



Reforming the Commonwealth's \$2 Billion Purchase of Human Services: Meeting the Promise for Clients and Taxpayers

Massachusetts Taxpayers Foundation

in collaboration with

Massachusetts Council of Human Service Providers, Inc.

with the support of

The Boston Foundation

About The Massachusetts Taxpayers Foundation

Through its independent, unbiased research, the Massachusetts Taxpayers Foundation has played an instrumental role in achieving major reforms and promoting sound public policy in state government since 1932. The quality and impact of the Foundation's work is reflected in the eight national awards received in the past eight years.



Massachusetts Taxpayers Foundation

About The Massachusetts Council of Human Service Providers, Inc.



Massachusetts Council of
Human Service Providers, Inc.

The Massachusetts Council of Human Service Providers, Inc., widely recognized as the leading voice for change within the human service sector, is the largest statewide trade association for community-based organizations providing social, rehabilitation, education and health care services. People served by member organizations include: individuals with mental, developmental and physical disabilities; people who are homeless; the frail elderly; abused children or those in danger of abuse; victims of domestic violence; troubled children and others. The mission of the Council is to promote a healthy, productive and diverse human services industry.

About The Boston Foundation

The Boston Foundation, one of the nation's oldest and largest community foundations, has an endowment of more than \$500 million and made grants of \$53.7 million to nonprofit organizations last year. The Boston Foundation is made up of 750 separate charitable funds, which have been established by donors either for the general benefit of the community or for special purposes. The Boston Foundation also serves as a civic leader, convener, and sponsor of special initiatives designed to build community. For more information about the Boston Foundation and its grantmaking, visit www.tbf.org, or call 617-338-1700.



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Introduction: Purpose of the Study

Despite the striking differences in their missions, the Massachusetts Taxpayers Foundation and the Massachusetts Council of Human Service Providers share a common interest in the success of the human services system. MTF, through its independent, unbiased research, has long played an instrumental role in achieving major reforms and promoting sound public policy in state government. MCHSP, as the largest statewide trade association for community-based organizations providing social, rehabilitation, education and health care services, is a leading voice for change within the human services sector.

The Foundation has had a longstanding interest in the purchase of services system, calling for reforms as far back as 1980 when the system was in its early stages. In the years since, purchase of services has grown to a \$2 billion enterprise, or nearly ten percent of the state budget. Over the same time, the shortcomings of the system have become more and more serious, despite a number of studies and attempts at reform. The problems affect everyone involved – clients and their families, service providers, state agencies that purchase services, oversight departments and the Legislature.

Our study takes a detailed look at how Massachusetts' system for purchasing human services functions today. The research draws heavily upon the first-hand experience of a cross-section of individuals who either receive services or work in the system.

This report intentionally parts company with earlier studies of the purchase of services system in several ways. It does not focus on organizational restructuring or bureaucratic tinkering among state agencies. It does not recommend adding new regulations on top of old regulations, or new oversight and auditing entities on top of existing agencies.

Nor does the study call for radical changes that would disrupt a highly complex system serving hundreds of thousands of people each year. Instead, the report offers broad recommendations for fundamental improvements in the management and operation of the purchase of

services system with two overriding goals in mind: meeting the critical needs of clients and providing value to the taxpayers of the Commonwealth.

Project Funding

The Boston Foundation, in its role as civic leader, convener and sponsor of special initiatives designed to build community, generously agreed to underwrite the majority of the project's costs for researching and preparing this report. Several other foundations recognized the importance of this work and agreed to support the project:

- Fidelity Foundation
- Shaw Foundation
- Irene E. and George A. Davis Foundation
- State Street Foundation
- BankBoston Foundation
- Community Foundation of Western Massachusetts

MTF and MCHSP would like to express their deepest appreciation and gratitude to the Boston Foundation and the other funders for their generosity – and their patience – which have made this work possible.

Scope of the Study

For the purposes of this study, the purchase of human services system has been defined to include contracted services under the jurisdiction of the Executive Office of Health and Human Services (EOHHS) that are funded with state general fund dollars. Of the 15 agencies under the EOHHS umbrella at the time we initiated this study, seven agencies – the Departments of Mental Retardation, Mental Health, Public Health, Social Services, and Youth Services, the Office of Child Care Services and the Massachusetts Rehabilitation Commission -- purchase substantial amounts of services from over 1,100 providers, both for-profit and nonprofit. Four of those agencies account for the bulk of purchased services: DMR, DMH, DSS and DPH. Other EOHHS agencies, such as the Department of Transitional Assistance, also purchase smaller amounts of services.

We did not focus on departments outside of EOHHS that also purchase human services: the Department of Corrections, the Department of Education, which purchases special education services from private providers, or the Executive Office of Elder Affairs (which has recently been moved under the EOHHS umbrella). Finally, we did not include Medicaid-funded services which are managed and paid through mechanisms other than purchase of service contracts.

These agencies were not studied in detail because (a) purchased services constituted a very small portion of the operating budgets of the Departments of Corrections and Education, (b) all three of these agencies regulate, procure, and set rates for purchased services in a manner that is not comparable to EOHHS, and (c) Medicaid-funded services are purchased on a fee-for-service reimbursement basis from certified providers who typically do not have to participate in competitive procurements or have detailed contracts as a precondition for receiving funding.

However, most of the 1,100 providers doing business with EOHHS agencies also receive funds from other outside sources, typically including special education and/or Medicaid funds.

Project Organization

MTF and MCHSP selected a joint venture of two Boston-based consulting firms, the Technical Assistance Collaborative (TAC) and the Nessen Group, to undertake the research and analysis for the report. The Technical Assistance Collaborative is a nonprofit consulting firm specializing in health and human service issues including government purchase of service, contracting and privatization. TAC has been commissioned by a variety of states and counties across the country to conduct studies of purchase of service systems. The Nessen Group is a consulting practice engaged in the development of creative strategies and resources for state and municipal governments and nonprofit organizations, and has a strong familiarity with the Commonwealth's purchase of service system.

A steering committee consisting of leaders and senior staff of MTF and MCHSP worked closely with the researchers by rigorously reviewing and evaluating the findings and analysis. MTF staff, principally Glen

Tepke, wrote the final report and formulated the recommendations in consultation with MCHSP.

An advisory board consisting of government and business leaders, policy makers and stakeholders served as a source of independent and diverse viewpoints on the issues raised by the study. The advisory board met a number of times to provide input in formulating the report and in developing strategies for implementing its recommendations. The members of the advisory board were:

- Marilyn Anderson Chase, United Way of Massachusetts Bay
- Cathy Dunham, The Robert Wood Johnson Foundation
- Joseph Feaster, Dimock Community Center
- Barbara Gomes-Beach, Multi-Cultural AIDS Coalition
- John Isaacson, Isaacson Miller, Inc.
- William O'Leary, Executive Office of Health and Human Services
- Richard Richardson, Children's Services of Roxbury

Study Methodology

The study sought answers to several key questions:

- How do clients, families, providers and state administrators and officials perceive the purchasing system?
- How are clients affected by the way the Commonwealth purchases services?
- How do statutory and regulatory requirements impact the performance of the purchasing system?
- How does the current method of pricing affect the quality and outcomes of services?
- What are the strengths and weaknesses of the current purchasing system?
- Does the taxpayer in Massachusetts receive good value on the investment in human services?
- How should the system be improved or redesigned to ensure that the Commonwealth is purchasing services of a quality that meets the needs of its most vulnerable citizens at a reasonable price?

To answer these questions, the study relied on key informant interviews, focus groups and data analysis.

Key Informant Interviews. Over 50 structured interviews were conducted with providers, state purchasers, policy makers, advocates and interested organizations, and others whose work involves provider issues.

Providers – Executive directors and business managers from a sample of providers selected to ensure diversity in geography, clients, and services, and including large (\$10 million or more in annual state contracts), medium-sized (\$1-5 million in annual contracts), and small providers (annual contracts ranging from \$100,000-500,000);

Purchasers – Commissioners, chief financial officers, contracting officers and program directors of the Departments of Mental Retardation, Mental Health, Social Services and Public Health, as well as the Massachusetts Rehabilitation Commission and the Office of Child Care Services;

Policy makers and overseers – The chairs of the Joint Committee on Human Services and Elderly Affairs, and senior staff from the House and Senate Ways and Means Committees, the Executive Office for Administration and Finance, the Operational Services Division, the Comptroller's Office, the Executive Office of Health and Human Services, and the State Auditor's Office; and

Advocates and others – Leaders of major advocacy and provider membership organizations representing people with physical disabilities, mental illness, mental retardation and other developmental disabilities, children, and persons suffering from addictions, as well as selected attorneys, accountants and consultants with practices principally devoted to providers or consumers.

The purpose of the interviews was to gather information and professional opinions from those individuals who are the most familiar with the purchase of services system. Questions were prepared in advance and shared with the interviewees prior to the scheduled meetings. The interviews elicited a wide range of responses about the purchase of service system and its impact, both positive and negative, from consumers, families, providers and all levels of state government involved in the purchase of services.

Without exception, everyone interviewed was interested in openly and forthrightly giving their opinions of the purchasing system and hopeful that in some way their participation might help to improve the system.

Focus Groups. The researchers hosted ten focus groups – five for providers and five for clients and family members – at five locations across the state. The purpose of the focus groups was to garner first-hand experiences of providers and consumers with the purchasing system. The questions posed to providers explored the strengths and weaknesses of the purchasing system. With clients and families, the questions focused on the accessibility and quality of services and their satisfaction with the services that were available to them.

Data Analysis. Available databases were analyzed including: the EOAF Uniform Financial Reports, budget and expenditure data from the Commonwealth's accounting system (MMARS), and purchasing agency contract data, financial data, performance data, and provider data. A variety of supporting documents were reviewed as well. These included the several previous studies of the purchase of services system, independent audits conducted by the State Auditor's Office, annual reports of purchasing departments, reports of purchase of services in other states, and literature on best practices in system design and service delivery.

Terminology Used in the Report

For economy in writing the report and the convenience of the reader, stakeholders in the purchase of services system are frequently referred to using short-hand terminology.

The term **clients** refers to the individuals that receive or are eligible to receive services, as well as family members and other caregivers that interact with the purchase of services system.

Providers are the private, nonprofit or for-profit organizations that contract with purchasing agencies to deliver and manage human services.

Purchasing agencies are the major service-providing departments that purchase services from the providers: the Departments of Mental Retardation, Mental Health, Public Health, Social Services, and Youth Services, the Office of Child Care Services and the Massachusetts Rehabilitation Commission. As discussed above, other state agencies that purchase human services were not included in the scope of the study.

The **oversight agencies** promulgate regulations related to the procurement of human services, oversee financial reporting, audit financial reports, and monitor and approve individual contracting and payment agreements. The oversight agencies include the Executive Office of Health and Human Services as the umbrella agency with overall budget authority over the purchasing agencies, Executive Office for Administration and Finance and its Operational Services Division, the State Auditor, and the State Comptroller.

The committees of the **Legislature** most directly involved in the oversight of purchase of services include the Joint Committee on Human Services and Elderly Affairs, which considers all legislation related to the statutory mandates for purchasing agencies and their contracted providers. In addition, the House and Senate Ways and Means Committees oversee the purchasing agency budget requests, and assess the costs, performance, and value to the public of the purchase of service budgets. Finally, on an ad hoc basis the House and Senate Post Audit and Oversight Committees monitor and prepare analyses of state human service expenditures.

The report also relies heavily on acronyms to conveniently refer to many of these organizations, as well as the system for purchasing services, which are spelled out below:

DMH	Department of Mental Health
DMR	Department of Mental Retardation
DPH	Department of Public Health
DSS	Department of Social Services
DYS	Department of Youth Services
EOAF or A&F	Executive Office for Administration and Finance
EOHHS	Executive Office of Health and Human Services
MRC	Massachusetts Rehabilitation Commission
OCCS	Office of Child Care Services
OSD	Operational Services Division
POS	Purchase of Services

Background: The Development of Purchase of Services in Massachusetts

With a long history at the forefront of providing social services for the poor and disabled, Massachusetts was a natural setting for the development of a new system to serve its most disadvantaged citizens. Seeking to offer better care for the residents of state institutions, the Commonwealth launched a bold venture to build a network of private providers to deliver human services in community settings. In its first 30 years, the purchase of services system has grown by leaps and bounds into a \$2 billion industry. At the same time, that growth has been accompanied by ever more serious flaws in the functioning of the system that a series of attempts at reform have failed to address.

Roots in Deinstitutionalization

The creation of a community provider-based system of human services in Massachusetts has its roots in the deinstitutionalization movement, which had its origins in the early 1950s and became a major force in the Commonwealth in the early 1970s. This conversion from state facility-based services was motivated primarily by humane concerns for the institutionalized individuals and by the growing recognition that institutional care had become more expensive than community-based alternatives.

Massachusetts had long been in the forefront of humane treatment for people with mental illness or other disabilities. In 1850 Massachusetts opened the first state hospital for people with mental illness. In the same year, the Commonwealth opened the first training center for youth in the juvenile justice system.

By 1950, Massachusetts had eleven state hospitals, eight state schools for people with mental retardation, and five training schools for adjudicated youth. At that time, the combined census of these facilities exceeded 23,000 individuals.

Strong philosophical shifts drove advocates to request that people with mental and cognitive disabilities be treated in “least restrictive settings” and have the opportunity to live in “normalized” environments. Similarly, alternatives to “reform” schools were sought

to permit the more humane and effective treatment of juvenile offenders.

Federal Initiatives Fuel Growth in Community-Based Services

At the same time that Massachusetts was moving toward small community-based models of care, a number of significant changes were taking place on the federal level that were as powerful as the deinstitutionalization movement in stimulating state initiatives to contract services to community provider agencies.

Prior to the early 1960s, the federal government played a relatively minor role in human services at the state and local levels. The federal government contributed only small amounts of money to human services and exercised little leadership in terms of preferred service models or clinical best practices.

However, beginning in the 1960s a stream of new federal legislation fundamentally changed the amounts and types of funding available for human services nationally and in Massachusetts. Equally important, the federal initiatives encouraged the development of community-based services purchased from provider agencies.

Most of the federal initiatives provided specific incentives for community-based non-institutional services as opposed to state-operated facility-based services. States accelerated the move to contracting with community providers in order to obtain maximum benefits from federal funding.

The goals behind much of the legislation was to encourage states to place greater emphasis on strengthening family life, and helping needy families attain the greatest feasible degree of economic and personal independence. The new federal mandates and funding sources created many new services beyond those developed as replacements for state-operated institutional care, such as foster care, day care, and a variety of elder services.

In 1962 the federal government began paying 75 percent of the costs of social services for welfare recipients. For the first time, states could receive reimbursement for providing community-based social services for families enrolled in Aid to Families with Dependent Children (now Transitional Assistance for Needy Families) and individuals receiving benefits under the Aid to Aged, Blind, and Disabled Programs (now Supplemental Security Income). Massachusetts quickly developed its administrative capacity in this area to ensure it could capture as many federal funds as possible.

This legislation was quickly followed by the Community Mental Health Centers Act of 1963, the Federal Economic Opportunities Act of 1964 and the Older Americans Act of 1965. Each of these laws continues to provide funding for both community-based services – Community Mental Health Centers, Community Action Program Agencies, and Area Agencies on Aging, respectively – and for service management and delivery infrastructure in Massachusetts.

In 1965 Congress enacted the Medicare and Medicaid programs, resulting for the first time in massive federal financing of primary health care and certain attendant social services for individuals who were over 65 or on welfare or otherwise indigent and uninsured. In most states Medicaid is now the single largest payer of services for youth, people with mental illness, and people with mental retardation.

The Federal Special Education Act was enacted in 1967, providing federal funding as well as requirements for special education and related services, including day and 24-hour residential services in the community for children under 22 with special needs. This federal law was preceded by Massachusetts' special education statute, Chapter 766, in 1966. As with Medicaid, state and local special education funding is now a major source of income for some human services providers.

Also in 1967, Congress enacted the Federal Social Security Act amendments that included the "donated funds" provision, which allowed states to

leverage additional federal matching funds based on private funds "donated" by private provider organizations. This provision stimulated rapid contracting of human services to provider agencies that had other sources of support, such as United Way, private fundraising and endowments.

Title XX of the Federal Social Security Act was enacted in 1974. This replaced the old welfare-based social services programs with broader eligibility standards and more flexible community services opportunities. In the area of youth services, Title IVA and later Title IVE provided funding for child care, adoption-related services, foster care, and family re-unification.

In 1984 Congress added the home and community-based waiver provision to Medicaid. This provided incentives and flexible Medicaid resources to move individuals with mental retardation and certain other disabilities out of large institutional settings and into small community-based programs.

Massachusetts Takes the Lead

The deinstitutionalization movement, fueled by the string of federal initiatives, came to a head in Massachusetts in 1972 under the leadership of Governor Frank Sargent. In that year, Jerry Miller, commissioner of the newly created Department of Youth Services, closed all of the state's notorious training schools and created, virtually overnight, a system of purchased services for juvenile offenders.

With this watershed event, the movement of human services to the community began in earnest.

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Lawsuits on behalf of residents of state institutions also figured prominently in the development of purchase of services. Deinstitutionalization of the Commonwealth's state schools for people with mental retardation was stimulated by the Belchertown consent decree in 1973. This settlement, which eventually applied to all state schools in the Commonwealth, established census limits and staffing requirements for state schools. Moreover, it required the creation of numerous community-based alternatives to the large, old state institutions.

When the Belchertown consent decree was signed, the census of the eight state schools exceeded 5,000. Today only three of the schools remain, and the total census is below 1,200.

Belchertown was quickly followed by the Brewster consent decree, which required a significant reduction in the census of Northampton State Hospital coupled with the development of new community-based services for people with mental illness in western Massachusetts. The consent decree was followed by rapid reductions in population at all the state mental health hospitals.

In the early 1970s, eleven hospitals housed over 23,000 people with mental illness. Today, the three remaining state hospitals have less than 800. As with the deinstitutionalization of the state schools, much of the reduced reliance on state hospitals was accomplished through contracts with private community provider agencies.

At the inception of the new system, the Commonwealth faced a fundamental “make or buy” decision. It could shift the residents of its large facilities to smaller, state-operated programs, or it could procure the services from private vendors. For the most part, the state opted for purchased services.

There are several reasons why the community-based system of care developed as a contracted rather than state-provided system. First, a network of charitable, nonprofit and advocacy organizations interested in providing services already existed. Rather than attempt to compete, government availed itself of these experienced, innovative and willing community providers.

