Performance Management Collaborative

Learning Project Report
Wisconsin Performance-Based Contracting
Madison, Wisconsin
February 11 and 12, 2002

Methodology of Site Visit and Materials

Larry Jones, Charles Smith and Drew Dawson of the Performance Management Collaborative along with Michael Hatcher and Tony Moulton of CDC spent two days reviewing the Performance-Based Contracting System (PBCS) of the Wisconsin Division of Public Health.

Prior to the site visit, the team was provided with the following documents:

- *Performance Based Contracting Functions, Division of Public Health*
- *Bibliography: Consolidated Contract*
- *Why is this process based on adversarial negotiations and not just friendly discussions among partners?*
- *Performance-Based Contracting in Wisconsin Public Health (a power point presentation)*

On the first day, John Chapin, Administrator of the Division of Public Health, Wisconsin Department of Health and Family Services and his staff presented a thorough, candid overview of the PBCS. The second day was spent reviewing the contracting system from the perspective of several local public health departments. Subsequent to the visit, phone calls were made to several additional local public health officials.

Wisconsin Performance-Based Contracting

History

In 1998, the Wisconsin Division of Public Health initiated a system for the implementation and management of performance-based contracting between the state and local health agencies. The Division did not ask the legislature, the executive branch or federal agencies for permission to initiate the system. They consider the proper management of state and federal funds as part of their fiduciary responsibilities.

Why was it implemented?

The Division noted a myriad of problems with the traditional contracting system that were not conducive to carrying out public health's assurance function

including the categorical program functions being carried out in isolation from each other, and the lack of partnership and coordination with non-public providers. From an administrative standpoint, the contract volume was high and the Request for Proposal process was extremely time-consuming. Contracts were based on process rather than on outcome; there was no penalty for non-performance and no reward for success.

From a local health department perspective, their state contracted programs were not based upon local needs assessments, but upon state dictates; there was no state/local negotiation of priorities. The contracting process was cumbersome and cash flow was frequently a problem because of cost-based reimbursement.

How does it work – the highlights

- The state contracts primarily with local public health departments (LPHDs); they no longer contract for services with non-public providers unless the LPHD is not qualified to provide services or chooses not to provide services. The LPHD choose their level of involvement.
    - LPHDs are not having the capacity to provide all services directly are encouraged to subcontract with non-public providers, to form multi-LPHD consortia, and to form a variety of local partnerships to achieve overall contract objectives.

- LPHD must meet minimum requirements (level I) before they can accept funds.

- Funding allocations to LPHDs are based on demographic and epidemiological need factors – not on how well they can write proposals

- The contract between the Division of Public Health and the LPHD is negotiated by the regional offices, and is based upon a "Quasi Market Setting". The state is the "buyer" and the LPHD is the supplier. Each party is free to not make a "deal".
    - Multiple state and federal programs that impact the same population (immunization, maternal and child health, reproductive health, childhood lead prevention, preventive health, women's health and tobacco) are treated as a single aggregate contract.
    - Boundary statements are defined for each program…what can be funded.
    - There is a move away from funding activities (process) and toward funding changes in health status (outcomes).

- Program quality criteria are preconditions for program participation including:

    - Assessment and surveillance
    - Delivery of public health services
    - Record keeping
    - Information, education and outreach
    - Coordination with related programs
    - Referral network
    - Provision of guidance to staff
    - Financial management practices
    - Data collection, analysis and reporting

- Specific outcome objectives are negotiated between the region and the LPHD, but final approval is required by the state.

- The risk profile is negotiated taking into account the complexity and the innovation of the objective. The Risk Profile determines the portion of the funds that will be recouped if the objective is not attained by the end of the contract year.

- An innovative web-based Contract Information Management Systems (CIMS) is used to negotiate and, subsequently, to write the contract. The CIMS is available to anyone.

- Flexibility is given to the LPHD to move funds within the contract across program boundaries to achieve negotiated program outcomes.

- LPHD is not required to make monthly expenditure reports.

- Cash flow management is stabilized through $1/12^{th}$ total funds monthly payment across all programs; it is not based upon the prior month's expenditures.

