the same service while providers attempt to keep the same revenue but deliver fewer units of service.

It is often possible to look at the same piece of evidence and

interpret it differently based on the four models. For example, providers suggested in both states that there was a "lack of clear standards." Following the systems management model it might be suggested that the standards were not objective and measurable, and that this created the problem. Following the bureaucratic process model it might be suggested that new standards too different from current practices would not be implementable. Using the organization development model it could be suggested that the problem with the standards is simply that providers had not participated in the process and therefore did not agree to follow the standards. Using the bargaining and negotiation model it could be suggested that there are really two sets of standards, state standards and provider standards, and that there is an on-going battle as to which standards will prevail.

As another example, many providers in States 1 and 2 contended that their own standards were tougher than the state's standards. Using for example the bureaucratic process model, this could be interpreted as meaning that providers declined to change their routine becuase they feel their current routines are better. In the organizational development model, this statement may indicate that providers are chortling because they know that if the state had checked with them first, they could have helped develop more meaningful standards. In bargaining and negotiation, the statement could mean that providers are indicating that they have won the negotiation process and are attempting to induce the state to accept their viewpoint. Under systems management, it could be suggested that the state was not able to interpret its feedback about too few vendors being cited, so that it could change state standards to make them more appropriate for improving care.

The actors in a contracting system may view their world in a way which appears to match one of the models. The overwhelming evidence appears to support bargaining and negotiation as the model being implicitly used by participants in State 2. Virtually all monitoring processes in State 2 are based on the differences between what the state is entitled to do and what it actually does. The state agencies recognize that they do not have the resources to accomplish their mission and use the more severe compliance procedures mostly as a threat. However, it often appears that the state agencies would not use the more severe compliance procedures if they did have the resources, because they recognize their dependence on the providers.

In State 1, the evidence supporting a prevalent implicit model is less clear. Stability appears to be a dominant concern. Even the stress on community monitors could be seen as a traditional voluntary sector concern for community involvement. However, the role of community monitors was clearly as a means of generating information for and about providers. This pushes one toward the systems management model's emphasis on feedback. Consequently, the implicit model appears to be a mix of routines from bureaucratic processes and feedback from system's management.

When using the models as strategies, the choice of control mechanisms may create a system which resembles one of the other models. For example, in following the systems management model, attempts to clarify the reward/punishment incentives may easily result in more detailed monitoring procedures which may create a situation where providers believe the state is intervening in the internal operations

of their agency, which presents a situation best analyzed by the bureaucratic process model, or if bargaining about state intrusion occurs, by the negotiation model. In following the edicts of the organizational model, the process of keeping all actors involved and discussing the control system may evolve into a bargaining process best described by the bargaining and negotiation model. Accepting a lessened emphasis on detailed procedures, as best described by the bureaucratic process model, may well evolve into an active dialogue between the state and providers which may fall under the organizational development model. Finally, one way of strengthening a state agency's bargaining position would be to issue extremely detailed input standards which might shut off negotiation, in a relationship best described by the bureaucratic process model.

Chapter 8: Summary And Future Research

A. Summary

Literature from human services, defense and public works was used to develop relationships between the control mechanisms and the provider market as well as among each of the control mechanisms. These relationships represent the first time the entire contracting system has been viewed holistically.

The preferred relationships were compared to the control mechanisms found in six states. This review was based on materials concerning these states. Overall, the preferred relationships matched three of the six relationships it was possible to establish in the six states. One relationship had an opposite directionality to the preferred relationship, and two actual relationships were neither positive nor negative.

The preferred relationships among control mechanisms were combined in the most effective ways within three different constraints: few monitoring resources; rate negotiation by bidding and client placement by guaranteed areas; and pricing by relative efficiency. These three constraints were chosen for particular reasons. The reality of funding for many services is that monitoring is not a high priority budget item. In many states, contracts for all items must be established according to bidding procedures. Finally, the use of comparisons among providers for establishing rates has been promoted as a tool for increasing their efficiency.