Second, decentralized administration of local service delivery, especially by existing organizations, dovetailed with the fundamental purpose of community-based services: to involve home communities, and the citizens of those communities, in the delivery of social and rehabilitative services to needy citizens. Service delivery in the community helped to overcome the traditional isolation of service recipients and their families from natural supports.

Third, and perhaps most important, state government’s administrative systems and structure were

incompatible with community-based service delivery and the “normalizing” intent of deinstitutionalization. The state’s administration of direct service delivery had traditionally addressed institutional needs rather than the varying needs of clients in community-based care.

The roots of the purchase of services system in Massachusetts run deep. In 1850 when the first state hospital and first state training school for juvenile offenders were established, there were already a number of well-established nonprofit provider agencies in Massachusetts. These included the Massachusetts Society for Prevention of Cruelty to Children, Boston Family Services, and the New England Home for Little Wanderers (now the New England Home). These, plus faith-based organizations such as Catholic Charities and Jewish Family Services, were funded entirely by charitable donations.

The Commonwealth faced a fundamental “make or buy” decision and opted for purchased services.

The movement toward unified charitable fundraising came to Massachusetts in 1935 when the organization now known as the United Way of Massachusetts Bay was founded by 97 local social service providers. Today, many of the nonprofit agencies that receive funds through the Commonwealth’s purchase of services system also receive charitable contributions through the United Way and related fund-raising activities and endowments.

The deinstitutionalization of the 1970s fueled rapid growth in the provider system. In 1971 the Massachusetts budget for purchased human services was only \$25 million. In 1978 it had expanded to \$250 million, with over 2,500 separate contracts and 15,000 provider employees. By 1986 the Commonwealth was spending \$614 million, with 1,200 providers and 4,700 contracts.

This growth was accompanied by the development of new and varied service models to address emerging social priorities, such as more independent living environments for previously institutionalized individuals, homeless shelters, vocational programs, group homes, foster care, and early intervention for children up to age three.

Purchase of Services Today

Today, instead of large state schools and state hospitals, the Departments of Mental Retardation and Mental Health turn to community-based nonprofit providers for residential care, day programs, vocational training and mental health centers. Rather than reform schools, the Department of Youth Services relies to a large extent on a mix of secure residential, day reporting and foster care programs operated by private providers. In place of institutional group care, the Department of Social Services provides a variety of preventive and residential care programs tailored to the needs of children and families, ranging from day care to respite and foster care. The Executive Office of Elder Affairs offers home care services through 27 home care corporations and numerous local providers. The Department of Public Health administers early intervention programs for disabled infants and children as well as outpatient programs for alcohol and drug abusers.

All the state purchasing agencies have different ways of purchasing services for their clients. The Departments of Mental Retardation and Mental Health depend upon their area offices to negotiate contracts for all types of residential services, day treatment, medication clinics, employment and job training services, outpatient substance treatment, and short-term hospitalizations. The Department of Social Services employs a Lead Agency model, in which DSS contracts with a provider to manage services within a specified region. The Lead Agencies in turn subcontract with other providers for residential care and family-based services. The Massachusetts Rehabilitation Commission pre-qualifies provider agencies to provide employment services to people with disabilities, and then uses consumer-specific service authorizations to initiate services. The Office of Child Care Services issues vouchers for child care services, but uses standard contracts and fee-for-service payments for other types of service.

EOHHS Purchase of Services Spending, FY 2002

\$ millions

Agency	Total FY 2002 Budget	FY 2002 Purchase of Services Expenditures	POS as % of Budget
Department of Mental Retardation	\$ 930.4	\$ 618.7	66.5%
Department of Social Services	569.5	314.0	55.1
Department of Mental Health	590.9	350.9	59.3
Department of Public Health	513.4	249.0	48.5
Office of Child Care Services	395.4	176.9	44.7
Department of Transitional Assistance	818.0	101.9	12.5
Department of Youth Services	123.9	78.8	63.6
Mass. Rehabilitation Commission	43.5	37.4	85.9
Mass. Commission for the Blind	26.4	9.5	36.0
Comm. for Deaf & Hard of Hearing	5.5	1.6	29.1
Total – EOHHS	\$ 4,016.9	\$ 1,938.7	48.3

Source: EOHHS and Comptroller's Office

While the number of providers has remained relatively constant over the last 15 years, state spending on purchased services has continued to expand rapidly. The purchase of services budget has tripled since 1986 and is now more than \$2 billion annually. Today the provider network employs over 60,000 people, with more than 30,000 directly funded by state contracts.

The growth of purchased services is the result of a number of factors. State-funded community-based programs have been expanded to reduce waiting lists and serve more residents, such as developmentally disabled residents served by DMR. The Commonwealth has also moved aggressively to take advantage of federal reimbursements for Medicaid-eligible services. At the same time, the process of moving clients from state-operated institutions to community settings has continued.

Purchase of Services Today

- Over 600,000 individuals and families – nearly one in ten people in the Commonwealth – directly receive services through the purchasing system.
- The state spends about \$2 billion annually on purchased human services.
- Human services are purchased primarily by departments under the Executive Office of Health and Human Services, as well as the Departments of Corrections and Education.
- The Departments of Mental Retardation, Mental Health, Social Services and Public Health are the largest purchasers of human services.
- About 1,100 private providers, primarily nonprofit corporations, contract with the state to provide human services.
- The provider community employs an estimated 60,000 people. Of these, over 30,000 social services jobs are directly funded under state contracts.

The human services sector has a significant economic impact in Massachusetts. Virtually all of the \$2 billion in spending remains in the state to be recycled back into the local economy. While there are no statewide analyses, several local studies have attempted to estimate the economic impact of human services expenditures.

An analysis by the University of Massachusetts Center for Economic Development

found that the human services industry accounted for 4.6% of total employment in the Pioneer Valley, compared to only 3.1% for the construction industry and 3.9% for the transportation, communications and utilities industries combined. The study concluded that every four jobs in the human service sector creates one additional job in the regional economy due to spending on insurance, business equipment and supplies, building maintenance and security, and professional services. Similarly, a Clark University Study in Worcester County found that each dollar of social service spending produced an additional \$0.74 of local business income.

Human services also have a less direct economic impact by enabling thousands of people to go to work every day knowing that a vulnerable family member is being cared for. Were these programs not in place, family members would be pulled from the workforce to provide care.

As the Worcester report stated: "The critically important role of the human services industry in enhancing the quality of life in the areas and thus fostering a more inviting and productive environment for all businesses in the county is not taken into account in the numbers, but is of great importance."

Human services enable thousands of people to go to work every day knowing that a vulnerable family member is being cared for.

Attempts to Correct the Course

The problems and flaws in the purchase of services system detailed in this report are not new, but have been growing along with the system itself almost since its inception. Private research organizations, the Legislature and the administration have been criticizing the system and calling for reforms for years.

In 1980, the Massachusetts Taxpayers Foundation released *Purchase of Service: Can State Government Gain Control?*, which argued that state government needed to maintain a strong negotiating position as providers took over more and more state human service functions. It also observed: "Social and rehabilitative services lack the entire array of regulatory mechanisms that the health care industry has which facilitate setting fair, reasonable, and adequate rates." The report bemoaned the fact that the rate setting commission in existence at that time merely approved contracts and rates that had been negotiated between purchasing agencies and providers.

In 1986 the Senate Ways and Means Committee under the leadership of Chair Patricia McGovern issued a comprehensive review, *Purchase of Service: Protecting the Promise of Community Based Care*, which called for an improved, systemic, professional approach to the management of POS. At the same time, the State Auditor's Office published the *Blue Print for Reform* critiquing the conduct of the system.

At the end of the 1980's, Governor Dukakis engaged Assistant Secretary of Administration and Finance Peter Nessen to propose a plan for reform of the POS system. His *Purchase of Service Reform: Final Report* concluded that:

The past ten years has seen the growth of a contracting system which has been encumbered with bureaucratic procedures and paperwork. Such procedures are designed to achieve the same kind of control over provider entities as that which exists over state operations. This has resulted in micromanagement of contractors. Providers have sacrificed the fiscal viability of their agencies to serve more and more clients with inadequate resources.

As recently as 2002, former Health and Human Services Secretary Charles D. Baker, Jr., prepared a report for the Pioneer Institute that called for reorganizing the human services bureaucracy along functional lines and integrating data management across the system.

While each of these reports was successful in drawing attention to the growing problems in the purchase of services system, none led to major or lasting reforms.

Findings: A Flawed System for Purchasing Human Services

While the Commonwealth's vast human services system has an impressive record of accomplishments, the business relationship between the state and the private agencies that provide the bulk of services is urgently in need of an overhaul. State agencies and providers are trapped in a web of redundant and outdated organizational structures, bureaucratic paralysis, micromanagement and misplaced priorities that make it nearly impossible for service providers to deliver quality services while remaining financially sound. Clients – the Commonwealth's most disadvantaged residents – face waiting lists, duplicative and uncoordinated care management, and services ill-matched to their needs as they attempt to navigate a Byzantine system.

The problems in the purchase of services system run deep. Excessive time and money is spent on contract administration by both purchasing agencies and providers. Numerous state agencies are involved in the oversight of each contract, with each agency employing its own performance standards, contract requirements, policies and procedures. Several human services departments operate a bewildering array of area and regional offices that create overlapping, duplicative layers of management.

Procurement and contracting focus on processes rather than results. Monitoring and evaluation concentrate on satisfying bureaucratic requirements rather than ensuring quality services and positive outcomes. Critical resources are spent preparing financial reports and providing performance data that is not used in managing the system. Policymakers and taxpayers have little or no concrete information on what the state's investment in human services produces.

The bureaucratic impediments to performance compound the financial pressures faced by providers. Rates for many service contracts have been frozen for more than a decade while administrative requirements have increased, leaving many providers inadequately

funded to attract and retain qualified staff. Special appropriations to increase the salaries of the lowest-paid direct care workers have made only a small dent in a problem that has reached crisis proportions. Budgets are not reconciled with service levels, and agencies are expected to do more with less.

These shortcomings produce a lower quality of services for clients and their families, who frequently face waiting lists, barriers to access, and difficulty negotiating their way around the system. Care management functions are sometimes duplicated between the state and providers. Individual clients and families with multiple needs often work with multiple case managers. In many instances, care management is program-focused rather than client-focused, often resulting in poor fits between needs and services provided.

These problems are systemic, the results of the structures, practices and incentives that have evolved and become ingrained in purchase of services over the last three decades. Many stem from policies and procedures that served legitimate purposes at the time they were implemented, but have had unintended consequences or have grown less functional over time. The weaknesses are not the fault of any particular group of people involved in

human services. All of the actors in the system, from providers to purchasing agency staff to oversight officials and the Legislature, are doing their best to perform their respective functions and help meet the real needs of the clients. But they are playing their parts in an increasingly flawed system that gets in the way of accomplishing their shared goals.

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A Record of Accomplishment

As reviewed in the preceding chapter, the Commonwealth's purchase of services system originated in the era of deinstitutionalization in the late 1960s and early 1970s. The shift from large, state-operated facilities to services provided by community-based private

agencies was expected to bring a number of advantages:

- Allowing clients to live in home-like settings to encourage independence, self-reliance and greater involvement with work, family and community;
- Developing flexible, appropriate, close-to-home programs that give clients and families a greater voice in the programs in which they participate;
- Taking advantage of providers' creativity and dedication, as well as their network of relationships and supports in the community; and
- Shifting considerable savings realized from institutional closings to support program, staff and capital costs in the community.

Much of this vision has been achieved, producing significant benefits for the Commonwealth and its citizens. Hundreds of thousands of individuals are served close to their home communities. Many of these individuals, both adults and youth, would have been institutionalized or incarcerated without these community services. Thousands of children can now remain at home and in school, and thousands of adults with serious disabilities can work towards independent living and self-sufficiency.

Since the early 1970s, many large institutions have been closed: Metropolitan State Hospital and Gaebler Children's Unit, Danvers State Hospital, Gardner State Hospital, Foxboro State Hospital, Boston State Hospital, Grafton State Hospital, Belchertown and Monson State Schools and all five of the DYS training schools. Others have been substantially downsized. The savings resulting from these changes have been significant both in terms of operating costs and avoiding long term capital costs to the state. The vision and commitment of providers and state government and legislative leaders have assured that much of these savings is reinvested in community human services.

In addition, Massachusetts has taken maximum advantage of federal initiatives and funding sources to finance new community-based services. Nationally, Massachusetts is recognized as a leader in using federal funds creatively to expand services for citizens in need. The presence of a large and vital private provider industry was a key factor in being able to utilize new federal funds quickly and effectively.

The early spirit of cooperation and partnership that developed between state government and nonprofit providers spawned innovation and creativity in program design. Many states now emulate Massachusetts' models for rehabilitation and recovery for people with disabilities, for supported housing and employment and for youth services and juvenile justice programs. Massachusetts has also developed some innovative models for purchasing services, such as the Department of Social Services' Lead Agency approach.

Elements of a Functioning System

These achievements are all the more remarkable – and a tribute to the dedication of Massachusetts human services workers, both state and private – in light of the serious problems plaguing the system today. The shortcomings identified in this chapter can be traced to a series of fundamental structural flaws in the purchase of services system. These weaknesses are not the result of conscious design, but the end result of 30 years of organic growth and evolution. Policies and procedures have been developed incrementally over the years in response to the problems and issues of the day, but typically without sufficient attention to their impact on the overall functioning of the system. In several cases, reforms intended to strengthen accountability or save dollars have had the unintended effect of undermining the performance of human services.

To effect the transition from a system of state-operated institutional care to one of provider-operated, community-based services, the state had to build a functioning market for human services where none had existed before. Such a system would necessarily have several essential elements:

- Managing the system by assessing the needs for services, setting priorities, and using evaluation results to improve performance;
- Holding the system accountable for performance and assuring citizens that quality services would be provided with proper responsibility for the public dollar; and
- Coordinating access so that clients receive the right services in appropriate settings;
- Purchasing services in a competitive market that fosters high performance and quality care by providers;

- Setting prices that adequately reimburse providers for the costs of developing and operating community programs that meet the state's standards for quality of services and outcomes for clients;

However, this study concludes that these basic elements of a system of human services are not functioning correctly or, in some cases, not functioning at all. Policies and structures that were initiated for these purposes have fallen into disuse, no longer serve their original purpose, or were never developed in the first place. As a result, said one senior policymaker, "There is no system for purchasing human services in Massachusetts."

The remainder of this chapter will look at each of these basic elements of a purchase of services system, contrasting the way each element should contribute to a functional whole with the way POS actually works – or doesn't work – in Massachusetts.

Managing the System

Purchased human services should be an integral part of a coherent system for providing care and support to the state's most disadvantaged residents. Each of the other elements discussed in this report – ensuring accountability, coordinating client access to services, procuring in a competitive market, and setting prices – is a key piece of the service delivery system. At a broader level, the state needs to define its objectives and manage the system to achieve them by:

- Assessing the needs for human services and the state's capacity to meet those needs;
- Setting priorities for the allocation of limited state resources among competing needs;
- Planning services to meet the highest priorities;
- Budgeting for services according to the plan;
- Evaluating the results of the system against the plan, and
- Building the capacity of the system through dissemination of best practices based on evaluation results.

Uniform, reliable data about clients served, services delivered, their costs and their outcomes is an essential element for creating a true system of purchasing

The basic elements of a system of human services are not functioning correctly or not functioning at all.

services that works for clients and families, providers, purchasing agencies, oversight agencies, and the Legislature, and that creates the best value for the citizens of the Commonwealth.

Clients and family members need to have comparative performance results for making informed choices about selecting providers and services that will meet their needs.

Providers need to know which methodologies and practices produce the best results, as well as to benchmark their own performance against other providers, in order to win contracts, meet performance standards, improve the quality of services and attract clients.

Purchasing agencies must have information about service needs, program costs and client outcomes to help make the case for budget appropriations, determine the appropriate allocation of resources, award contracts and support system improvements.

Oversight agencies need to know whether human services programs are meeting their objectives, who is being served and the volume and cost of the services provided, as well as the extent of service gaps and unmet needs, to inform service planning and budgeting.

The **Legislature** needs information on the costs and results of existing services, as well as the costs of meeting service quality standards and filling service gaps, to be able to evaluate purchasing agency budget requests and set priorities.

Taxpayers need to know that their investment in human services is producing the positive results they expect.

In Massachusetts, there is no overarching plan for human services, just a disjointed collection of statutory mandates and departments focused on serving certain populations of clients, and programs designed to provide specific types of services. Inadequate information about service needs and impacts contributes to a budget process that fails to set priorities or provide resources sufficient to the meet the state's statutory commitments. Policy decisions are more often made

Policy decisions are more often made in reaction to the latest crisis rather than in response to needs assessment and evaluation of the current system.

in reaction to the latest crisis rather than in response to needs assessment and evaluation of the current system. None of the participants has information on system performance adequate to meet their needs, and sharing and dissemination of the information that is generated is hindered by disconnected information technology systems. There is little use of evaluation data to improve quality or build capacity.

Over the last decade the state has attempted to provide a wider range of services to a growing number of clients without committing the resources needed to adequately fund the new services. At the same time, the demand for services and the acuity of client problems have escalated, pushing up the cost of providing care. The emphasis has been on serving the maximum number of clients at the least cost rather than on the quality and outcomes of these services. The effectiveness of existing services has been diluted as a result. With the cost of human services determined by both the volume of services provided and the quality of those services, increasing volume while holding spending essentially constant inevitably drives quality down.

Planning and Budgeting in a Vacuum. There is no master plan or agreed-upon set of priorities, or even a widely held vision, for human services delivery in Massachusetts. The Legislature, administration, providers and client advocates share no broad understanding of what human services are supposed to accomplish or what populations are to be served.

For some human services issues, such as developmental disabilities, the extent of the problem and the population of potential clients is relatively well known. However, there have been few comprehensive assessments of needs for most human services. As one state official said, "Many programs don't know how many people they serve, much less how many they don't serve."

Because the state does not operate with the benefit of clearly articulated plans and cohesive policies for providing services, major players in the system compete more often than they collaborate. Purchasing departments serve particular populations of clients, create their individual rules of operation, and seek their own categorical funds. They are not encouraged or rewarded to work with each other to reach common purposes and goals. There is no central or uniform assessment of the impacts on other purchasing agencies of one agency's service definitions for clients or requirements for providers.

