Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump

Making government work better

Official Audit Report – Issued May 8, 2019

Review of Certain Aspects of the Implementation of Chapter 257 of the Acts of 2008

For the period July 1, 2015 through June 30, 2017

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May 8, 2019

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
1 Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders:

I am pleased to provide this performance audit of certain aspects of the implementation of Chapter 257 of the Acts of 2008. This report details the audit objectives, scope, methodology, finding, and recommendation for the audit period, July 1, 2015 through June 30, 2017. My audit staff discussed the contents of this report with management of the Executive Office of Health and Human Services, whose comments are reflected in this report.

I would also like to express my appreciation to the Executive Office of Health and Human Services for the cooperation and assistance provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

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LIST OF ABBREVIATIONS

ALTR	adult long-term residential services
CMR	Code of Massachusetts Regulations
DDS	Department of Developmental Services
EOHHS	Executive Office of Health and Human Services
MMARS	Massachusetts Management Accounting and Reporting System
OSD	Operational Services Division
UFR	Uniform Financial Statement and Independent Auditor’s Report

EXECUTIVE SUMMARY

On August 8, 2008, the Legislature enacted Chapter 257 of the Acts of 2008, establishing that pricing for social-service programs other than special-education programs would be set by the Secretary of the Executive Office of Health and Human Services (EOHHS). Before this, state agencies typically negotiated multiyear contracts with human-service providers and established individual reimbursement rates for program services. However, a study conducted by EOHHS issued in 2008 concluded that the funding provided under such contracts might be affecting the stability of some human-service provider organizations.

In this performance audit, we reviewed certain aspects of the implementation of Chapter 257, including rate development, provider financial stability, wages paid to direct-care workers, and monitoring of provider quality, for the period July 1, 2015 through June 30, 2017.

Below is a summary of our finding and recommendation, with links to each page listed.

Finding 1 **Page 15**	EOHHS has not established policies and procedures regarding the rate-setting process for programs subject to Chapter 257 of the Acts of 2008.
Recommendation **Page 16**	EOHHS should establish written policies and procedures for the rate-setting process.

OVERVIEW OF AUDITED ENTITY

The Executive Office of Health and Human Services (EOHHS), through its 16 departments,[1] is responsible for providing a variety of human and social services to eligible citizens in the Commonwealth. In addition to providing some of these services directly, EOHHS departments also purchase services through contracts with a large network of private, mostly not-for-profit, organizations.

Before Chapter 257 of the Acts of 2008 was enacted, contracts between EOHHS departments and individual service providers were usually executed using rates negotiated between the department and the provider. However, a report titled *Recommendations for Reforming the Purchase of Service System*, dated January 2008 and prepared by EOHHS for the Executive Office for Administration and Finance, states,

> *For decades there has been wide-spread acknowledgement that the following challenges complicate the management of the Purchase of Service (POS) sector and compromise the stability of provider organizations:*
>
> - ***POS reimbursement rates are not set with reference to market prices. . . .***
> - ***POS reimbursement rates are non-standard and often not transparent. . . .***
> - ***Multi-year contracts are not reviewed with reference to inflationary cost increases. . . .***
> - ***There is no consistent way of identifying similar services across [EOHHS's] purchasing agencies.***

To address these issues, on August 8, 2008 the Legislature enacted Chapter 257 of the Acts of 2008, establishing that pricing for social-service programs[2] other than special-education programs would be set by the Secretary of EOHHS. The authority to award contracts to selected providers remained with

1. The departments are the Department of Children and Families, the Department of Developmental Services, the Executive Office of Elder Affairs, the Department of Mental Health, the Department of Transitional Assistance, the Department of Public Health, the Department of Veterans' Services, the Department of Youth Services, the Massachusetts Commission for the Blind, the Massachusetts Commission for the Deaf and Hard of Hearing, the Massachusetts Rehabilitation Commission, the Office of Medicaid (MassHealth), the Office for Refugees and Immigrants, the Soldiers' Home in Chelsea, the Soldiers' Home in Holyoke, and the Board of Registration in Medicine.
2. Section 3 of Chapter 257 amends Chapter 118G of the Massachusetts General Laws to define "social service program" as "a social, mental health, mental retardation, habilitative, rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational, employment and training, or elder service program or accommodations, purchased by a governmental unit or political subdivision of the executive office of health and human services, but excluding any program, service or accommodation that: (a) is reimbursable under a Medicaid waiver granted under section 115 of Title XI of the Social Security Act; or (b) is funded exclusively by a federal grant."

the purchasing departments, which were required to use rates developed by EOHHS to develop contract pricing.