- Year end audits focus on health-related outcomes, not fiscal accounting

- Each contract objective is "mapped" to Federal 2010 objectives, state priorities, core public health services and core functions.

Advantages/strengths

- The PBCS focuses on health-related outcomes rather than process measures

- The contact objectives are negotiated based upon local assessments

- Local Public Health Departments do not have to compete for programs dollars; the amount of funding is determined by an epidemiological formula. There is no emphasis on grantsmanship.

- LPHD are provided flexibility in the expenditure of dollars, are released from detailed financial reporting, and their cash flow is stabilized. This is a move away from cost-based reimbursement and toward outcomes-based reimbursement.

- The expectations between the state and local health departments are clearly established through a contractual relationship.

- PBCS encourages the categorical programs to coordinate and to cooperate rather than continuing their "silo" approach.

- State and local public health officials are becoming much more adept at writing S.M.A.R.T objectives focusing on outcomes rather than process. Presumably, the outcome-based focus may translate to other components of their health department management.

Challenges

- The transition to PBCS does not have the widespread support of LPHDs.

- While there is enhanced flexibility to LPHDs, the absence of federal waivers to move funds among categorical program areas limits additional flexibility.

- From a LPHD perspective, the amount of funds subject to PBCS is still relatively small compared to their overall funding stream.

- The negotiating process, which is predominantly done by the regional staff, is a bit cumbersome and time-consuming. According to local officials, there is a bit of a "disconnect" between the state health officials who manage categorical grant programs and the regional and local officials.

- Basing the funding on an epidemiological formula resulted in fairly substantial funding decreases for some of the larger health departments.

- According to LPHD officials, there should be additional training in the principles of PBCS…particularly for regional and state staff. There is, according to them, significant variation in the application of PBCS across the state.

- The risk profile is negotiated by the regional office. There is considerably variability in this negotiation and, according to local health officials, regional staff are not well-trained to do this negotiation. The risk profile upon which recoupment is based is, perhaps, one of the more contentious elements of the PBCS.

- The regional staff is responsible for providing technical assistance and support to LPHD. Their role as contract negotiators sometimes put them in conflict with the LPHD with whom they are to provide technical assistance and with the state staff.

- Determining an appropriate and reasonable maintenance of effort for LPHD is an ongoing challenge. Economic conditions influence the ability of LPHD to assure a maintenance of effort.

- Because the contracts are based on outcome objectives, there is an interest among local health officers in making five-year objectives. It is difficult to demonstrate changes in health outcome in one year.

- Although this is called a consolidated contract, it is really one contract with 5 different work plans and data set requirements, according to some local health officials.

- For local health departments that receive limited funding, it is difficult for them to meet the Quality Criteria. Local health departments were quite concerned with the extent of the Quality Criteria. Meeting these criteria, for which there is no funding, is more expensive than the available funds.

- According to local health officials, while the emphasis is on population-based health, the evaluation is still based more on the provision of health services. State program managers are frequently not "bought in" to the concept of population-based health and may insist on service provision criteria in the contracts.

- PBCS applies to a limited portion of overall local public health department funding.

- According to some local health officials, innovation is killed because it is too risky. If the LPHD does not meet the outcome criteria, they must return a portion of the money. However, the risk profile does take this into consideration.

<u>Observations and Lessons Learned</u>

A performance-based contracting system can be an extremely useful tool in an overall statewide public health performance management system. A PBCS can provide for

increased emphasis on the core public health functions, increased coordination with statewide public health system goals, and an improved accountability for the expenditure of limited public health funds. A PBCS can shift the programmatic focus from process to outcomes and provide contractors with significantly more flexibility in meeting their contract expectations. Likewise, a PBCS can help assure compliance with uniform statewide public health system standards.

While PBCS is theoretically sound, there are numerous practical and logistical difficulties with its implementation. Maintenance of the status quo and a failure to understand the core functions of public health are powerful obstacles to its successful implementation. Continuous quality communications among state, regional and local public health partners is essential to the implementation of a statewide performance-based contracting system. Focusing on outcomes rather than process requires a paradigm shift among public health personnel and a long-term vision of the contracting process.