With no common vision for the effects and outcomes of service delivery, there is no foundation for integrating services for individuals and families with multiple needs. As one senior state official put it:

The purchasing system as it functions today cannot be characterized as a system with a common purpose. Instead of a system, the Commonwealth has a loose amalgamation of organizations that have developed isolated ways of doing business. The products, eligibility thresholds, access procedures and service planning are not guided by or evaluated against, and ultimately do not serve, a common purpose.

The lack of collaboration and integration between a host of semi-autonomous human services agencies contributes to budgeting that pits individual programs against each other for funding. With no comprehensive assessment of service needs and impacts to guide them, policy makers have no rational way of determining if funding levels are appropriate or of choosing among competing needs. The result is a budget that often fails to set priorities or to consider the appropriate level of funding required to provide quality services.

Budgets are usually based on what was provided in the previous year rather than the cost of meeting current needs. While spending on human services has increased to cover expanded services, purchasing agencies typically receive level funding for existing programs, and this level funding is passed on to existing providers through the contracting process.

Increases in funding, when they occur, are more often the result of media attention to a crisis, a successful lawsuit seeking to extend services to unserved

individuals, or persistent pressure by client advocacy groups than any assessment of service gaps or calculation of the cost of providing quality services. As one legislator said, "Sometimes it takes a tragedy such as the death of client under state care to get our attention and focus some resources on the underlying problem."

Another example is the issue of "stuck kids," children who unnecessarily remain in psychiatric hospitals because of a lack of appropriate community facilities. In this case, a combination of media accounts and advocacy by DMH and client advocates led to additional funding to help address this problem, but the larger issues of unmet mental health needs and the quality of mental health services remain unresolved.

The budget process does not allow a purchasing agency to define its service delivery system in a way that clearly spells out the numbers of clients they plan to serve, the types of programs and services the clients need, and how much funding is necessary to meet its obligations. As one purchasing agency manager stated:

Department budgeting is bottom-line driven. The departments, in practice, do not develop budget requests based on actual need because they are instructed by the Executive Office for Administration and Finance what budget levels they may submit.

As a result, information regarding agency performance and funding concerns does not get translated in a meaningful way to the Legislature. "State agencies haven't done a good job at educating budget analysts," said one legislative committee staff person. The Legislature does not know the level of need or the costs of serving mandated client populations. As one legislator explained:

We rarely have a good sense of whether a program is adequately funded or whether we are meeting even the minimal needs. Of course, the advocates always argue that we need to spend more, but we rarely have the data to really know the answers.

The dearth of useful information often leads to misplaced priorities and misallocated resources. As another legislator lamented, "The state will pay \$600 per day for a kid to stay in the hospital, but will not pay half that much for them to be in a residential program in the community."

In fairness to A&F and the budget process, there is relatively little objective and reliable information produced by purchasing agencies to document unmet client needs or to validate service costs. With little systematic assessment of which populations are adequately served and which are not, participants in the system lack the data needed to develop such an understanding.

As discussed in the following sections of this chapter, the lack of meaningful outcome measures, the emphasis on service inputs and compliance in provider reporting, and the inability of purchasing agencies to aggregate, analyze and use the

"Neither the agencies, the Legislature nor the public have a clear understanding of what their investments in human services accomplish."

performance data they do receive mean that there is little systemic evaluation of the impacts of human services. "Neither the agencies, the Legislature nor the public have a clear understanding of what their investments in human services accomplish," said one human services advocate.

The lack of systematic evaluation data impedes the Commonwealth's ability to strengthen the quality of services and build the capacity of its human services system by identifying and sharing

information on best practices among providers. "We periodically evaluate effectiveness on a program-by-program basis, but we do not have the ability to evaluate all of our contractors to determine which approaches have the greatest impacts," said one state purchasing agency manager. A provider added, "The state can tell us how we did in meeting the terms of our contract, but not how well our services really work, so it's no surprise that they can't tell us much about what works best based on their experience with other providers."

Barriers to Producing Information. Most state purchasing agencies do not have effective information systems or communications technology for collecting and reporting their own performance information, nor can they easily compile or share information across agencies, even at an aggregate level. They have little capacity to track clients across agencies or families' interaction with the system over time, and cannot facilitate each others' information collection activities. "We have a hard enough time tracking the services we provide to our clients, much less the services they receive from other departments," said one agency manager. "We often do not know about the involvement of other family members in human services, which would make it easier for us to coordinate with other departments," added another.

It is even difficult or impossible for some purchasing agencies to calculate an unduplicated count of people served over a given time period, though EOHHS has made considerable progress on this issue with its MassCARES technology initiative to aggregate data from disparate departmental databases. However, isolated information systems mean that there is still no centralized data on the cost and pricing of services.

All of the purchasing and oversight agencies have some automated capacity for data collection and reporting, and all purchasing agencies have access to the central state data warehouse. However, because there are no consistent outcome and performance measures, such data is virtually useless for evaluating and comparing performance.

In DMH, for example, some providers submit performance reports against specific indicators included in their contracts. However, the reports are submitted manually and reside in the regional offices. No central, consistent automated compilation or review is done of the performance indicator information.

There are several barriers to obtaining this type of information. There is no unique client identifier in general use throughout the system, making it far more difficult to track client service access, utilization and costs across multiple providers or payment sources. There are still no common assessment instruments and no uniform measures of acuity and level of functioning for clients and families in the system, so there is no way to compare levels of service utilization

and costs between groups with differing levels of service needs. There is no uniform service taxonomy, or definitions of service types, that would permit comparisons of client service activity and costs within like service types across different providers, purchasing agencies and funding sources.

Purchasing agencies would like to have better capacity to track and report on clients served, services utilized and the costs of services. They agree, for the most part, that adopting a common list of service types and unique client identifying numbers among purchasing agencies would simplify contract monitoring and reporting and satisfy the Legislature's and oversight agencies' demands for more accurate and consistent information. However, they hold out little hope it can ever be accomplished because of the complicated changes in policies and practices that would have to take place both internally in state government and externally with federal funding agencies. Some agencies such as MRC would have difficulty adopting a common service categorization because their unique service categories are specifically required by their federal funding sources.

Individual purchasing agencies have taken significant steps to develop more useful information systems for their own programs. The Department of Mental Health has developed a system that reports service utilization compared to capacity by program and contract. The system includes state hospitals, state-operated programs and vendor-operated community services. DMH has also enhanced client record keeping with an enrollment and registration system that tracks client use of case management and residential programs. According to a DMH manager:

Now we can answer the question 'How many clients do we serve?' and we can maintain our waiting lists with much greater accuracy. But we still cannot tell you in any systematic way what services our clients receive from other departments.

Increased Demand vs. Limited Resources. The problems faced by the human services system in assessing needs, planning and budgeting for services, and evaluating their impacts come at a time when the changing needs of clients and families are becoming more difficult to meet. A variety of social, economic and political factors – ranging from rising levels of

drug abuse to a growing shortage of affordable housing to increased attention focused on child and domestic abuse – have contributed to a rising demand for services to clients with more acute and more complex problems.

To some degree, the human services system is a victim of its own successes. An unintended consequence of this revolution in community-based care is that community providers now must serve those with the most complex disabilities. Great strides have been made in providing services and supports in the community for people with development disabilities or mental illness. People who would have been institutionalized for life only a generation ago now live relatively independent and self-sufficient lives in the community. At the same time, modern neo-natal care has saved the lives of many disabled and developmentally delayed infants, some of whom have very complex medical and developmental conditions requiring highly specialized care.

The interconnected nature of many of these problems makes their treatment increasingly complex. For example, many young adults with developmental disabilities also have mental health needs, and substance abuse is growing among these individuals as well. Substance abuse contributes to family violence and sexual abuse, which in turn adds to the number of young children needing extensive services. Abused youth are also at high risk of becoming abusers themselves and more likely to suffer from depression and other mental health conditions. Drug and alcohol use also contributes to homelessness, which is further exacerbated by the lack of affordable housing in most Massachusetts communities.

Increasingly complex family issues add to the demand for services. More families with a wider variety of needs are being served by the different parts of the system. Coordinating these services can improve the outcomes for families, but adds to the complexity of the Commonwealth's challenge.

As a result of these and other factors, the state is expected to provide services to an increasing number of clients, to provide a wider range of services to many clients, and to provide more costly services. However, the rising costs in most cases have not resulted in significant new appropriations. Purchasing agencies have broad statutory mandates for the citizens they

The purchasing agencies are caught in a tight squeeze. The result is that services are rationed.

serve, but, almost without exception, the cost of meeting the mandates exceeds the agencies' resources.

As one senior state official put it, "The purchasing agencies are caught in a tight squeeze between legislative appropriations that are fixed and specific in nature, the mandates of oversight agencies, and the urgent program needs of clients and their families."

The result is that services are rationed. In many cases new clients are placed on waiting lists and only urgent client crises receive an immediate response from the system. Successful lawsuits have forced the Commonwealth to fund additional services for developmentally disabled residents on DMR waiting lists, but DMH and other departments still have thousands of adults and children awaiting services. DMH has implemented stringent eligibility requirements, particularly for those who need outpatient treatment, and an individual must have been hospitalized several times to be eligible for these services.

When new clients come into the system without additional funding, provider agencies are often asked and sometimes required to add the new clients within existing contracts. In addition, providers are frequently asked or required to take on more difficult and complex clients than the program was originally designed and staffed for, without additional funds. "We are frequently referred clients whom we aren't really equipped to serve because the agency cannot find a more appropriate placement with another provider," explained one veteran provider.

Such placements are far more likely to result in inappropriate services and unfavorable outcomes and, in some cases, increased risks for the provider, the direct care staff, the clients, families and the community. The additional cost of serving these clients compounds the fiscal squeeze providers already feel from living with stagnant rates and rising costs, including those resulting from state mandates.

While substantial funds have been appropriated to serve clients on waiting lists, primarily in DMR, existing programs and clients are funded at old rates that do not reflect changing client needs. Obtaining a contract to serve new clients at higher rates can help a provider get by with the lower rates on their older contracts, but the additional funding is never sufficient to compensate fully for inadequate funding for earlier contracts.

Low rates paid to providers also contribute to the difficulty of providing appropriate services to clients. As noted above, many children remain in expensive inpatient hospital settings because no appropriate community settings are available. At the same time, providers have residential space available, but are not paid enough under state POS contracts to hire sufficient staff for these programs.

The emphasis has been on serving the maximum number of clients at the least cost rather than on the quality and outcomes of these services.

degree to which services fit client needs.

The implications of the human services formula are clear. If the state increases the volume of services while maintaining quality, costs will inevitably rise. On the other hand, if the state increases the volume while holding prices constant, quality has to decline.

The unresolved tension between the quality of human services, the number of clients served, and the size of the state's investment underlies and often overshadows the other problems facing the purchase-of-services system identified in this report. While there are numerous structural and bureaucratic problems that hinder the performance of the system, the most

fundamental issue is the expectation that the Commonwealth can provide high-quality services to more clients without spending more money.

The state has never come to grips with this basic question: how many clients can it serve and at what level of quality? If the cost of the purchase of services system is thought of as the product of the number of clients served and the quality of services provided, answering these questions would require striking a balance among the competing variables.

Instead, the state requires more and more clients to be served at the same contract rates year after year. This inevitably results in fewer services for each client and lowers the quality of services overall. The difficulties faced by clients and providers in the POS system, such as the waiting lists for services and the trouble providers have in attracting and retaining qualified staff, are evidence that the impact is already being felt.

Purchasing departments, for the most part, would rather see fewer people served in a higher quality system. Some have attempted to reduce the volume of services in order to bolster quality. For example, the former Commissioner of Mental Health adopted a position that no provider staff would be paid less than \$20,000 and that services would be cut, if necessary, to preserve that threshold. The department's primary concern was better treatment for DMH clients rather than adequate resources for providers. However, DMH received no support for the policy from the oversight agencies or the Legislature and was unable to maintain the salary standard in the department's contracts.

This thinning-the-soup syndrome is difficult not only for clients, their families and providers, but impacts the performance of all the players in the system, whose efforts to bring about positive outcomes for clients are undermined by the nature of the system in which they work. The state agencies that purchase

The state struggles to serve its most vulnerable citizens, and the taxpayers are not getting a fair return on their enormous investment in human services.

services and oversee the system struggle to meet legislative mandates to serve the state's most vulnerable citizens, and the taxpayers are not getting a fair return on their enormous investment in human services.

Holding The System Accountable

A system for purchasing human services needs to be held accountable for its results – to its clients and their families, to the Legislature and administration, and to the taxpayers. Providers need to establish that they are qualified to offer services, while purchasing agencies need to demonstrate that they are meeting their statutory requirements to care for the state's most disadvantaged residents. Providers and state agencies alike need to be able to show that their services meet quality standards, that they spend state dollars appropriately and efficiently, and that their clients achieve the positive outcomes intended.

Accountability measures should be one of the primary means of strengthening the quality and impact of services. The methods and processes for holding the system accountable need to be cost-effective, providing useful information and ensuring results without diverting excessive amounts of time and money from the delivery of services. Accountability data should have multiple uses in managing the system, including licensing and contracting with providers, facilitating client access to appropriate services, evaluating the effectiveness of programs, planning and budgeting for the system as a whole, and demonstrating that taxpayer dollars are well-spent.

The purchase of services system in Massachusetts has a host of accountability mechanisms at work, but they do not serve these purposes well. Monitoring and review focus on financial accountability and meeting process requirements rather than ensuring the quality of services. There is little real quality assessment or program evaluation.

As with the procurement processes discussed in a later section of this chapter, providers doing business with multiple state agencies face a myriad of often conflicting accountability policies and procedures, including multiple licensing visits and varying data collection and study requirements. Purchasing

agencies are mired in costly and duplicative contract monitoring procedures. These complications add to the financial squeeze on both providers and state agencies and divert resources from improving the quality and impact of services.

Providers spend excessive time and money preparing extensive financial reports that duplicate the purpose of required outside audits, and providing performance data that are not used for managing the system. Even though a huge amount of data is generated, neither the state agencies that purchase services, the Legislature, nor the public has a good understanding of what their investment in human services buys.

Duplicative and Inconsistent Layers of Oversight. There is no lack of oversight in the purchase of services system.

Each provider is subject to licensing and certification reviews that qualify them to bid on state contracts; evaluation of proposals during contract procurement; monitoring and reporting requirements during the performance of the contract; and fiscal audits after the contract is complete.

Numerous organizations play a part in the accountability process. In addition to the purchasing agency, the Operational Services Division of the Executive Office for Administration and Finance, the State Comptroller and the State Auditor are involved in the oversight of each contract. Providers that seek national accreditation are also evaluated by outside organizations such as the Council on Accreditation. The Executive Office of Health and Human Services and the Fiscal Affairs Division (formerly the Budget Bureau) of the Executive Office for Administration and Finance maintain high-level oversight and fiscal control over human services programs. In the Legislature, the Joint Committee on Human Services and Elderly Affairs, the House and Senate Ways and Means Committees, and the House and Senate Post Audit and Oversight Committees all have a hand in overseeing the POS system as whole.

While each of these agencies has a distinct and important role to play in monitoring the system, their efforts are often fragmented, duplicative and

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inconsistent. Rather than a coherent system for holding POS accountable, oversight is a hodgepodge affair, with no inter-connections among the various licensing, contracting and quality assurance procedures. There is no mechanism for sharing performance information and no structure that ties these functions together for the purpose of improving services for clients.

This fragmentation of accountability mechanisms was not created intentionally, but resulted from years of independently developing programs that were created to serve distinct groups of clients. In many cases, accountability measures were added to correct problems in the system without adequate regard for how the new controls would interact with other measures already in place.

The providers who serve people in residential or other facility-based programs funded by two or more state agencies often have to satisfy multiple licensing requirements and certification and compliance reviews. These licensing or certification requirements are inconsistent among purchasing agencies, and may at times be conflicting. As one provider explained:

Four different state agencies regulate how children's medications can be administered. They all mean to represent the best interests of the children, but they approach the issue from different perspectives and the providers get whip-sawed between them trying to comply. And the rules keep changing.

While each major service type is licensed by a single agency under the EOHHS umbrella regardless of which agency is purchasing the service – OCCS for residential programs and daycare, DPH for clinics and DMH for adult services – the results are still a range of duplicative and, at times, conflicting regulations, multiple licensing reviews for providers, and higher administrative costs for the state. Many of these regulations were adopted in response to a particular problem that existed at a particular time. As the system has developed and matured, some of these have lost their value and degenerated into paperwork exercises.

Another provider described the requirements for children's educational programs:

All residential schools for children must be OCCS-licensed and approved by DOE. This approval is a license by another name and it is illegal to operate without it. Both the license from OCCS and approval from DOE require totally separate voluminous applications for initial operation and subsequent renewals. If the program includes a residential school and services for adult developmentally disabled, we also need DMR certification through the Quest process. Quest surveyors spend at least a week at a program and come in teams of four or five people. In addition, if the program is campus based, each cottage requires a separate license. Supposedly each license covers separate functions or areas, but there is significant overlap among the reviews.

In addition to purchasing agency requirements, providers frequently must comply with Medicaid certification standards and procedures and with local occupancy and health and sanitary codes. Providers report having five or more inspections or compliance reviews per year. These often take several days, and command substantial staff time in preparing for and participating in the on-site reviews.

Accreditation – intended to be a seal of approval that demonstrates that the provider meets national quality standards – does not relieve providers of any of the duplicative, costly and time consuming reviews conducted by state and local agencies. Providers that are accredited by a nationally recognized body, such as the Council on Accreditation, the Council on Accreditation of Rehabilitation Facilities, or the Joint Commission on Accreditation of Health Care Organizations, still need to go through the state's licensing processes.

Providers argue that accreditation requires its own set of rigorous evaluation reviews against higher national standards that add real value to client care. Purchasing agency officials respond that obtaining accreditation requires meeting only minimum quality standards and that the state needs to be able to hold providers to higher or different standards, particularly where the health and safety of clients is at issue. Nevertheless, there have been few attempts to reduce the duplication

of effort in those areas where accreditation standards overlap with state requirements. DMR recently indicated that it would soon allow national accreditation to substitute for its own certification, but only after providers had satisfied state standards for health and safety for a two-year period.