Chapter 257 required new rates to be implemented in stages, by October 1 of each year, as follows: 10% of rates set by 2009, 40% of rates set by 2010, 70% of rates set by 2011, and 100% of rates set by 2012. Chapter 9 of the Acts of 2011 amended the deadlines to January 1, 2012 (40%); January 1, 2013 (70%); and January 1, 2014 (100%). In addition, Section 13D of Chapter 118E of the Massachusetts General Laws requires rates to be reviewed at least once every two years.

On June 30, 2014, the Massachusetts Council of Human Service Providers and some individual providers filed suit against the Secretary of EOHHS for not having met the deadlines. On January 12, 2015, the Superior Court ordered that within 90 days of the order, the Secretary of EOHHS must establish payment rates for all social-service programs covered by Section 13C of Chapter 118E of the General Laws so that the rates would be in effect for services rendered on or after July 1, 2015.

Section 13C of 118E of the General Laws states,

> *The secretary of the executive office shall have the responsibility for establishing rates of payment for social service programs which are reasonable and adequate to meet the costs which are incurred by efficiently and economically operated social service program providers in providing social service programs in conformity with federal and state law, regulations and quality and safety standards; provided, that the secretary may designate another governmental unit to perform such ratemaking functions. When establishing rates of payment for social service programs, the secretary of the executive office shall adjust rates to take into account factors, including, but not limited to: (i) the reasonable cost to social service program providers of any existing or new governmental mandate that has been enacted, promulgated or imposed by any governmental unit or federal governmental authority; (ii) a cost adjustment factor to reflect changes in reasonable costs of goods and services of social service programs including those attributed to inflation; and (iii) geographic differences in wages, benefits, housing and real estate costs in each metropolitan statistical area of the commonwealth and in any city or town therein where such costs are substantially higher than the average cost within that area as a whole.*

On May 4, 2015, a settlement agreement was reached between certain provider groups and individual providers and EOHHS that required one-time payments in the form of cost adjustments for delayed biennial rate reviews. The agreement provided for three tiers of rates to be implemented according to the following schedule: tier 1 by July 1, 2015; tier 2 by June 30, 2016; and tier 3 by July 1, 2017. These

new deadlines were met, except rates for Community Based Flexible Supports,[3] which were delayed because of new federal requirements.

In fiscal year 2017, nine EOHHS departments spent more than $2.39 billion on services subject to Chapter 257, representing 11% of EOHHS's $21 billion budget. According to the Massachusetts Management Accounting and Reporting System (MMARS), Chapter 257 program spending in fiscal year 2017 was as follows:

Department	Fiscal Year 2017 Payments	Percentage of Total Payments
Department of Mental Health	$ 87,665,239	3.66%
Department of Developmental Services	1,323,043,573	55.25%
Department of Public Health	167,031,981	6.98%
Department of Children and Families	426,571,859	17.82%*
Department of Youth Services	74,772,540	3.12%
Executive Office of Elder Affairs	253,252,598	10.58%
Massachusetts Commission for the Blind	12,204,692	0.51%
Massachusetts Rehabilitation Commission	39,130,025	1.63%
Department of Transitional Assistance	10,830,900	0.45%
Total	$ 2,394,503,407	100.00%

* Discrepancies in totals are due to rounding.

Chapter 257 Rate-Setting

The rate-setting process for Chapter 257 is conducted every two years and includes the following processes:

- Data are extracted from the Uniform Financial Statement and Independent Auditor's Report database maintained by the Operational Services Division for items such as revenue, expenses, full-time equivalents, and operating results for all providers associated with the specific activity codes that are under review.
  - The data for each expense category are totaled for all associated providers, and a weighted average is developed.
  - The data are then compared to the previous year's model budgets.[4] The model budget with the highest expense amount is used to develop the new rate.

3. The Community Based Flexible Supports program has changed its name and is now referred to as the Adult Community Clinical Services program. The rate for this program was set on July 1, 2018.

- The cost allocation factor, an applied percentage increase, is determined by using forecasting data received from an economic research firm each spring and fall.
- Discussions are held with contracting agencies regarding the program services provided and the proposed rates.
- Once rates have been drafted, the rates and the information used to develop them are sent to EOHHS's legal counsel, to the Secretary of EOHHS, and to the Commonwealth's Secretary of Administration and Finance for review.
- Once rates are approved by the Secretary of Administration and Finance, a public hearing is held, and concerns and questions are documented and addressed in a public document.
- If necessary, rates may be adjusted based on the public hearing; otherwise, the regulations establishing the new rates are published and filed with the Office of the Secretary of the Commonwealth.