The preferred relationships were then compared to the mechanisms in two states that were studied in detail. These two states had very different provider markets which was the basis for choosing them. In addition, one state had a centralized case allocation process and an

emphasis on informal means of monitoring, while the other had a decentralized case allocation process and an emphasis on formal means of monitoring.

Two things were apparent in these case study states. First, the amount of actual variation in the control mechanisms fell far short of the potential variation. The pricing, reimbursement, standards and monitoring mechanisms tended to be low-end control mechanism options (left-side of the axes); client placement was effected either by case managers' efforts or providers' choice; contracting occurred primarily through cost reimbursement; payment perspective was usually prospective; and rate negotiations were settled by options at either end of the axis. Less variation occurred within the case study states when compared to other states researched in Chapter 3.

Second, the preferred relationships in the signed digraphs matched the majority of actual relationships in the case study states with a few exceptions: most notable, the relationships between contracting and three other control mechanisms. In fact variation in control mechanisms throughout the case study states was limited which reduced the possibility of establishing a pattern.

Working the responses given in the case studies into a larger framework proved more interesting than expected. Four models of implementation were chosen to provide a strategy to guide decisions about which mechanisms should receive the most emphasis. Each model did not generate the same advice for how and when to intervene in the contracting process to make improvements. The same data was interpreted in very disparate ways by the four models. The assumptions of all four models were supported by the responses in the case study states, so no

model could be preferred by the weight of the evidence. In following the propositions of any of the models, one would ultimately find oneself in a situation best described by a different model.

Consequently, the choice of a model to guide the points of intervention in a contracting system remains an art without well-defined parameters. The choice may rest primarily on personal preferences without explicit criteria for guidance. Nevertheless, these models are extremely helpful from both explanatory and normative viewpoints.

My bias is the systems management model with which I have had success in improving contracting systems. I believe the explanatory and normative aspects of the model create a superior structure for making changes. The model creates a structure that is less dependent on personal idiosyncracies for making changes than other models.

The systems management model has been adopted in special education as a way of standardizing and improving service delivery. The model's use in education has proven to be capable of absorbing features of other models. For example, the necessity for mutually determined standards has allowed systems management to capture a positive attribute of the organizational development model. A similar benefit might accrue to the contracting process if state agencies adopt mutually determined behavioral objectives for changing vendor staff behavior as well as changing state agency staff behavior.

This research has established a complex set of relationships among control mechanisms and the provider market. While additional research is needed to increase the variation in the control mechanisms, the proposed set of relationships are a good first step and will prove useful to providers and state agencies.

B. Future Research

Future research should focus on expanding the variation in the control mechanisms, studying the effects of using the four implementation models as change models, and quantifying the interrelationships among the endogenous and exogenous variables. The variation in the control mechanisms could be expanded definitively by finding examples of the use of control mechanisms that are on the right side of the axes for standards, monitoring (what, how, who), the method of pricing and contracting. A second method of expanding the variation would be to study types of states unlike the case study states, such as large contracting states - New York, for example - and states where contracting is not widely used. In both types of states it is possible that the provider market would be different from the case study states.

The four models of implementation are used to suggest areas of change. However, it is unclear how fruitful using the implementation models as change models would be. Two options for study would be to analyze the effects of using an implementation model which matches the implicit model in use, and to analyze the effects of using an implementation model which differed from the implicit model. This variation might occur naturally, because a new manager may or may not share the prevalent implicit model.

The area of future research which could be most helpful to state agency managers and to providers would be to build a model of the varied interrelationships which exist among the control mechanisms and the

provider market. It is unlikely that such a model could be definitive, given current knowledge about the effects of model use and such inter-relationships. Rather, the model would represent a next step after the signed digraphs and could generate likely best choice mechanisms after the provider market and other constraining variables have been determined.

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