Each purchasing agency monitors its contracts in a different way, which is frequently related to the purchasing agency's history. Agencies with long histories as direct service providers, such as the Departments of Mental Health and Retardation, tend to micromanage contracts at the level of the client-provider relationship. Other agencies with strong in-house case management components, including the Department of Social Services and the Massachusetts Rehabilitation Commission, tend to have more of an arms-length relationship with providers. As a result, the time a provider spends meeting the requirements of one purchasing agency may be of little value in working with another.

One provider with contracts with several agencies described the requirements for reporting and record keeping:

For example, if you have a program that serves DSS kids and some are Commonworks and others are direct DSS referrals, the billing, record-keeping, and reporting are totally different. In addition, OCCS has their own requirements for records and regulations. DMH kids, DYS kids, and LEA (school district) kids all require different data sets and reporting.

State agencies have no mechanism or incentive to share information about providers doing business with multiple purchasers. Historically, there have been examples of one purchasing agency trying to close down a provider agency for non-performance while at the same time another purchasing agency is awarding new contracts to the same provider. Even within a given purchasing agency, oversight procedures – and results – can vary dramatically among different regional and area offices.

Accountability in the POS system is often synonymous with financial reporting and compliance with accounting requirements.

Focus on Process and Finances. As discussed in the Creating a Competitive Market section of this chapter, few contracts for human services are based on performance in terms of client outcomes or service quality. Instead, contracts typically spell out the volume of services to be provided, procedures to be followed and reporting requirements to be met. This focus on inputs and process is enforced and reinforced by oversight and accountability mechanisms, often leading to micromanagement of provider operations by purchasing and oversight agencies. Staff of oversight agencies, purchasing agencies and providers frequently offered assessments similar to those of one agency manager:

The Commonwealth needs to be an evaluator of what it is purchasing and not a micromanager. They need to use performance data for quality improvement and best practice development, not for punishment for failing to cross every 't' and dot every 'i.'

Accountability in the POS system is often synonymous with financial reporting and compliance with accounting requirements. One provider put it this way:

The state is focused on finances, not clients. There is no emphasis on how to make a better product, just on compliance. Regulating input causes us – both providers and agencies – to lose sight of the important things.

All providers are required to document their finances in a detailed annual Uniform Financial Report (UFR), perhaps the only consistent feature of POS across human services agencies. The UFR was adopted in 1990 and was intended to be a management and oversight tool. However, few of the participants in this study found the UFR to be useful or believed that it added significant value to purchased services.

The UFR includes both cost and performance data, but the cost reporting focuses on accounting for spending of state dollars rather than the actual cost of providing services. With no analysis of how providers cut legitimate expenses to stay within contract budgets, the data is inadequate for calculating true program costs.

State officials argue that the UFR is necessary for ensuring fiscal accountability and meeting federal reporting requirements. "Without the UFR, we would have no way of knowing if the providers spent state funds on the programs we are contracting for," said one purchasing manager.

DMR reports using the expense reports for comparing costs of programs with contract budgets. The UFR data is also sometimes used for assessing market conditions and competition among providers, but not for seeking efficiencies or better ways to do business. One agency manager said, "The Department downloads the UFR database but uses it primarily for pre-qualification purposes, not for evaluating the effectiveness of purchased services."

Most purchasing agencies and providers reported that UFR data is not used for rate negotiations or performance monitoring. No one takes data collected on the UFR and employs it for developing outcome or quality standards.

The reports do include standardized performance data, but the data is rarely used. The performance data focuses on inputs – units of service and staff hours – rather than client outcomes or measures of quality.

No routine management reports or comparative analyses are produced from the data for general use by oversight agencies or by the Legislature. Purchasing agencies do not receive regular analytic reports or other feedback from the UFR data submitted to the Operational Services Division by their contract provider agencies.

Providers typically perceive the UFR as a waste of time and money. They find it time-consuming and costly to prepare, averaging about \$10,000 on top of the cost of an independent external audit. As one provider argued:

The UFR process is a useless exercise from the provider point of view. It is just another form, not a financial analysis. It tells the state in which programs their money was being spent, but doesn't help the providers run their business. It would be better to put the time and energy into monitoring the services rather than monitoring the dollars.

In some respects, the uniformity of the UFR makes it even more difficult to complete. As another provider explained:

Providers' operations and complicated service elements don't fit into the UFR format. When you compare all the differing departmental rules to the UFR, it looks to us like the different parts of the system are at war with each other.

There is a great deal of redundancy in financial reporting. Providers are also required to prepare and submit annual outside audits that document their financial activities and status, but the differing and specific requirements of the UFR make preparing the two documents largely separate activities. One oversight agency official argued that training purchasing agency staff in how to read and use audits would eliminate the need for the UFR.

In addition to audits and UFRs, cost reimbursement contracts typically require monthly billing statements, which also differ in their requirements from the UFR and vary from department to department and contract to contract. Reconciling accounting records with the formats of these reports adds considerably to the administrative burden on providers – especially those that contract with more than one state agency – and on state staff who monitor programs as well. One provider reported that the UFR "almost requires a second set of books since the chart of accounts used by the provider is tied into the contract and often differs from that required by the UFR."

Conflict Between Purchasing and Oversight Agencies.

Concern with misdirected oversight is by no means limited to providers. Just as providers feel micromanaged by the purchasing agencies, purchasing agencies feel micromanaged by the oversight agencies. Purchasing agency staff argue they are prevented from developing creative solutions to funding problems by the rigid regulations and oversight requirements of the Operational Services Division and the State Auditor's Office. Fiscal staff in the

Purchasing agencies feel micromanaged by the oversight agencies; staff at the oversight agencies are equally frustrated.

purchasing departments perceive that the Fiscal Affairs Division, the Comptroller's Office and legislative budget staff focus on budget minutiae that are not important to departmental service delivery, while at the same time major budget policy and funding issues remain unattended. Even the oversight agencies agree that no one is empowered to make decisions that could enable more flexible and creative implementation of purchased services.

As with the providers, oversight of purchasing agencies focuses on compliance rather than results. Purchasing agencies argue they are over-regulated and lack authority commensurate with their responsibilities. As one Commissioner put it: "We need more latitude and flexibility about how things are done. We should be evaluated on our accomplishments for clients, not on how closely we adhere to regulations."

Staff at the state's oversight agencies are equally frustrated. They point out that collectively they have engineered many reforms in the contracting system in the past few years, but get no credit for the reforms. They cite the process for extending multi-year contracts without re-bidding as an example of new flexibility, noting that several purchasing agencies seem reluctant to take advantage of this change. The Comptroller's Office argues that purchasing agencies fail to take advantage of the capabilities of the state's accounting system for tracking contract expenditures and services delivered, or to make good use of the state's data warehouse to conduct special analyses and generate management reports. Finally, the oversight agencies feel they are simply following federal and state mandates and statutory requirements, and thus should not be blamed for causing problems in the system.

Oversight agencies are also concerned that purchasing agencies sometimes fail to manage procurements and contract monitoring properly. Purchasing agencies advocate for sole source contracting in situations where a competitive procurement would produce better results. Purchasing agencies often allow services to start before a contract is officially signed and do not assign enough staff to contract monitoring and contract auditing, thereby making the oversight agencies' jobs more difficult. Because they don't

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adequately track provider expenditures, agencies frequently scramble at the end of the fiscal year to reclaim money from some contracts to cover other overspent contracts. If purchasing agencies would respect the process, treat the contract as a serious document, and monitor contracts effectively, the oversight agencies argue they would not be put in the position of micro-management and stringent auditing.

Accountability to the Legislature. The purchase of services system is ultimately accountable to the Legislature and the taxpayers they represent. In order for legislators to fulfill their oversight responsibilities and make the hard choices required in setting budgetary priorities, they need to have an informed understanding of:

- The number of clients served by each human service program compared to the number of residents that are statutorily eligible for those services;
- The performance of each program – measured in terms of client outcomes and quality of services at an aggregate level – compared to the outcome targets and quality standards that have been established for each service type;
- The cost of serving currently unserved or underserved clients;
- The cost of improving substandard services so that they achieve the outcome targets and quality standards;
- Potential savings in the system, such as duplicated services or administrative activities, and how those savings would affect the program's outcomes and quality.

However, accountability breaks down at this critical juncture because legislators almost never have clear and consistent information on how well the system is serving hundreds of thousands of clients with a wide range of social and health needs. As one legislator put it, "The Legislature doesn't know what their money is buying them and the agencies can't tell them."

The frustration over inadequate information and analysis felt at every level of the system reaches its apex in the Legislature. Lawmakers are put in the

nearly impossible situation of having to make difficult decisions over priorities without having enough relevant facts about the tradeoffs involved. The result is “management by crisis and anecdotes” as one legislator described. Budget issues are debated without clear information, and the Legislature has no objective basis for resolving competing interests and priorities.

In the absence of data collection and analysis that could provide answers to their questions, legislators get much of their information about human services in piecemeal fashion from stakeholders – clients, family members (who may also be constituents), service advocates and program managers – and do their best to sort through the different and sometimes conflicting viewpoints. Legislators who are involved in human services issues may value the information they get from the stakeholders, but argue that it cannot substitute for comprehensive, coherent data. As one legislator explained:

[The stakeholders] come to the Legislature every year for more money, yet are never satisfied when new funds are appropriated. They constantly want more money, but they can't seem to explain how the money they already have is spent. Who gets served? Why does it cost what it does to serve these people? What is the real benefit to both clients and to the Commonwealth from the expenditure of these funds for purchased services?

Most legislators recognize the need for improvements in the human services system, and calls for reforms have been heard in the Legislature for years. Those efforts culminated in the enactment this year of a sweeping restructuring of human services agencies as part of the fiscal 2004 budget. The reorganization and related reforms are reviewed in the Recommendations chapter of this report.

While the new structure is an important initial step that will serve as the foundation for more fundamental reforms, reorganization by itself will not address the Legislature's concerns regarding purchase of services. Purchasing and oversight agencies alike still need to do a much better job of explaining the benefits that human services produce in return for the substantial sums allocated by the Legislature, and of documenting what will be required to fill gaps in services and strengthen the quality of existing programs.

Difficulty Demonstrating Results. The fundamental problem shared by the Legislature and the oversight agencies is that there is no good information to answer their questions. The inability of the system to measure and communicate its performance underlies many of the concerns over accountability. There is no overall plan for purchasing services against which to measure the performance of the purchasing agencies, and there are no reports produced on a regular basis that analyze system and provider performance and costs.

The problem is not a lack of data – reams of data are generated – but an inability to distill the data into meaningful information about the results of services delivered and to use the information to improve management of the system. Neither oversight agencies nor purchasing departments have the ability to evaluate the results of purchased services without objective and consistent outcome and quality measures. As noted above, the performance data collected as part of the Uniform Financial Report focuses on inputs and units of service rather than quality and outcomes. Even if departments have the capacity to quantify their services, there is no objective basis for assuring that the state is purchasing high quality services and achieving the intended results for clients.

Purchasing and oversight agencies alike are also seriously handicapped in their contract compliance and performance monitoring by a lack of consistent, automated data collection and reporting capabilities, as discussed previously in the section on Barriers to Producing Information. In DMH, for example, providers submit performance reports against specific indicators included in their contracts. However, the reports are submitted manually and reside in the regional offices. There is no central, consistent and automated compilation and review of the performance indicator information, so it is not presented in way that policy makers and overseers can use it to evaluate and manage the system as a whole.

Coordinating Access

Even in a system where most human services are purchased from private providers, state agencies remain the first point of contact for most clients. The state's role is to ensure that eligible clients have access to and receive services that are appropriate for their needs. The state, acting either directly or through a

case management provider, assesses the needs of the client, refers the client to appropriate service providers, and follows up to ensure that the client receives the right assistance.

The role of the client and family is to choose a provider based on information about the kinds and quality of services offered. Client choice, where appropriate, is a key element in developing a competitive market for human services that rewards high-quality services and positive outcomes.

In cases where clients and families need help from more than one provider or more than one state agency, the Commonwealth is responsible for coordinating the care so clients receive the best combination of complementary services while minimizing service gaps, duplication and conflicts. Effective case management can help the client maneuver through a complex system and receive the best care possible. Ideally, case management transforms the wide array of services offered by a host of bureaucratically distinct organizations into a seamless continuum of care.

Instead of ready access to a network of individually tailored services, clients of the POS system in Massachusetts experience a fragmented, disjointed system where they often end up falling through the cracks. Clients and their families frequently face waiting lists, barriers to access, and difficulty navigating the system. There are few effective mechanisms to coordinate services for clients across multiple agencies, and clients and their families often face tedious and incomprehensible requirements to receive services from more than one agency. Case

management is program-focused rather than client-focused, often resulting in poor fits between needs and services provided.

Clients and their families often have no choice among providers, and when they do,

they rarely have appropriate information to select the best provider for their needs. Client choice contributes little to competition among providers that would improve services and strengthen results.

**“No one tells
you the rules.
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Barriers to Navigating the System. Clients and their families are deeply concerned about how to overcome the multiple and indecipherable barriers to accessing the services they need. Many are frustrated that no one gives them the information to make informed choices about services. One parent of a client related:

No one tells you the rules. If you can get to the right person, you can find out about a particular service that might help, but no one can give you the big picture view. If you want to find out what options you have, you have to search yourself, which is not easy. The system is a real maze.

Rather than having a representative of the state to help them find their way around the system, clients and family members usually have to advocate for themselves. Clients and their caregivers across all disabilities, service types and purchasing agencies reported spending inordinate amounts of time and effort to learn about services for which they might be eligible, and then to find out how to access those services. As one client said, “If you don’t make it happen, it won’t happen.” Several reported that without the assistance of outside advocacy organizations like The Arc (originally the Association for Retarded Citizens) and the National Alliance for the Mentally Ill, they would have been unable to determine how to get “into the system” and receive needed services.

Clients often have little choice among providers. With demand exceeding supply for most human services, finding even a single appropriate placement in a program can be difficult. “We often have to scramble to come up with a suitable slot, and then offer it to the client on a take-it-or-leave-it basis,” said one state program manager.

When purchasing agencies are able to offer clients a choice of providers, they rarely can supply information about provider performance to help the client choose. As discussed in the preceding section on accountability, this is because purchasing agencies focus on compliance with rules and financial record-keeping in the data they collect from providers, and are unable to aggregate and distill the performance data they do collect into information that is useful to clients and their families.

"We selected a program for our child based on the advice of our caseworker and what little we could learn by word-of-mouth from other parents," said one parent. "The caseworker was able to give us her impressions of the programs from other families she had referred there, but she did not have any statistics on how well each program had done for the children."

Falling Between the Cracks. Navigating the system is most difficult for clients who need services from more than one purchasing agency, a common situation. Many clients and family members expressed frustration with the lack of integration, or even cooperation, among state purchasing agencies. They felt that they should not be required to understand and navigate all the different eligibility and access requirements of different state agencies. Nor did they feel that they should have to go from agency to agency shopping for services because their needs do not fit into any one agency's narrowly defined service or funding model.

Families and individuals often go without necessary services because it is too difficult to access all the different pieces from different places. One parent who had legally adopted disabled children that previously had been in the custody of the Commonwealth described his situation:

I had to quit my job as a lawyer because it became a full-time proposition to access all the services needed by the children. I was spending too much time in state offices and on the phone and couldn't do that and simultaneously work full-time.

There is frequent duplication of case management functions between the state and providers, and individual clients with multiple needs often work with more than one case manager. Clients and their families receiving services from some combination of DYS, DSS, DMH and DMR reported being confused and frustrated when each agency assigned a case manager to work with the family. It is also common practice among these agencies to assign state case managers and then to require case management services from providers as well. Families often have to

coordinate among these separate case managers, rather than having a single case manager responsible for coordinating all services on behalf of the family. This 'double-teaming' is confusing for clients and families as well as being redundant and unnecessary. As one family member described:

You tell your story to the caseworker from one department, and then you have to do it all over again when you meet with someone from another department. Half of the time, what one of them tells you is totally inconsistent with what you heard from the other one. And they can only offer their department's programs. Don't these people ever talk to each other?

Passing the Buck. The impact of poorly coordinated services on clients and their families is aggravated by the practice of shifting responsibility for clients – and the costs of serving them – from one state agency to another. For example, there is considerable overlap in "shared kids" among the six state agencies that are responsible for children's services and a tendency to move children among the departments.

Caseworkers generally refer cases to another department in an attempt to match the client with more appropriate services, or because the original department does not have adequate funds to serve the client. However, the result is that some clients move from department to department until they disappear or reach an age where they are no longer eligible for services without ever receiving the services they really need.

"You tell your story to the caseworker from one department, and then you have to do it all over again when you meet with someone from another department."

Parents in one focus group told of their daughter being shuffled from the Mass Rehabilitation Commission to the Department of Mental Retardation to the Department of Mental Health. Over the course of more than ten years after her 22nd birthday, this young woman never received the coordinated services she needed, and no single agency would accept responsibility for coordinating her care. This resulted in a steady decline from relative independence and self-sufficiency to almost total dependence on her family and on expensive residential services. The outcome was bad for the individual and her

The state does not issue contracts for integrated care – each department provides its own particular services.

family, and also resulted in higher costs for the purchasing agencies. Luckily, after consistent hard work and advocacy on the part of her parents, this young woman is now receiving more appropriate services and returning to greater self-sufficiency and independence.

Poor Fits Between Needs and Services. Human services in Massachusetts are provided by an array of largely uncoordinated departments, each

with its own funding sources, categorical definitions, service methodologies and provider relationships.

The state does not issue contracts for integrated care – each department provides its own particular services. Staff at the Department of Social Services expressed interest in a joint procurement process that would eliminate strict departmental client definitions to better serve children's needs, but this idea has not been implemented.

These divisions are not the products of a conscious design, but the result of staff in each purchasing agency focusing on their mission to meet the needs of a particular group of clients. This fragmented system leads to disparities in the services provided to clients of multiple agencies. For example, providers are required by different state purchasing agencies to implement different clinical assessment and treatment planning systems, often for the same individuals or families. And too often it results in clients not getting the services they need.

Many clients and family members are angry at the way they have been treated by state agencies and providers. Clients with mental illness and mental retardation and their families often feel despair about the poor fit between what they need and what is available to them. They report that the state's residential and day programs are often inadequate to enable them to live in the community. They believe that their changing needs are often disregarded, particularly as they grow older and need greater assistance with different supports in their homes.

Other parents feel that they have not been given the kind of help they need to keep their families together and their children in school and at home. They believe that they and their children would have benefited from family-centered community supports, such as training in parenting children with behavioral problems, but these services were not available. Instead, their children were sent to foster homes or spent years in residential treatment, even though those services were more costly and, in some cases, less appropriate.