EOHHS has developed hundreds of rates that are set out in various regulations in the Code of Massachusetts Regulations. Payments pursuant to the rates encompass 172 distinct activity codes[5] in MMARS. These activity codes and regulations are detailed in the Appendix of this report.

4. Model budgets are electronic worksheets used to analyze a variety of factors, including revenue and expense line items obtained from Uniform Financial Statement and Independent Auditor's Report data, to determine new rates.
5. An activity code is a number assigned by the Comptroller of the Commonwealth to a type of service or activity purchased by a department. Activity codes are used for reporting and budgeting in the Commonwealth's accounting system, and each department may have several unique activity codes. Rates under Chapter 257 are developed for each activity code.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of certain activities of the Executive Office of Health and Human Services (EOHHS) for the period July 1, 2015 through June 30, 2017.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Has EOHHS established an adequate rate-setting process in accordance with Chapter 257 of the Acts of 2008?	**No; see Finding 1**
2. Did the Department of Developmental Services (DDS) adequately monitor providers of adult long-term residential services (ALTR)?	**Yes**
3. Has the implementation of Chapter 257 improved the financial positions of providers and positively affected salaries for direct-care workers?	**Partially; see Initial Impacts**

ALTR spending by DDS represented 41% of all expenses associated with contracts subject to rates set by EOHHS under Chapter 257 in fiscal year 2017. Based on its level of funding, we selected rates under DDS activity codes 3153 and 3753 promulgated under Section 420 of Title 101 of the Code of Massachusetts Regulations (CMR). Expenditures under these activity codes represented 97% of ALTR spending by DDS. The initial rate for this program was set in April 2014, making it one of the earliest rates set under Chapter 257.

To achieve our audit objectives, we gained an understanding of EOHHS's internal control environment for the Chapter 257 rate-setting process by reviewing laws, regulations, policies, procedures, budgets, and other pertinent supporting documentation. We conducted interviews and observations with EOHHS

management. In addition, we gained an understanding of DDS's internal control environment related to monitoring service providers that were contracted to provide ALTR and had their contracts priced in accordance with Chapter 257. We also conducted interviews with DDS management.

Chapter 257 Rate-Setting

We obtained model budget worksheets supporting 55 out of 356 rates developed by EOHHS during the period July 1, 2015 through June 30, 2017 for the ALTR program. We reviewed the model budget rates for compliance with the Chapter 257 rate-setting process. We reviewed the rates for compliance with the public hearing and codification requirements of Section 13D of Chapter 118E of the General Laws. We also verified that the rates were approved by the Secretary of Administration and Finance, and we traced the approved rates to 101 CMR 420. We used nonstatistical methods in selecting our sample; therefore, we cannot project results to the population.

DDS Provider Monitoring

We identified 89 ALTR providers that had received funding from DDS and had filed Uniform Financial Statements and Independent Auditor's Reports (UFRs) from fiscal year 2010 through fiscal year 2017. From those 89 providers, we selected the 20 that received the most DDS revenue. We reviewed the ALTR program's Request for Response, which was incorporated into the ALTR contracts, to determine the main performance monitoring objectives. We tested 20 DDS Provider Licensing Reports to determine whether DDS adequately monitored its contracted providers. We used nonstatistical sampling and therefore cannot project our results to the population.

Impact of Chapter 257 on Providers' Finances and Direct-Care Wages

Using the UFR database maintained by the Operational Services Division (OSD), we obtained the net operating results of the providers and salaries for Direct Care I, II, and III[6] employees for the 89 ALTR providers for fiscal years 2010 through 2017 to determine the effect of the implementation of Chapter 257 on providers' finances and direct-care workers' salaries. Using the UFR data for fiscal years 2010 through 2017, we calculated the average direct-care worker salaries for the three direct-care worker levels in the ALTR program.

6. OSD's *UFR Audit & Preparation Manual* defines Direct Care / Program Staff I employees as "Staff . . . who are responsible for the general daily care of program clients / service recipients." Direct Care / Program Staff II and III employees have "experience or specific skills" and "significant experience, or specialized skills," respectively.

In addition, we sent a questionnaire to all 89 providers to gain an understanding of their perspectives on the effect of the implementation of Chapter 257.

Data Reliability Assessment

For the rate-setting review, we obtained information from EOHHS, including ALTR UFR Excel worksheets containing service provider income, expense, and salary data. We determined the reliability of the data obtained by observing access and lockout controls at the EOHHS office in Quincy and by comparing EOHHS worksheet data to the OSD UFR database filings for agreement. We also assessed the validity, reasonableness, and completeness of the ALTR Excel worksheets using Audit Command Language software. We reviewed for duplicates, missing values, whether required values were populated correctly, and data outside the audit period. We obtained rate model budget Excel worksheets from EOHHS and completed a document inspection scan for hidden rows, columns, or worksheets. We determined that the data were sufficiently reliable for audit testing purposes.