Creating a Competitive Market for Human Services

A results-oriented system of purchasing human services needs to harness the power of competition to produce high quality and effective services at a reasonable cost. In such a system, the state would specify the results it sought in terms of quality of services and outcomes for clients. Providers would compete on performance – those producing the best results would attract the most contracts and clients.

Market forces, restrained by the quality standards and cost-based rates discussed in the following sections, would produce the optimum balance between performance and price. Cost-based rates would also avoid competition based on price, which would trigger a race to the bottom where quality is sacrificed. Direct services provided by the state would be subject to the same competitive pressures to push quality up and costs down. To accomplish these objectives, the POS procurement process needs to foster a competitive market for human services.

Such a market has failed to develop in Massachusetts. While hundreds of providers have stepped up to offer services, competition, to the degree it exists, tends to drive quality down rather than up.

A host of uncoordinated state agencies purchase services, and providers frequently have several contracts with each of several state purchasing agencies. Each agency has its own – and often inconsistent – performance standards, contract requirements,

Competition, to the degree it exists, tends to drive quality down rather than up.

policies and procedures. These differences stem from a time when purchasing departments served unique groups of clients using specialized providers. But over time, the differences have become more costly as clients and families are frequently served by multiple departments and providers often work for several agencies. Excessive time and money is now spent on contract procurement and administration by both purchasing agencies and providers, money that could be better used for direct services.

While the methods differ, procurement and contracting generally focus on process management, not results. Rather than tapping the energy of providers to produce quality services and positive outcomes for clients, the procurement process has devolved into a tool for micromanagement and compliance with bureaucratic requirements.

Rather than using competition to drive continuous improvements in quality, the system requires providers to compete on the basis of their ability to conform to reporting requirements and to survive with rates that do not cover their costs.

As discussed further in the Coordinating Access section of this chapter, a lack of information on provider performance for clients and their families, and, in many cases, lack of choice of among providers prevents client selection of providers from being a powerful tool for promoting competition and strengthening services.

Specifying Results. Procuring products or services of any kind requires the purchaser to specify the qualities of the end product or what it wants that service to achieve. When the state contracts for the design of a bridge, it spells out how much weight the bridge needs to carry, how much traffic it needs to accommodate, and how long the bridge needs to last.

For a service intended to improve the lives of disadvantaged Massachusetts residents, the state would be expected to specify the health, level of functioning, behavior and quality of life it wants to help bring about for its clients. Contracts with human service providers would spell out the performance expected from the provider. These performance standards would define success in terms of the quality of services and the results achieved.

In Massachusetts, the purchase of services system has standards for everything but performance, quality and outcomes. The focus of contract requirements is on the means rather than the ends, inputs rather than outcomes, units of service rather than quality, and micro-management rather than achieving results for clients. Financial reports submitted by providers do include performance data, but outcome measures are poorly developed and inconsistent, and the results are rarely used for evaluating programs or managing the system.

If the POS system were used to build bridges, the state would define successful performance in terms of the number of hours the contractor worked on the bridge, the number of pieces of equipment used, and the amount of financial documentation produced by every subcontractor involved in the project.

Over the years state government has promulgated extensive procurement requirements, but these regulations and procedures bear little relationship to the effectiveness of human service contracts and have little effect on program quality. In lieu of true performance measures, contracts typically specify the volume of services, such as the number of bed-days, inputs such as the number of staff hours, and compliance with extensive reporting requirements.

As one experienced state program manager put it, "We are buying slots for kids rather than results. If the program is effective and helps the client, it's not because our contract with the provider required it."

In the absence of performance-based standards, purchasing

If the POS system were used to build bridges, the state would define successful performance in terms of the number of hours the contractor worked on the bridge, the number of pieces of equipment used, and the amount of financial documentation produced.

agencies are forced to manage the process rather than the results. By necessity, human services providers focus on what is measured. The time and cost of meeting administrative requirements such as certification reviews, accounting procedures and financial reporting – which are often not reimbursed by the state – divert money, time and energy from improving the quality of services and outcomes for clients. The system's focus on bureaucratic processes acts as a barrier to change.¹

"So much of our staff time goes to record-keeping and filling out paperwork for the state that we never have the opportunity to step back and evaluate how we are really doing. And even if we could demonstrate our results, it wouldn't make any difference in terms of our contract," said one provider.

There are exceptions. The Massachusetts Rehabilitation Commission uses a performance-based approach for employment training and placement activities. In these contracts, providers get paid only after an individual has been successfully placed in a job and has remained employed for a specified period of time. A variety of contracts in other human services fields, including the Department of Social Services' Commonworks Lead Agency program, contain targets for outcomes and quality that supplement the usual input and process measures. However, such measures are typically developed on a contract by contract basis, with no uniform or consistent definitions, measures, standards or benchmarks for client outcomes and provider and service performance.

Without such outcome and performance measures it is impossible to develop report cards that would assist clients and families to select among service providers, or allow purchasing or oversight agencies to assess the value of dollars spent for services, nor is it possible to construct a reliable and fair way to provide performance incentives to providers or to use objective information to improve the quality and efficiency of services over time. And, as presented in the next section, without such measures, there is little basis for setting prices for human services.

Uncoordinated and Inconsistent Approaches to Procurement.

Until regulations were loosened several years ago to give more leeway to purchasing agencies, the Operational Services Division exercised tight control over procurement practices. The shift in authority has had some unintended results. While the advertising of contracts is still centralized under the Operational Services Division, purchasing agencies now have the latitude to employ a variety of different ways to procure services.

These variations have developed over the years and are greatly influenced by the clients served, geography, program types, leadership styles and philosophies, and legal and political demands. Some procurements are very specific to defined individual clients or small groups of clients, such as those of DMR, DMH and DYS, while others are more generic and relate to service types and capacities, e.g., DSS, MRC, OCCS and DPH. In some purchasing agencies, such as DMH and DMR, the process is primarily the responsibility of local area offices, while in others – MRC, OCCS, DSS, DYS – the function is centralized or regional. In some cases, particularly DSS' Commonworks program, private providers referred to as Lead Agencies have taken on some of the contracting functions.

Given this diversity, it is not surprising that purchasing agencies vary widely in the standards and requirements for providers, the information required in requests for responses, and the policies and procedures used in administering contracts. State agencies differ on everything from how medications should be dispensed to how third-party funds should be accounted for to offset state costs.

Some agencies, such as DMR, and DSS for its adoption services, use performance and cost data for contracting, while others, such as DMH, may exclude such information from the procurement process. Some agencies treat overhead costs as a line item expense, while others calculate it as a percentage of the total contract, with wide differences between agencies as to what costs are acceptable.

¹ Administrative processes and requirements are discussed in more detail in the "Creating a Competitive Market for Human Services" and "Holding The System Accountable" sections of this chapter.

Some contracts reimburse providers for actual costs; others rely on negotiated rates for each case or unit of service. While there may be legitimate reasons to favor one approach over the other, in no case are clear and uniform criteria or approval processes used to decide which method to use.

The differences between human services departments are compounded by the administration of POS by area and regional offices, where methods and styles can differ dramatically, even within the same department. As one department chief put it, “Area staff is both headstrong and idiosyncratic about provider reporting requirements and maintaining their own data systems.” The central office staff is often concerned about the lack of standardization but defends the field’s right to get information they need.

The variations in approach among local offices stem from a long-held philosophy of decentralized decision-making. As one area office staff person explained:

“Who knows our clients and our providers better than we do? We have a long history with our network of providers, and the ways in which we work with them reflects the relationships and the understandings of their capabilities that we have built over time. No one in Boston is close enough to the trenches to do the job as we do.

The impact of these disparate approaches is exacerbated by the sheer number of contracts. Purchasing agencies rarely join forces in shared procurements, even if it’s for the same service from the same vendor. One purchasing manager explained, “We often have shared or similar clients receiving services from the same provider, but state procurement regulations do not encourage two or more agencies to join forces and write one contract and share in the cost.” The multiplicity of contracts multiplies the costs of procuring, monitoring and processing payments for purchasing agencies, and the costs of preparing proposals, reports, audits and evaluations for providers.

Buried in Paperwork. These variations may seem legitimate until one realizes that the same providers have to do business in the same geographic area with similar client populations, but often with different purchasing agencies under different conditions with different requirements and expectations. Providers typically contract with more than one agency and

have multiple contracts with each. A single provider may have as many as 20 unique contracts with four or five purchasing agencies, each with its own special requirements and limitations. One purchasing agency may have five or more contracts with the same provider for similar services to similar clients in different parts of the state, with each of the agency’s area or regional offices imposing different requirements on the provider.

From the provider perspective, the purchasing agencies share little in terms of procurement or contracting standards. This means that providers must generate different types of information for each purchasing agency during the procurement process, and also that much information must be replicated over and over again both among and within purchasing agencies.

The paperwork for providers with multiple contracts can be overwhelming and costly. One provider related:

It takes six to nine person-weeks, or about \$8,000, to respond to each RFR. The state’s POS manuals for providers are very complicated and difficult to use, and when we have questions about the rules, we often get different interpretations and bad information from the departments.

From the perspective of the purchasing agencies, the biggest problem with providers is a lack of sophistication in fiscal and administrative systems. “Most of the providers, even the executive directors and managers, come from a direct service background,” said one purchasing official. “Many get degrees or training in management and build their skills along the way, but at any point in time, providers will be positioned all along the learning curve.” Providers agree that there is often not enough money to hire a fiscal person who is savvy enough to deal with the complexities of the system and its multiple contracts, particularly for smaller agencies.

On the other hand, providers are quick to acknowledge improvements that have made their jobs more manageable. Most purchasing agencies and their contracted providers now employ the ready payments system to simplify the payment process. Ready payments have reduced cash flow problems for providers and decreased the time state agencies spend on “chasing checks.”

DMR recently developed an interactive, on-line billing system intended to reduce paperwork for the agency and providers. Other providers commented that the state's contracting website is very helpful and that the development of a single contractors' manual, though difficult to use, is still an improvement over the separate manuals previously issued by each department.

Contracting Not Focused on Results. Rather than setting performance expectations for providers and letting them determine the best way to meet the standards, purchasing agencies exercise considerable control over how providers operate through contract procurement and administration. This is particularly true for cost reimbursement contracts. Under these contracts, which are widespread in some departments, providers are retroactively reimbursed for eligible actual costs, as opposed to receiving negotiated rates for individual cases or units of service.

The use of cost reimbursement contracts illustrates the tendency of purchasing agencies to focus on inputs and processes in the absence of reliable outcome and performance information. As one purchasing manager explained:

It is often difficult to know when human services are successful, either because outcomes are difficult to define or because we simply don't have the data. If we are unable to contract for positive outcomes, we at least need to be able to ensure that public dollars are not being spent inappropriately.

Several purchasing agency officials agreed that they prefer using cost reimbursement contracts because they give the purchasing agency more direct control over the providers. "The ability to approve or disapprove specific costs gives us greater comfort that we know where the dollars are going," said one purchasing manager.

Contract administration staff in area and regional offices like cost reimbursement contracts because the monthly expenditure reports act as a monitoring

tool that allows them to identify staffing vacancies. "Without the monthly report, we would not be able to force providers to keep adequate staffing levels," said one area office manager. Purchasing agencies also report preferring cost reimbursement contracts for start-up programs in which historical cost information has not yet been developed.

However, most providers dislike cost reimbursement contracts, primarily because payments can be delayed – in some cases for up to nine months – while cost reports are scrutinized, challenged and reconciled. Providers need to put extra effort – purchasers call it discipline – into their accounting to know what to bill. Several small neighborhood-based providers reported that they spend inordinate time and cost trying to get paid under cost reimbursement contracts. As one put it:

Getting reimbursed for what we spend is like pulling teeth. I have two people working full time just on contracts. How many hoops do we have to jump through? CR should not exist unless it is the first year.

Rather than setting performance expectations for providers and letting them determine the best way to meet the standards, purchasing agencies exercise considerable control over how providers operate.

On the other hand, if providers succeed in obtaining payments, cost reimbursement can actually be financially advantageous for providers compared to contracts in which rates for individual cases or units of service do not reflect the providers' cost of doing business. Cost reimbursement contracts can also be helpful for new providers or new programs, because startup costs can be recouped even before any clients are served.

Purchasing agencies agree that with few exceptions cost reimbursement contracting incorporates no incentives for either efficiency or performance. Moreover, it often requires providers and purchasing agencies alike to devote more scarce resources to accounting, reporting, reconciliation and resolving disputes than is necessary to ensure accountability for public dollars. As a result, cost reimbursement contracting tends to move the purchase of services system further away from performance and quality rather than closer.

The shortcomings of cost reimbursement contracts are acknowledged in the Commonwealth's own purchasing manual:

This compensation structure provides the least support for the delivery of outcomes, since its focus is on the individual components of expense, and, therefore should be limited in use. Departments are encouraged to reduce their reliance on the cost reimbursement structure.²

However, in the absence of reliable data on outcomes that would enable more widespread use of performance contracting, the use of cost reimbursement persists.

Fortunately, cost reimbursement is not the only means of paying for human services. At the other end of the spectrum are purchase orders or service authorizations: a package of services for a particular client at a pre-arranged price. The services are often tailored to the needs of the individual, and payments to the provider may be tied to specific client outcomes.

The Massachusetts Rehabilitation Commission makes extensive use of service authorizations for vocational rehabilitation (VR) job training and placement. VR providers are pre-qualified, and then receive service orders for specific individual consumers generated by counselors in regional MRC offices. Successful performance of the contract is tied to employment for the client. This, said one MRC administrator:

...puts the power of purchasing in the hands of the VR counselors – they buy specific employment-related outcomes for each consumer. The pre-qualification process results in lots of choice among providers for consumers and VR counselors, and lots of competition in the provider marketplace.

According to MRC staff, the department is not constrained by POS regulations in this area – current rules allow this method of pre-qualification and service order process.

While service authorizations are considered to be a preferred practice in many other state jurisdictions, they are most applicable to services where successful

outcomes can be clearly defined. At the same time that MRC uses service authorizations for job training and placement, it continues to use more traditional unit and cost reimbursement contracts for residential services for head-injured clients.

Despite the wide variety of approaches to procuring services, purchasing agencies also frequently feel micromanaged by the offices that oversee their operations. Restrictions such as limitations on sole source contracts – where a provider is selected without an open request for responses – severely constrain flexibility and innovation, they argue. In cases where there are very few vendors capable of providing a service, or where a unique service model is needed, the RFR process is perceived to be a waste of time. One purchasing official related:

We have been trying to establish a public/private partnership with two providers for assistive technology, with a total budget of about \$150,000. It requires doing a sole source contract with the two providers, which has been held up for over six months. We don't see any reason why this can't be done more easily.

On the other hand, procurement reforms adopted in the 1990s have had a positive impact, according to purchasing departments. The ability to enter into longer-term contracts – up to five years, for example – has created flexibility at the departmental level around how and when to conduct procurements. Enhancements to the ready payment system have also helped purchasing departments streamline their operations.

Lack of True Competition. While the procurement process for human services often appears to be quite competitive, with multiple responses to RFRs the norm, the POS system does not make good use of this competition to improve services and maximize the return on the taxpayers investment. With the focus of the procurement system on process and compliance, and rates frozen below costs, POS has little capacity to ratchet up performance through competition.

While the procurement process gives the state negotiating leverage it needs to ensure it receives the

² Commonwealth of Massachusetts, Procurement Policies and Procedures Handbook, p. 58.

With the focus of the procurement system on process and compliance, and rates frozen below costs, the purchase of services system has little capacity to ratchet up performance through competition.

right services for its clients, there is no real competition in the system. The lack of objective and consistent information on quality and outcomes, compounded by fragmented and inconsistent procurement methods, makes it difficult for purchasing agencies or clients to evaluate and compare providers.

Without such data, purchasing agencies cannot award contracts and clients and their families cannot choose providers based on performance, and a competitive market for human services cannot develop. Contracts are often awarded on the basis of the relationships between providers and the state, and in the absence of consistent

information on outcomes, the experience – good or bad – of the most recent clients sent to the provider can have undue influence on contracting decisions. The issue of client choice is discussed further in the Coordinating Access section of this report.

Competition based on price cannot work in a system in which the state is, in most cases, the only buyer of services and, in effect, sets the price. With prices set below the actual costs of providing services, price competition would only accelerate the erosion of quality that is already taking place.

The administrative demands of a procurement system based on compliance with accounting and reporting requirements have led to significant consolidation in the provider industry, with mergers and closings leaving a smaller number of agencies providing an increasing share of the services. Larger organizations are also more likely to be able to achieve the economies of scale that enable them to survive with level-funded state rates. The trend toward larger providers has also been accelerated by the advent of managed care in Medicaid-funded human services

and involvement with third party payers, which requires substantial investments in technology.

This consolidation has benefited the human services system in some respects. As one purchasing official explained:

The trend toward fewer, bigger organizations is a good trend up to a point. It's malls versus boutiques. We need to see some consolidation within the nonprofit community. The state is paying too much for inefficient operations that could be improved through consolidation.

However, consolidation has also reduced competition for human services contracts. Some providers alluded to an “understanding” that agencies will not compete for some contracts. Purchasing departments sometimes encourage this trend. As one manager said:

Departmental dependence on providers because of their need to take care of their clients leads to an incestuous relationship. Many RFRs are written for specific blocks of business held by specific providers – this virtually eliminates competition.

Despite the reduced competition, providers have been unable to use their market power to increase the price for services. Even the largest providers cannot avoid the “race to the bottom” in terms of quality caused by the growing gap between rates and costs, reducing even further what little performance-based competition there is.

Frustrated by limitations of contracting policies and procedures, a few of the larger Massachusetts human services providers have expanded and implemented innovative programs in other states. Providers feel they cannot develop innovative programs and services in a system that is needlessly restrictive. Massachusetts purchasing agencies are not perceived by providers to have the flexibility to encourage the creation of new program models and the development of best practices, particularly as the providers attempt to meet increasing demands and political mandates for services without new resources.

Setting Prices

Any system for purchasing products or services needs a means of setting prices. While there are a variety of ways to arrive at a price – competitive bidding, negotiation or a data-driven formula – the end result should be a price that reflects the cost of achieving the performance required by the contract.

For the purchase of human services, the price should be based on the costs of meeting the standards for quality of services and client outcomes specified in the contract. The price should reflect a balance between the dual objectives of enabling the provider to operate effectively and ensuring the best use of public dollars. The pricing mechanism should also provide incentives for superior performance in order to encourage the creativity and quality that purchase of services was intended to achieve.

In Massachusetts there is no price-setting mechanism currently operating in most of the purchase of services system. Rates are typically carried over from preceding contracts even without adjustments for inflation, and most rates have not been increased at all for well over a decade. As a result, rates do not cover the cost of providing the specified services or meeting administrative requirements, resulting in compromised standards of care for service recipients and fiscal distress for providers.

Rather than providing incentives to improve performance, human services contracts force providers to focus on operating at the lowest possible cost. Not only are providers not rewarded for real efficiency – finding ways to save dollars while meeting or exceeding state standards – low reimbursement rates effectively inhibit cost-effective performance.

The growing gap between rates and costs is precipitating a workforce crisis in human services. With extremely low salaries, providers are facing increasing difficulty in attracting and retaining a high-quality workforce. The state's response, intermittent special funding to increase the salaries of the lowest-paid human services workers, has been a band-aid

approach that fails to address the symptoms, much less the causes, of the problems.

High turnover rates and minimally qualified staff are having a direct impact on the quality of care. Many of the participants in this study expressed sentiments such as those of one provider director who felt that "agencies face a choice between bankruptcy and unprofessional, unethically low-quality service." As a result, taxpayers are getting smaller and smaller returns on their investment in human services.

No Rate Setting Process. There has been no consistent approach to determining rates for the majority of human services purchased in the state for the last 15 years. Rates are negotiated with providers on a contract by contract basis by the area and regional offices of the purchasing agencies, with no consistent rules or procedures. Contracts typically cover a five-year period with options for renewal at the same rate for an additional five years. Rather than reviewing rates in light of actual costs for providing services, more often than not old contract rates are simply carried forward into the new contract.

Stagnant rates are partly the result of a budget process (discussed in the section on Managing the System) which often puts funding for expanded services ahead of covering the costs of existing programs.

Rolling over contract rates allows purchasing agencies to live within level-funded appropriations indefinitely without coming to terms with the reality of rising costs for providing services.

Purchasing department officials recognize that rates are not covering program costs but have little ability to make adjustments and stay within their budgets. As one state manager said, "Most of the new money we get goes to serving previously unserved clients. The only way we could increase rates would be to cut existing services, and no one wants to do that."

Some purchasing agencies have requested budgets that reflect providers' true program costs. However, even when human services budgets were growing, most increases in funding were devoted to serving more clients, and the departments defaulted to rolling

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over old contract terms. Now, budget cuts make rate adjustments even more difficult.

The state's Operational Services Division (located within the Executive Office for Administration and Finance) calculates an annual inflation factor for purchased services – 2.66 percent for fiscal 2004, with a cumulative 65 percent increase since 1988. The Department of Education builds these inflation factors into the rates it pays providers for special education services, but the Executive Office of Health and Human Services does not do so for the rates offered to its providers.

The rate-setting process has been discontinued despite statutes and policies that call for setting fair and reasonable rates. The methods prescribed by the Operational Services Division in determining prices "shall be fair to both governmental units and providers."³ The Departments of Mental Health and Mental Retardation are required to pay "ordinary and reasonable compensation,"⁴ and other departments are required to pay "reasonable prices."⁵

With the demise of the Rate Setting Commission in 1990, there is currently no entity to which providers can appeal for a fair hearing about their rates. The Rate Setting Commission could and did set rates based on actual costs, and providers could appeal to the Commission if they believed that the rate for a given service was clearly inconsistent with the requirements of the contract.

"Submitting cost reports was tedious, and it often took many months to get a final rate established, but now we look back and think of the Rate Setting Commission as the good old days," said a veteran provider.

Providers now have no recourse but to accept the rate a purchasing agency is willing to give them. The rate "negotiation" process is rendered meaningless when

there is no independent mechanism for objective cost determination or conflict resolution. With contract funding always "subject to appropriation," even agreed-upon rates are not guaranteed.

"The contract is offered as a take-it-or-leave-it proposition, and at the end of the day we have little choice but to accept last year's rates," one provider observed. "Walking away would mean going out of business."

With some exceptions, such as the Department of Social Services' Commonworks initiative, rates for services include no financial rewards for high productivity and superior performance. In some purchasing agencies information about vendor performance is not even reviewed during the procurement process.

With no consistent process for reviewing and setting contract rates, providers can go through multiple contract cycles over several years without an adjustment. In fact, many rates have been stagnant since the late 1980s. Providers with the oldest contracts, most often found in the Departments of Mental Health and Mental Retardation, are least likely to have rates that reflect the true cost of providing services.

"Rather than basing rates on the current cost of providing services, our payments are based on prices we negotiated during the Dukakis administration," said one state purchasing agency manager.

The only rate adjustments for most contracts since 1988 have been small increases in the wages of the lowest-paid direct care workers. Since 1988 funding for salary increases has added just \$98.5 million or six percent to the state's \$1.8 billion purchase of services budget, in contrast to the 65 percent increase in costs calculated by OPS.⁶

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³ Acts 1993, Ch. 110 sect. 274 and 310.

⁴ M.G.L., Ch. 19, sect. 1, and Ch. 19B, sect. 1.

⁵ Procurement Policies and Procedures Handbook, pg. 55.

⁶ A separate salary reserve account for child care workers was funded at \$12.5 million in fiscal 2001.

The debate between the administration and the Legislature over salary reserves has taken the place of reviewing and adjusting rates based on the costs for meeting state requirements. While the salary increases funded by the reserves have been critically important to the lowest paid employees of the providers, vital professional staff such as nurses, physicians, teachers and social workers have received no salary adjustments and the reserves have done nothing to reconnect contract rates with the costs of providing services.

Rates for similar services can also vary considerably from contract to contract, depending on when the contract was first established. DMR recently launched an initiative to reduce discrepancies in rates by recalculating rates when contracts are renewed. The new rates will be tied to a clinical assessment of each client. However, while the initiative will result in more equitable rates, the new rates will still not be based on the current cost of providing services. The plan will increase rates for some providers while reducing rates for others, but the average rate will remain the same.

Rising Costs. Providers, like any other business, are impacted by rising costs for labor, health benefits and space for offices and residential facilities. Costs for

health, property, liability and auto insurance have been increasing especially steeply. Keeping up with rapid changes in technology adds to costs. Unlike any other business, however, they cannot raise their prices to compensate.

Most of what providers spend is determined by state requirements. Staffing ratios, food allotments, occupancy, safety equipment, building codes and computer capacity are all spelled out in contracts. With such a high proportion of their costs fixed, providers have few options for reducing costs when state funding is cut or fails to keep up with inflation.

“Of course we want to pay our staff adequately and provide a safe workplace and all the training they need, but having to pay for all of these things is pushing us close to the edge.”

Over the last several years the state has required providers to implement costly new requirements without additional compensation. These “unfunded mandates” result from a variety of federal and state laws and regulations. The most costly have been minimum wage increases, training in medication administration and restraint procedures, complying with federal Occupational Safety and Health Act regulations on blood-borne pathogens and vaccinations, Americans with Disabilities Act requirements and human rights education. Other examples include increased federal reporting requirements for rehabilitation services, shifting to state computer-based contract administration, and first aid certification.

State oversight agencies do not conduct cost-benefit analyses prior to adding new requirements to provider contracts. A state program manager acknowledged, “We have no way of knowing if the costs of these requirements outweigh the benefits or how they will impact provider programs, operations or finances.”

Providers argue that unfunded mandates cut deeply into program budgets and further weaken their capacity to pay adequate salaries to direct care staff and to operate quality programs. “Of course we want to pay our staff adequately and provide a safe workplace and all the training they need, but having to pay for all of these things without any budget relief is pushing us close to the edge,” said one provider.

Changing demographics also take their toll on costs of services. Level-funded contracts fail to take into consideration the fact that clients with developmental disabilities and mental illness are living longer, or the increasing importance of primary health maintenance and support services in residential programs. As clients living in residential programs age, their health, mobility and social support needs also increase. At the same time, children and adolescents in care exhibit far more serious cognitive and emotional disorders, which require skilled and costly care. Yet the contract rates for these individuals rarely increase to cover the higher costs.

Provider organizations with high caseloads of ethnically and linguistically diverse clients have high hidden costs related to translation services, support services to extended family members, and diversity training for staff. These services are frequently not recognized as necessary program costs by the

purchasing agencies. Outpatient mental health clinics in inner cities are particularly hard hit by these costs when they serve large numbers of recent immigrants from Russia, Haiti, Southeast Asia, and Spanish-speaking countries.

Growing Gap Between Costs and Rates. The growing disparity between prices and the costs of services destabilizes provider finances, and some are experiencing severe fiscal distress. An analysis of financial data submitted by providers for 1998 showed that 173 out of 757 in the database – 23 percent – lost money on their state contracts. EQUIP, a child care coalition, reported that it costs on the average 15 percent more to provide early child care programs than the state rates allow. In fact, the average salary of a child care worker is so low that many are eligible for child care subsidies themselves.

Outpatient drug programs have not had rate increases in the last 12 years, and half of the detoxification programs in the state were reportedly on the verge of closing, even before funding for the programs was reduced in recent budget actions. The Department of Public Health recommended rate increases eight years ago, but no action has been taken.

State purchasing agencies sometimes find that they cannot purchase services at the going rate. One community mental health center had to return a contract to the Department of Public Health because it was losing too much money on a detoxification program, even though it had proven to produce good client outcomes. When the program was re-bid, the Department had to award the new provider higher rates or the service would not have been offered.

An emergency shelter provider reported that the state last year purchased 15 extra beds at a non-negotiable \$10 per day with the expectation that the program would be open 24 hours. When these beds were quickly filled, the state rented motel rooms at \$47 a day.

While Office of Child Care Services licensing regulations require cash reserves of two months for center-based child care programs, and three months for group care or residential treatment programs, most providers average less than three weeks of operating reserves. In 1998 over 70 percent of providers in the POS system reported having less than three months of operating capital. Independent

auditors recommend that providers have six months of operating expenses in reserve.

The lack of cash reserves also reduces the ability of providers to make necessary capital investments, such as buying or renovating property for residential facilities. The state does not typically pay for capital or program development costs in advance, but expects those costs to be covered by the regular rates. For most programs, providers cannot begin billing the state for these costs until clients take up residence or otherwise start receiving services in the program.

Private Fundraising to Fill the Gap. Providers, using non-state funds for development, turn to private fundraising to try to fill the gap between program costs and state reimbursements.

State purchasing agencies sometimes find that they cannot purchase services at the going rate.

Some nonprofits have pursued private fundraising activities for years while others are almost completely funded by state contracts.

Nonprofit organizations that contract with the Commonwealth are more than just arms of the state, but community-based organizations accountable to clients, their families, local residents and others in their broader

constituency. As such, fundraising not only is a means to generating new sources of revenue, it is a way of building relationships with a broader constituency (other than direct clients and the state) invested in the agency's mission. Private fundraising becomes an exercise in community accountability, a way to keep stakeholders informed about the agency's work and overall direction.

A diverse funding base, just like a diverse investment portfolio, makes for a healthier nonprofit organization. Independent, private funding also allows nonprofits to pursue public policy advocacy activities they cannot pursue with state dollars. Some providers are moving more aggressively into private fundraising, not just to recoup state budget cuts, but to raise more flexible dollars that will not tie them to state mandated categorical funding streams and will instead enable them to provide comprehensive, client-centered services.

However, private fundraising cannot adequately fill the gap created by stagnant state reimbursement rates and by new state budget cuts. Until 1997 state regulations required that any funds raised from private sources be used to offset state costs, reducing the incentive to seek charitable contributions for state-funded programs. Even with this restriction removed, fundraising from major donors and through special events is expensive and time-consuming, and very few providers have the time or resources to raise donations from private sources. Many report that devoting more and more of their time to fundraising activities in order to cover basic program costs is undercutting their ability to manage and operate their programs.

Foundation grants often cannot be used to support operating costs for programs that are supposedly funded by the state. Foundation funding is time-limited and often does not support ongoing delivery of direct services. Most foundations prefer to fund demonstration projects that have the promise to yield important new program models that can ultimately be funded with public dollars. During economic slowdowns, when contracts are most likely to be cut and fund-raising becomes most critical, it is all the more difficult to entice donors to subsidize programs the state has promised to fund. Even when providers are successful in raising private funds, they run the risk of undermining their fiscal stability by relying on one-time funds to pay for ongoing costs.

Diminishing Returns on Efficiency. With rising costs and largely fixed incomes, providers have strong incentives to operate as efficiently as possible. As one provider put it, "We have no choice but to cut costs, to stretch the state dollars as far as they will go, and then look for other funding sources to fill the gap when the state money runs out."

Providers reported cutting staffing to the minimum levels needed to provide services, freezing wages, and shifting rising benefit costs to employees. Spending on equipment and supplies is often supplanted by out-of-pocket contributions from staff, and maintenance on property is deferred indefinitely. Training budgets, a key to quality services, are regularly trimmed.

Expansion of human services has allowed many providers to develop new programs, thereby spreading fixed administrative costs over a larger financial base. As a result, administrative costs, including salaries of administrative personnel, have been held to an average of just 7.6 percent of total contract dollars, according to the Operational Services Division.⁷

Up to a point, requiring providers to operate as efficiently as possible produces positive results. The lower costs offered by private providers compared to state-operated services was one of the primary motivations for shifting to a purchase of services system, and keeping a lid on provider costs helps ensure that taxpayer dollars are well spent.

However, the point of diminishing returns was reached years ago. With rates that cover a smaller fraction of their costs every year, providers increasingly have to choose between meeting the administrative requirements of their contract and providing quality services.

The point of diminishing returns was reached years ago.

A Growing Crisis in the Human Services Workforce. The pressure to control costs has pushed wages and benefits for human services workers so low that providers are experiencing difficulty attracting and retaining qualified staff. With the performance of all programs directly dependent on the knowledge and skills of their staffs, this emerging workforce crisis is further undermining the quality of human services.

A series of analyses and reports have documented the impact of the financial squeeze on providers' employees. With contract rates frozen, salaries for human services workers cannot keep up with inflation or the marketplace. One large provider calculated that the

⁷ Operational Services Division, *Estimated Rate of Inflation for Fiscal Year 2004*, November 27, 2002.

purchasing power of their entry-level direct care staff has decreased by 17 percent between 1988 and 1999.⁸

Direct service staff are paid poorly, averaging \$9.52 an hour or \$19,811 annually in 2000. The average starting salary for an entry-level direct care worker was \$18,567. An Operational Services Division report on the impact of the salary reserves found that 17,932 provider employees in positions eligible for the increases made less than \$20,000 and 34,353 made less than \$30,000 per year in 2000.⁹

These salaries are inadequate for single-income human services workers with families to make a living in a high-cost state like Massachusetts. A recent study found that an adult with one preschool-age child and one school-age child required \$51,284 per year to live self-sufficiently in the Boston area and \$36,603 to live in Springfield.¹⁰

These salaries are low, even by industry standards. Across the border in Connecticut, providers' direct care staff salaries begin at \$27,400 and can reach \$31,000 for entry-level positions. Even in a weak economy, qualified workers can command better salaries and benefit packages in other fields.

In response to rapidly rising premiums for health insurance, providers, like employers everywhere, have shifted costs to employees in the form of higher cost shares, deductibles and copays, or increased their reliance on part-time employees who are ineligible for coverage. As a result, 45 percent of provider

Massachusetts providers cannot keep well trained and experienced staff.

employees have no health benefits according to a survey conducted by the Massachusetts Council of Human Service Providers.¹¹

As a result, Massachusetts providers cannot keep well trained and experienced staff. It is not unusual for existing provider agency staff

to be recruited for state-operated programs where salaries and benefits are considerably better. Before the current economic downturn, replacing staff could easily take up to six months, especially if special language skills are needed. Layoffs in other sectors and higher unemployment have recently eased hiring problems for entry-level workers. Nevertheless, the direct care workforce is increasingly made up of recent immigrants and transient, low-skill workers who may be minimally qualified for the demanding work. Finding qualified clinical and educational staff remains a serious challenge, even in a softer labor market.

A 1996 Division of Purchased Services study reported that very low direct care salaries resulted in high staff turnover rates.¹² The report found average annual turnover rates of 32 percent for entry level Direct Care I positions, and 27 percent for Direct Care II staff.¹³ The 2001 Operational Services Division report found turnover rates of 25.6 and 28.0 percent, respectively,

⁸ The symptoms and implications of the human services workforce crisis – and potential approaches to addressing it – were identified at a conference held by the Pioneer Institute for Public Policy Research in April 2002, and in two publications, *Innovation Out of Crisis I: Making Human Services More Humane*, and *Innovation Out of Crisis II: Solutions to the Human Services Workforce Crisis*.

⁹ Operational Services Division, *Outside Section 445 – Study of the Impact of Salary Reserve, FY 1997 to FY 2000*, January 2001.

¹⁰ Diana Pearce with Jennifer Brooks, *The Self-Sufficiency Standard for Massachusetts*, Women's Educational and Industrial Union, April 2003.

¹¹ Massachusetts Council of Human Service Providers, *The State of Health Care Insurance Costs for Human Service Providers in Massachusetts*, June 2001.

¹² The Division of Purchased Services preceded the current Operational Services Division in overseeing POS.

¹³ Division of Purchased Services, *An examination of compensation paid to private mental health, mental retardation and day care workers employed through contracts with the state departments of mental health, mental retardation, social services and transitional assistance*, 1996.

for the same positions and 25.8 percent for purchase of services positions overall.¹⁴ In our study, providers reported staff turnover rates ranging from 40 to 70 percent in community residences and other direct care services, with vacancy rates typically in the 20 percent range.¹⁵

These findings are mirrored on the national level by a recent Brookings Institute study which concluded that the average annual turnover rate among child welfare workers in private agencies and among child care teachers is 40 percent. The survey also found that 81 percent of the workers agree that it is easy to burn out in the work they do, 75 percent describe the work as frustrating, and 67 percent agree that their pay is low.¹⁶

Staff shortages exacerbate the fiscal difficulties of the providers. Relief staff costs more than double that of regular employees, and overtime costs at least half again as much as regular salaries. A large and experienced provider who has been contracting with the Department of Social Services and the Department of Youth Services for 25 years described the dilemma:

Some of my staff work 60 to 70 hours of overtime in a two-week period. I have to pay time-and-a-half, which kills me, but I don't have any choice. I can't find enough staff and if they don't get the OT, they don't make enough to live and will leave for other jobs.

Another provider related that he needed 280 hours of staff coverage but only had staff available for 80 hours. One of his employees worked 120 hours one week to cover staff shortages.

High vacancy and turnover rates compromise the continuity of programs and the quality of care. Clients and families feel the impact of serious disruptions in program services. Frequent departures of direct care staff leave clients and their families confused and feeling vulnerable.

As one parent of a group home resident said, "Seeing so many staff come and go makes my child anxious, and I worry about whether the program will be able to operate in the future."

Staff turnover can break the personal links that develop between clients and caregivers that are essential for recovery and return to independence. Having two or more new case managers every year frustrates families and clients alike. Families in particular resent having to "break in" new case managers or other direct care staff who do not know as much about the system as do the parents.

¹⁴ Operational Services Division, *Outside Section 445 – Study of the Impact of Salary Reserve*, FY 1997 to FY 2000, January 2001.

¹⁵ The turnover rate is the total number of vacancies over the course of a year as a percentage of the total number of staff; the vacancy rate is the proportion of positions that are vacant at a point in time.

¹⁶ Paul C. Light, *The Health of the Human Services Workforce*, Brookings Institute, March 2003.

Recommendations: Building a High Performance System for Clients and Taxpayers

The citizens of the Commonwealth are clearly committed to helping the less fortunate among them, and the purchase of services system has an impressive record of accomplishments in meeting that commitment. Dedicated public and private employees, supported by a strong network of advocacy groups, have built a creative and vibrant array of services, and the majority of clients receive good care from the system.

Nevertheless, the Commonwealth's vast system for purchasing human services is clearly in need of an overhaul. The problems engulfing the system range from insufficiently integrated care for clients to difficulties in attracting and retaining a qualified workforce for providers to a lack of basic information about how well the system is working for the Commonwealth. The time has come for a far-reaching and sustained effort to reform the way the state purchases and delivers human services. While the system's flaws impact all of its stakeholders – no one involved thinks the system works well – in the end, the burden falls on the clients, who too often do not receive the quality services they need, and the taxpayers, who are not getting a fair return on their \$2 billion investment in purchase of services.

First Steps Toward Reform

Reform of state government is now at the forefront of the Commonwealth's agenda. While the search for solutions to the state's ongoing fiscal crisis is driving much of the current interest, policy makers also recognize that changing the way the state does business can improve the quality and equity of services, make better use of taxpayer dollars, and help restore public confidence in state government.

The Governor and the Legislature clearly recognize the need for changes in purchase of services and deserve

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credit for initiating the first phase of a reform agenda. The fiscal 2004 state budget enacts a major restructuring of human services agencies intended to strengthen coordination among departments, improve access to care, and reduce administrative costs. The new structure lays the groundwork for fundamental reforms to the purchase of services system.

The reorganization groups 17 departments and offices that provide human services into five clusters:

- The Office of **Health Services** includes the Division of Medical Assistance (including Medicaid except for seniors), Department of Public Health, and Department of Mental Health;
- The Office of **Disabilities and Community Services** includes the Department of Mental Retardation, Massachusetts Rehabilitation Commission, Massachusetts Commission for the Deaf and Hard of Hearing, Massachusetts Commission for the Blind, and the two Soldiers' Homes;
- The Office of **Children, Youth, and Family Services** includes the Department of Transitional Assistance, Department of Social Services, Department of Youth Services, and the Office of Child Care Services;
- The Executive Office of **Elder Affairs** was moved under EOHHS umbrella but retains its cabinet-level status, and now includes Medicaid for seniors, including nursing homes and community-based services; and
- The Office of **Veterans' Services** was also moved to EOHHS.

Each of the new offices is headed by an Assistant Secretary who is also an agency commissioner. The Secretary of Health and Human services for the first time has been given budget and regulatory authority over the departments in the secretariat, and

administrative functions such as human resources and finance will be centralized under the Secretary.

The grouping of departments into clusters should help break down their isolation – the “silo” effect – and foster greater communication and collaboration. By developing more integrated approaches to serving broad groups of clients – the mentally ill, the disabled, and children and their families – services delivered by multiple agencies can be better coordinated and the “maze” of departments and programs can be made more accessible. The plan also seeks to produce savings by consolidating shared administrative functions and area and regional offices.

Restructuring by itself is not reform, and realigning organizational reporting relationships alone will not bring about changes to the way human services operate or improve the quality of life for the Commonwealth’s most disadvantaged residents.

However, restructuring can create an organizational environment in which more fundamental reforms can be developed and implemented. Just as importantly, the debate over human services restructuring in the budget process has drawn the attention of policy makers to the problems of the current system and created momentum for reform.

The new authorizing statute for EOHHS requires the secretariat to develop and implement a numbers of measures that will underpin future efforts to reform purchase of services, program evaluation and data collection:

- Uniform contracting and payment procedures for purchased services;
- Standardized service delivery areas for all agencies;
- Performance measures to evaluate all programs; and
- Regulations to protect client confidentiality while insuring the ability of agencies to share information.

On the other hand, the Governor vetoed a number of additional reform measures that had been approved by the Legislature, including requirements to increase funding for providers to offset the costs of new mandates, and to create interagency children’s services teams. The Governor also rejected legislative requirements to study and make recommendations regarding reform of the purchase of services system, consolidation of agency offices, and elimination of

duplicate licensing functions, arguing that the administration could accomplish these purposes without a legislative mandate.

At the same time that it reorganized the human services system, the budget made substantial funding cuts to a wide range of human services programs, making the need for fundamental reforms all the more urgent. The budget cuts are not the source of the problems described in this report, which were sapping the performance of the system even when human services budgets were growing. But budget reductions are exacerbating the problems clients already face in negotiating an increasingly dysfunctional system for providing services. With providers and state agencies mired in a tangle of bureaucratic impediments to delivering high-quality services, it will take a thoughtful and sustained reform effort to strengthen the performance of the system in this era of sharply limited resources.

Recommendations

Organizational restructuring of state agencies needs to be complemented by fundamental reforms of the business relationship between the Commonwealth and the private providers that deliver the bulk of human services in Massachusetts. The ultimate goal of these reforms is to get more responsive and valuable services delivered for the public dollars spent – better outcomes and quality of life for the clients, and, at the same time, a healthier return on the taxpayers’ massive investment in human services.

Meeting the Commonwealth’s commitment to care for its most disadvantaged residents requires a high-performance human services system that features:

- Coordinated, focused case management to help clients and their families access services, starting with a clear point of entry into the system and continuing with consistency and clarity throughout the period of service;
- Efficient procurement of a well defined array of high-quality, individually tailored services that the coordinating case manager can combine into a service package for the client; and

- Access to information that enables clients and caregivers to make meaningful choices among providers, caseworkers to coordinate services across agencies, purchasing agencies to award contracts and manage programs, and policymakers to set priorities and evaluate the performance of the system.

The recommendations in this report are intended to achieve these objectives by building a system that works for everyone involved, from clients and providers to public employees, purchasers and policymakers. The system should harness the power of competition to drive continuous improvements in quality and produce better value for the taxpayers. This will require a new emphasis on measuring service quality and outcomes and making performance information readily available throughout the system.

The changes recommended here are profound but not radical. The purpose is not to reinvent purchase of services, but to restructure the policies and practices that currently create so much drag on performance and prevent any of the participants in the system from truly accomplishing their missions.

The recommendations in this report are a set of principles that, taken together, offer a broad vision of how the purchase of services system should work. The recommendations are intended to serve as a framework for developing more specific reforms rather than a prescription for detailed changes. Designing and implementing major changes in human services will take time and the involvement of all of the system's stakeholders. The purchase of services system provides a vast array of services to a wide variety of clients, and because the recommendations refer to the system as whole, they may not apply in every situation or to every program.

To achieve this vision, the Commonwealth needs to rethink its approach to each element of the purchase of services system and refocus its role on six primary responsibilities:

- ① Setting priorities for human services within the state's fiscal constraints based on assessments of client needs;
- ② Setting standards for performance and quality of services that reflect the Commonwealth's priorities;

- ③ Setting reasonable and adequate prices for purchased services based on the cost of achieving the performance and quality standards;
- ④ Purchasing services in a competitive market that rewards quality, performance and value;
- ⑤ Coordinating access to care so that clients and family members can readily locate and consistently receive appropriate services; and
- ⑥ Holding the system – from providers to overseers – accountable for results.

The recommendations that follow are organized into these six themes.

Set Priorities for Human Services and Budget

Accordingly. The Commonwealth has to find a better way of setting priorities to meet a dizzying array of needs for human services ranging from residential care for the developmentally disabled to treatment for mentally ill homeless residents to protective custody for abused children. In the present era of fiscal constraints, the state is struggling to maintain the services it has traditionally provided and, at the same time, attempting to expand services to underserved clients. The Commonwealth cannot afford to stay on this course. Even in the best of times, the state could never meet all of the needs.

There will never be a perfectly rational and objective method for deciding to put one need ahead of another. However, the current practices – basing budgets on past spending levels without accounting for the quality of services or changes in costs, expanding funding for new services without addressing the shortcomings of existing programs, and making budget cuts without any strategy to guide the choices – cannot continue.

The Commonwealth needs to set priorities with realistic expectations about what it can afford. Continuing to expand services without adequate funding for existing programs will only further erode their impact on clients and value to the taxpayer. Attempting to bring every service that the state now provides up to a high level of quality would undoubtedly cause the state's \$2 billion investment to grow far beyond what the Commonwealth can afford.

In order to set priorities in a more rational and intelligent way, EOHHS needs to be able to answer a

series of basic questions: What is the extent of the needs for human services? What level of quality is needed to ensure positive outcomes? What would it cost to attain that level of quality? Where are the potential savings in the system? Which services are the most essential?

As part of the development of priorities to recommend to the Legislature, EOHHS should evaluate the quality and performance of the human services system by:

- Using needs assessments and tracking service utilization rates to identify gaps in – and duplication of – services;
- Using performance data and program evaluations to gauge the outcomes of services;
- Using financial data to assess the fiscal health of providers and of the system as a whole; and
- Comparing the costs – and quality – of state-operated services and institutions with purchased services.

These evaluations would need to be undertaken and updated regularly. They would need to be flexible to respond to new and emerging issues, such as changes in the prevalence of social problems, providing services to new immigrant groups, or advances in the methods and technology of providing human services.

The results of these evaluations should inform the priority-setting process in the administration and the Legislature. Priorities would be expressed in the annual human services budget, which should be based on realistic assessments of the number of clients to be served, the extent of services to be provided, and the cost of providing those services at an acceptable level of quality. The budget will necessarily require difficult choices about which needs can be addressed and which services provided, but the tradeoff should not be between the number of clients and the quality of services.

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Set Standards for Performance and Quality in Human Services.

For a service intended to improve the lives of disadvantaged Massachusetts residents, the state should specify the health, behavior and quality of life it wants to help bring about for its clients. Contracts with human service providers should spell out the performance expected from the provider in terms of the quality of services and the outcomes achieved rather than inputs and units of service.

EOHHS, in collaboration with purchasing agencies, providers, service advocates and clients and their families, should establish outcome measures and standards of quality for human services programs. These performance standards would define success in terms of results and value. The purposes of the standards would be to improve service quality and outcomes for consumers, create a rational basis for setting rates, and ensure that taxpayers are buying high-quality, effective services. Providers, purchasing agencies and the system as a whole would be evaluated against their ability to meet the standards.

Quality standards and outcome targets should be set high enough to ensure program quality and results at a reasonable cost, and specific enough to assign costs to meeting them, as discussed in the next section.

Since the purpose of providing human services is to produce significant improvements in the lives of clients and their families, outcome measures that gauge the impacts of services should be used far more than they are today. Ideally, the outcomes of all human services could be accurately measured and the performance of the system could be presented entirely in terms of client outcomes. Examples of outcome measures would include assessments of mental health, level of functioning, recidivism, and satisfaction with services.

However, in many cases the outcomes of human services are difficult to measure or are affected by

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many factors other than the services provided. For these reasons, performance standards should also specify the quality of services provided. All human services contracts should have quality standards, supplemented by outcome measures where appropriate. Quality standards would include measures of consumer-focused services, access to services, service methodologies and use of best practices, staff competency, accreditation, and quality management and improvement.

Quality standards would differ from current licensing and certification requirements in two key respects. Quality standards would be specific to each type of service, while licensing applies to broad categories of services such as residential programs. And while licensing or certification qualifies a provider to bid on a contract and provide certain types services, quality standards would be incorporated into each contract, and providers would be required to meet those standards in order to fulfill the terms of the contract.

Developing these performance standards for the full range of services would require a substantial initial investment of time and effort, but the standards could not be static. Quality standards and outcome measures would need to be refined and updated based on performance data and new developments in the delivery of human services.

Establish Reasonable and Adequate Rates for Services Based on the Costs of Meeting Standards. Prices for purchased human services should be based on the costs of meeting the performance standards for quality of services and client outcomes specified in the contract. The current disconnect between rates and costs contributes to fiscal distress and a growing workforce crisis for providers and, ultimately, a decline in the quality and impact of services for clients.

Reasonable and adequate rates would reflect a balance between the dual objectives of enabling providers to operate effectively and ensuring the best use of public dollars. Cost-based rates would support the achievement of performance standards for quality and

outcomes, allow for a viable provider industry, and foster innovation in the provision of services.

The Commonwealth needs a new rate-setting mechanism for human services. There is no mechanism operating now in most of the system. An independent body under the Executive Office for Administration and Finance should set rates for each type of human service with input from EOHHS, purchasing agencies and providers. Placing the rate-setting function with a third party outside of EOHHS would allow for objective consideration of rates, and create a system of checks and balances between the agencies that purchase services and those that evaluate their costs.

The basis for rates should be rational and defensible. Rates should be based on analysis of the market costs of meeting the performance standards. All legitimate costs of delivering services and administering contracts should be included, such as personnel costs for the number of qualified staff necessary to meet quality standards. Other costs that should be reflected in the rates include staff training, facilities that meet licensing and building code standards, health and liability insurance, and administrative staff for meeting state reporting requirements.

Rates should be adjusted annually to reflect increases in the cost of doing business. Failure to keep up with inflation over the last 15 years is the root cause of many of the problems with purchase of services described in this report. Rates should also reflect geographic variation in costs, as well as differences in the acuity of client needs.

Rates should reflect new or increased standards, regulations or other requirements imposed on providers that materially affect the cost of meeting the terms of a contract. Examples include increases in the minimum wage, higher staffing levels required to meet quality standards, or new data collection and reporting requirements. If such a requirement is imposed after a rate is established or a contract is awarded, providers should be able to appeal to the rate-setting body to review and adjust the rate if an increase is warranted.

The rate-setting process should have a mechanism whereby providers – or purchasing agencies – can appeal the rates established by the EOAF body. A successful appeal would have to demonstrate that rates were inadequate to cover costs necessary for meeting the quality standards for the service in question.

The pricing mechanism should also provide incentives for superior performance in order to encourage the creativity and quality that purchase of services was intended to achieve. For example, providers could be eligible for premiums for exceeding targets for client outcome measures, or penalties if they failed to meet the targets.

DSS's Commonworks program offers a model for how incentives can work. Commonworks provides bonuses for moving clients to less intensive – but clinically appropriate – services and for getting them through the system and discharged from Commonworks.

Another example is the Massachusetts Behavioral Health Partnership contract for Medicaid-funded mental health services, which includes a long list of goals and benchmarks with incentives and penalties.

Establishing cost-based rates and setting priorities for service delivery go hand in hand. Adequate rates are needed to determine the cost of competing services, and setting budgetary priorities among services will be necessary to make rate adjustments within the Commonwealth's limited financial means. Having rates based on the cost of providing services would also be a prerequisite for competitive procurement of services based on performance, as described under the following recommendation.

Streamline Purchasing to Foster a Competitive Market for Human Services.

A results-oriented system of purchasing human services needs to harness the power of competition to produce high quality and effective services at an affordable cost.

Providers should compete based on performance rather than on their ability to conform to reporting requirements and to survive with rates that do not cover their costs. Providers' performance should be defined in terms of attaining targets for client progress and quality of services.

In a competitive market, providers that produced the highest quality services and the best outcomes would attract the most contracts and the most clients. Market forces, governed by standards and cost-based rates, would drive continuous improvements in quality, producing the optimum balance between performance and price.

Purchasing agencies should negotiate with providers over levels of services, not rates, which would be predetermined by the rate-setting process described above. Rates based on the cost of providing quality services would provide a level playing field for provider competition. The alternative – competition based on price – would inevitably lead to a race to the bottom in terms of quality of services and a diminished return on the Commonwealth's investment in human services. Taxpayers would pay less for services, but would get less effective services in return.

Other elements of the purchase of services system recommended in this report are prerequisites to developing a competitive market for human services:

- Outcome measures and quality standards would be required to assess provider performance;
- Cost-based rates would help ensure that providers compete based on performance rather than price;
- Accountability monitoring and reporting systems that focus on outcomes and quality rather than compliance with regulations and accounting requirements would create new incentives to improve services, provide the data necessary for evaluating performance, and ensure that providers are qualified to compete for contracts; and
- Integrated performance information would enable clients, caregivers and their caseworkers to select the best provider for their needs and purchasing agencies to award contracts to the most qualified providers.

Facilitating the development of a competitive market would also require a streamlined procurement system that puts more emphasis on provider performance. The current system features uncoordinated

Providers should compete based on performance rather than on their ability to conform to reporting requirements and to survive with rates that do not cover their costs.

and inconsistent approaches to procurement by each of the purchasing agencies, voluminous paperwork and, in many cases, cost reimbursement contracts that offer more state control of provider operations than incentives for performance.

Changing these dynamics and fostering a competitive market for human services will require significant changes to the way purchasing agencies procure services. The multiplicity of policies, procedures and requirements, adopted for legitimate reasons when departments served unique populations of clients with their own specialized providers, is no longer sustainable in a system where many clients and families are served by, and many providers contract with, more than one department. The administrative costs of coping with the discrepancies and duplication are unacceptable when program budgets are being cut and quality is falling because of inadequate rates.

New approaches to procurement would:

- Eliminate bureaucratic requirements that do not contribute to the quality of services and positive outcomes for clients;
- Reduce administrative costs for both the state and providers, allowing savings to be redirected to services and more adequate rates;
- Balance workloads, resulting in more thoughtful procurement and increased competition for contracts; and
- Generate savings from economies of scale.

EOHHS should use the new authority given to the Secretary in the reorganization legislation to develop and enforce consistent procurement policies and procedures for each purchasing agency and provide stronger oversight of the system. This is not a recommendation for centralized purchasing – the purchasing agencies have the necessary knowledge of their clients' needs and providers' capabilities and should continue to have the lead role in procurement –

but for eliminating differences in approach wherever feasible.

Uniform licensing requirements should be developed as part of a detailed review of licensing and certification regulations. The purposes of a licensing review would be to:

- Eliminate any unnecessary differences in regulations imposed by different departments;
- Consolidate licensing and certification reviews to reduce costs for both providers and the state;
- Eliminate regulations and requirements that no longer serve the function of ensuring safe and effective services; and
- Determining which licensing requirements that overlap with national accreditation standards could be waived for accredited providers.

These objectives could be accomplished by creating a centralized licensing body for all service types under the Secretary, or by enforcing greater collaboration between the departments that currently have licensing authority.

Providers with national accreditation by a recognized body should be deemed to meet the state's licensing requirements and exempted from the licensing process, except in cases where the state has a legitimate need to set higher standards than those required for accreditation. Accreditation requires rigorous reviews and evaluation that often replicates the state's licensing and certification processes, creating extra costs that neither the providers nor the state can afford. Where the state has a valid reason for regulations that are stricter or more specific than accreditation standards, such as the health and safety of clients, the state should be able to impose higher standards through licensing, but accreditation should still suffice to meet most licensing requirements.

Purchasing agencies should utilize uniform contracting procedures to reduce the costs of procurement itself. Standardized requests for proposals across departments would reduce the cost of preparing a proposal and promote more competition for contracts, while still allowing for the collection of information that is specific to the type of service being purchased. The quality standards and outcome measures that would be included in RFPs

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and contracts, while differing for different service types, should be applied consistently across agencies and providers that offer similar services. Differences in financial data reporting requirements and quality and performance monitoring procedures, discussed further below, should be eliminated wherever possible.

Purchasing agencies should make greater use of joint purchasing for similar services. For example, two departments that were both seeking community residential services for children in the same region could issue a joint RFP, reducing the costs of procurement for the state and the costs of preparing proposals for providers.

The state and providers alike could also make better use of their administrative dollars by spreading out

the procurement process across the year. Procurement should be staggered so that about one quarter of the contracts are extended or bid each quarter instead of trying to squeeze the process for all contracts into one month, as is often the case now.

Developing a competitive market for human services will also require the state to become more business-like, functioning as a true purchaser and not a direct manager of services.

Purchasing agencies should reduce their reliance on cost reimbursement contracts, which put too much emphasis on state control over provider operations and

too little on provider quality and client outcomes. Cost reimbursement contracts should be reserved for the start-up and initial operating costs of new programs and for providers that are not yet offering enough services to survive with case- or unit-based rates.

Contracts that paid providers when clients attained specified outcomes, such as MRC's employment services contracts, would be the first choice in a system where providers compete based on their performance. For services with outcomes that are difficult to measure,

contracts should be based on rates for serving individual cases or providing units of service that meet the quality standards specified in the contract.

Strengthen Coordination of Care. Even in a system where most human services are purchased from private providers, state agencies remain the first point of contact for most clients and families. The state's role is to ensure that eligible clients have access to and receive services that are appropriate for their needs. The state, acting either directly or through a case management provider, assesses the needs of the client, refers the client to appropriate service providers, and follows up to ensure that the client receives the right assistance.

The role of the client and his or her family is to choose a provider based on information on the kinds and quality of services offered. Client choice is a key element in developing a competitive market for human services that rewards quality and outcomes.

In cases where clients and family members need help from more than one provider or more than one state agency, the Commonwealth is responsible for coordinating the care so clients receive the best combination of complementary services while minimizing service gaps, duplication and conflicts. Effective case management can help the client maneuver through a complex system and receive the best care possible. Ideally, case management transforms the wide array of services offered by a host of bureaucratically distinct organizations into a seamless continuum of care.

Achieving this ideal is too often frustrated by a confusing array of entry points into the system, by difficulty navigating the system to find appropriate programs, and by multiple case managers providing uncoordinated and conflicting guidance. Clients are more likely to be directed to an available slot in an existing program than to receive a package of services tailored to meet their particular needs. Taxpayers end up funding ill-fitting

Addressing these issues will require an unprecedented level of communication and collaboration between purchasing departments.

and sometimes duplicative services that may be more costly than necessary.

Addressing these issues will require a fundamental shift in the way care is managed, from a program-centric model to a more client-centered approach, with an unprecedented level of communication and collaboration between purchasing departments. It will also require that much better information about service options and provider performance be made available to clients and case managers.

Entry into the human services system should be simplified, with the ultimate goal of a one-stop-shopping approach to accessing services. Purchasing agencies and providers should be able to refer a client to any program to receive appropriate services no matter where the client comes into contact with the system.

Once they are in the system, clients and family members should be able to access services provided by multiple departments more easily. As a first step, state agencies need to standardize their service area boundaries, as required by the reorganization legislation. Currently, each agency divides the state into regions and areas in a different way, needlessly adding to the complexity of the system for clients and caseworkers alike.

A second step would be combining – or at least locating in close proximity – the purchasing agencies' area, regional and field offices wherever practical. Grouping offices would make it easier for clients to access services and for caseworkers to collaborate with their colleagues in other departments in managing services. In some cases, departments could realize economies of scale by sharing administrative costs. However, in many cases, moving offices will not be feasible.

Regardless of the physical location of offices, the state has a major opportunity to make better use of information technology to support collaboration between departments and coordination of services to clients. Caseworkers should be able to easily share information about clients – subject to confidentiality restrictions – and determine the availability of appropriate services across departments. Technology is also the key to streamlining client entry into the system.

A single case manager should be responsible for overseeing the services provided to each consumer by multiple purchasing agencies. With the long history of weak communication and collaboration between departments, and with each purchasing agency responsible for managing its services within a tight budget, this will not be easy. The new organizational structure for EOHHS is an important first step toward breaking down these barriers and developing a more integrated approach to case management.

There are a number of approaches to achieving this goal. A special unit of case workers could be created outside of any of the purchasing departments. Clients and families with a clear need for services from a number of agencies would be referred to the unit, where case workers would be trained and empowered to manage services offered by any purchasing agency.

An alternative would be to create interdepartmental teams to manage services for these high-need clients, with one member of the team assigned to be the primary contact with the client. A proposal to create interagency teams for coordinating services to children was passed by the Legislature as part of the EOHHS reorganization, but was vetoed by the Governor. In his veto message, the Governor indicated that the purposes of the teams could be accomplished administratively.

Another way to improve the coordination of services is to expand the use of the lead agency model. Under this approach, a provider known as the lead agency is responsible for managing a range of services within a specific region. Clients and families are referred to the lead agency, where a single case manager designs an appropriate package of services. The lead agency may provide some of these services itself or subcontract with other, more specialized providers in the area. The lead agency receives a rate for each client it serves, which it uses to purchase services. Because of regular working relationships with a network of providers, a case manager in a lead agency is often in a better position to put together a service package than her counterpart in a state purchasing department who may be less familiar with offerings of other departments and their providers.

The lead agency model should be used more widely, not only by more purchasing departments, but across

departments as a means of better coordinating services provided to clients by multiple agencies. At present, the primary large-scale application of the lead agency approach is the Commonworks program of DSS. Some purchasing agencies have considered a Commonworks approach to contracting and reimbursements, but to date none besides DSS has been willing to sustain such a change, and lead agencies have not been used to coordinate services provided by several departments.

Whichever model for case management is followed, the Commonwealth needs a better mechanism for funding services for multi-department clients. Clients should be referred to programs based on their needs rather than the availability of funding, and funding for services should follow the client. A truly integrated system of care management would allow caseworkers to design multi-departmental service packages, and program managers would adjust funding allocations to reflect the referrals made by the caseworkers. Referees assigned to resolve cost-sharing issues between departments would be an interim solution as the case management system evolves.

An integrated case management system would require far more information about services, providers and costs than is currently available. Clients, family members and their caseworkers need to know about the quality and outcomes of the services offered by alternative providers. Purchasing agencies must have information about service needs, program costs and client outcomes to help make the case for budget appropriations, determine the appropriate allocation of resources, award contracts and support system improvements. The importance of integrated data systems is discussed further under the next recommendation.

Hold the System Accountable. A system for purchasing human services needs to be held accountable for its results – to its clients, to the Legislature and administration, and to the taxpayers. Providers need to establish that they are qualified to offer services, while purchasing agencies need to demonstrate that they are meeting their statutory requirements to care for the state's most disadvantaged residents. Providers and state agencies alike need to be able to show that their services meet quality standards, that they spend state dollars appropriately and efficiently, and that their clients achieve the positive outcomes intended.

Accountability measures should be one of the primary means of strengthening the quality and impact of services. The methods and processes for holding the system accountable need to be cost-effective, providing useful information and ensuring results without diverting excessive amounts of time and money from the delivery of services. Accountability data should have multiple uses in managing the system, including facilitating client access to appropriate services, licensing and contracting with providers, evaluating the effectiveness of programs, planning and budgeting for the system as a whole, and demonstrating that taxpayer dollars are well-spent.

Achieving these goals requires collecting the right information, collecting information without unnecessary cost, and making the information readily available to everyone in the system who needs it to do their job. In the Commonwealth's purchase of services system, too little information is produced on service quality and outcomes. The cost of obtaining what information is collected – primarily on service inputs and compliance with accounting rules – diverts critical funds from providing services, and the information is too often inaccessible to those who need it and, therefore, is not used in managing the system.

Management for results rather than management of process will drive improved quality and outcomes, and create a true purchase of service marketplace with competition for customers based on quality and performance. Providers should be evaluated against the quality standards and outcome targets incorporated into their contracts, as recommended above. While purchasing agencies need to ensure that providers spend public dollars appropriately and comply with legitimate regulations, these measures are no substitute for real performance information.

The data collected on

Management for results rather than management of process will drive improved quality and outcomes, and create a true purchase of service marketplace with competition for customers based on quality and performance.

provider performance should be the foundation for the rest of the accountability system. Rigorous performance measures should be developed with input from purchasing agencies, providers, and clients and their families.

The cost of data collection and reporting needs to be minimized by requiring providers to report only data that will be used in managing the system and by creating uniform data reporting requirements and procedures across departments. Requiring providers to produce performance data in addition to all of the service input and regulatory compliance information that is now collected would drown the system in paperwork.

The Uniform Financial Report costs too much in time and money to prepare and process for the amount of useful information it provides, and should be either eliminated or reformed. If the UFR is retained, EOHHS, with input from providers, purchasing departments, oversight agencies and independent auditors, should revise the report to include only data needed to demonstrate fiscal accountability and provider solvency. Adequate audit mechanisms are in place to assess financial performance, and the UFR should not collect any financial data that is already available in provider audits.

In addition to refining the type of data it asks of providers, the Commonwealth needs to streamline the collection, synthesis and analysis of the data by establishing more uniform reporting requirements across purchasing departments, as well as their area and regional offices. It would do little good to develop new performance measures and streamlined licensing regulations and then collect the data in the same haphazard way.

The most positive aspect of the UFR is that it is uniform: Providers prepare one report no matter how many purchasing agencies they contract with. The purchasing and oversight agencies should adopt this approach for the other types of information they collect from providers, including compliance with licensing regulations and performance against quality and outcome measures. The specific performance information required will vary to some degree from department to department and service to service, but the procedures and formats for reporting the data should be made as alike as possible. This will reduce the costs to providers for collecting and reporting the

data, and to the purchasing departments for aggregating and analyzing the results.

Making better use of performance data is the key to holding the purchase of services system accountable to all of its stakeholders, from the clients to the taxpayers. The Commonwealth needs to employ data-driven management by using accountability information for case management, licensing, contracting, financial incentives, budgeting and evaluation of the system as a whole.

Performance information needs to flow through the system from bottom to top, further aggregated and distilled at each level. In order to select the most appropriate services, clients and their caseworkers need access to information on the outcomes produced by each potential provider. That same data would allow purchasing agencies to evaluate providers, award contracts, and determine the value of financial rewards or penalties. Aggregated at the program level, outcome data would be used to assess programs, allocate resources and prepare budget requests. At the department level, the data would be used to evaluate the performance of departments and the human services system as a whole. If a piece of information does not have at least two uses in the system, it is probably not worth collecting.

Being able to use this new performance information requires the development of information systems that are integrated, both vertically (throughout the levels of the system) and horizontally (across departments). Too often, the performance information collected currently is blocked from moving up the pyramid by inadequate systems that cannot combine data to be used at a higher level. EOHHS has made considerable progress over the last few years in tying together disparate departmental databases to produce aggregated data and summary reports, but the system has a long way to go before it can readily produce the information needed at every level of the system:

- Provider assessments for use by clients, families and caseworkers, as well as by providers to benchmark their performance;
- Evaluation reports that identify best practices for use by purchasing departments and lead agencies in providing technical assistance to providers;

- Program-level performance data for use by purchasing and lead agencies in awarding contracts, evaluating and reimbursing providers, and assessing program costs;
- Department-level performance reports for identifying under-performing programs and service gaps, preparing budget requests, and answering questions from the oversight agencies and the Legislature; and
- System-level analyses of what human services are – and are not – accomplishing to help oversight agencies and the Legislature determine priorities, and to demonstrate accountability to the taxpayers.

The recently adopted reorganization of the human services departments and the centralization of administrative functions in EOHHS are critical first steps towards developing the integrated data systems required for high-performance human services. Information sharing and integration initiatives within the new clusters can serve as pilot projects for the creation of system-wide accountability. Upgrades to information systems that are currently being developed or implemented should be required to help achieve this goal.

Costs and Savings

Implementing the recommendations in this report will have costs and, at the same time, will generate savings. The goal of the study was to develop broad principles for reform rather than detailed steps, and it was beyond our scope to estimate the magnitude of the costs and savings. While the savings should be substantial, they are unlikely to outweigh the costs, and the Commonwealth will still need to set priorities and make difficult choices about the services it provides. Even if no reforms were undertaken, the rising demand for services for clients with more serious needs in an era of limited fiscal resources would require the state to face up to these decisions.

As in any reform effort, many of the costs of reforming purchase of services will be incurred early in the process, while savings will take time to build. Higher costs will be extraordinarily difficult to absorb while the Commonwealth is cutting program budgets as part of the solution to the state's fiscal crisis. The costs of reform also come at a time when the state is still attempting to bridge gaps in services,

such as the increased appropriations for care for developmentally disabled residents currently awaiting services from DMR.

The most substantial costs resulting from these recommendations would result from establishing rates based on the cost of meeting quality standards. After more than a decade with no adjustments for inflation or other cost increases, most rates are far below the level needed to sustain a sound provider industry with a well-qualified workforce. Phasing in adjustments to bring rates up over time to the levels established by the rate-setting body recommended above will almost certainly be necessary.

Developing integrated information systems will also be a significant cost. However, major upgrades to departmental systems are already planned or underway, and some of the costs of integration could be covered by expenditures that would be undertaken even without reform. Other administrative costs associated with reform stem from the development of outcome measures and quality standards, the establishment of cost-based rates (aside from adjustments to the rates themselves), and the reviews of licensing regulations and the Uniform Financial Report.

Some savings will result from the first phase of reform that has already been initiated – the reorganization of human services agencies and, in particular, the centralization of administrative functions. The subsequent phases of reform recommended in this report will create more opportunities to reduce administrative costs:

- The development of more uniform policies and procedures for licensing, procurement, performance reporting and financial monitoring across purchasing departments should reduce costs for providers and state agencies alike;
- Streamlining the UFR to include only data that is not available from provider audits and that is actually needed to manage the system will cut down on duplicative preparation costs for providers;
- Granting deemed status for providers with national accreditation (except in areas where the state needs to impose higher standards) will reduce the time spent on the licensing process by both providers and state agencies;

- Consolidating area and regional offices will facilitate the sharing of administrative costs between agencies;
- Employing single case managers for clients of multiple departments and families with multiple clients should reduce the costs of connecting clients with appropriate services;
- Better, more integrated case management will reduce duplication of services and, in some cases, provide clients with more appropriate but less costly services.

In the long run, the greatest savings may result from the development of a competitive market for human services that creates strong incentives for providers to deliver more cost-effective services while meeting and exceeding performance standards.

Reforming human services should not be confused with resolving the state's fiscal crisis.

the difficulty of achieving administrative savings through restructuring. The human services system is a vast enterprise, with approximately 1,100 private providers and scores of state-operated programs. Human services needs run the gamut from a lack of affordable child care to severe mental illness. Services as disparate as group homes for the developmentally disabled, welfare payments and AIDS prevention are offered to 1.3 million clients. Many clients and their families with multifaceted problems receive services from more than one agency. Reorganizing and restructuring can streamline management and improve services but cannot eliminate the need for competent and capable administrative oversight of a complex array of programs and services.

Opportunities for savings are also limited by the fact that human services agencies have already been subjected to hundreds of millions of dollars in budget reductions over the last three years. Developing a

successful restructuring effort will be an elaborate undertaking with limited opportunities to realize savings in the short term. Moreover, restructuring is far more likely to succeed if its primary goal is improving the performance of the system rather than cutting the budget for human services.

Implementation

Significant reforms are already taking place. In addition to the recently enacted reorganization of the human services bureaucracy, the Department of Social Services, for example, is far along in the process of reviewing and reforming its operations, including purchase of services. Some departments, such as Mental Health, have made major strides in developing information systems to track clients and service utilization. The Executive Office of Health and Human Services has made substantial headway in integrating departmental databases to provide aggregated, systemwide information. The Department of Mental Retardation has indicated its intention to grant deemed status for certification to providers that attain national certification.

These initiatives are important steps in the right direction, but each deals with a relatively narrow set of issues or an individual department. The Commonwealth needs to build on the progress individual departments have made by launching an integrated, comprehensive reform effort that addresses the issues of the system as a whole.

The recommendations in this report are broad principles intended to guide the process of reform. Designing and implementing detailed reforms of human services will require an open, inclusive process that will take time. This process needs to be driven by the administration, which is ultimately responsible for the delivery of services, with the meaningful collaboration of other stakeholders, including the Legislature, providers, service advocates, and clients and their families. Regardless of the chosen route, reform will be successful if its primary purpose is to improve the quality of services and strengthen the Commonwealth's safety net for its most disadvantaged residents.

Notes