For DDS provider monitoring, we obtained provider reports from the DDS website. To determine reliability, we verified that DDS had reports for all 89 ALTR providers on the website. We determined that the data were sufficiently reliable for audit testing purposes.

For the assessment of providers' finances and direct care wages, we obtained UFR data from the OSD database on net operating income and direct care salaries from 2010 through 2017. We determined reliability by reviewing for blank fields and data outside the audit period. We determined that the data were sufficiently reliable for audit testing purposes.

INITIAL IMPACTS OF THE IMPLEMENTATION OF CHAPTER 257 OF THE ACTS OF 2008

1. A survey of human-service providers indicates mixed results.

During our audit, we surveyed all 89 human-service providers operating in the Adult Long-Term Residential Services (ALTR) program during our audit period that had been receiving contracts funded under Chapter 257 of the Acts of 2008 for at least four years. The purpose of our survey was to obtain information on what effects, if any, the implementation of Chapter 257 pricing has had on these providers' operations. Below is a summary of some of the questions from our survey and the information we received from the 78 providers that responded.

1. **How has the implementation of Chapter 257 impacted your organization?**

   - Fifty-nine providers (76%) indicated that it had a positive impact.
   - Seventeen providers (22%) indicated that there had been no noticeable impact.
   - Two providers (3%) indicated that it had a negative impact.

   The majority of the providers agreed that the implementation of Chapter 257 had enabled them to provide increased wages. Other comments included the following:

   - *Having uniform rates has allowed for streamlining budgeting and program monitoring. In addition, having transparency and consistency with rate structure instead of relying on rate negotiations for setting rates has allowed more consistent and predictable decision making.*
   - *Initially Ch. 257 allowed us to address longstanding structural deficits in our programs. It allowed us to increase direct care staff salaries from $11 to $13 an hour. . . . However, these initial gains have been eroded since implementation, as there haven't been the subsequent increases needed to maintain the initial improvements. . . . Ch. 257 raised the expectations for increased quality of service which has turned out to be an empty promise.*
   - *Chapter 257 in its implementation has made <u>some</u> good progress but has fallen short of its objective to completely stabilize the Human Services Sector. Rate increases have had a <u>positive impact</u> but have not entirely addressed the wage and benefit disparity between actual costs and those provided under Chapter 257 rate increases. The result is that Providers have not met the goal of real wage and income growth for employees—this is particularly true in a low unemployment environment where we need to compete for the best employees to meet our Social Service missions.*

2. **How has the implementation of Chapter 257 impacted direct-care wages and fringe benefits at your organization?**

- Fifty-six providers (72%) indicated that it had a positive impact.
- Sixteen providers (21%) indicated that there had been no noticeable impact.
- Six providers (8%) indicated that it had a negative impact.

A majority of providers commented that the initial implementation of Chapter 257 had allowed them to increase the salaries of their direct-care employees; however, a number of respondents also indicated that recently their ability to provide raises at or above the rate of inflation was becoming much more difficult. Other comments included the following:

- *When 257 was first implemented, we gave significant raises to all staff with a positive evaluation. Many got raises of 10%. It also has enabled us to deal with the large increases in the cost of benefits, especially health care.*
- *The inconsistency of implementing Chapter 257 has led to inequitable . . . reimbursement levels for non-residential services that are inadequate to cover the ever-increasing costs of health insurance and payment rates necessary to adequately staff programs.*
- *Our health care benefits increase by double digits each year: anywhere from 10% to 15% increases. Program rate increases have been at 1 and 2%—not enough to cover significant increases in health insurance costs.*

3. **What has been the impact of Chapter 257 on direct-care staff ratios?**

- Twenty-five providers (32%) indicated that it had a positive impact.
- Fifty-two providers (67%) indicated that there had been no noticeable impact.
- One provider (1%) indicated that it had a negative impact.

The majority of providers indicated that they had already maintained ratios as required by licensing regulations and that the rate-setting was based on preexisting ratios. However, some indicated that Chapter 257 was helpful, particularly in the area of recruitment and retention. Specifically, vendors stated the following:

- *Ratios are primarily impacted by the number of people in a home and the intensity level assigned by the Department of Developmental Services [DDS] based on the needs of the individuals living in the home.*
- *Staffing ratios within DDS programs are prescribed by DDS as based on the acuity of client needs.*

- *The Chapter 257 chart for residential [services] provides set standards for staffing ratios. This makes it easier to staff and plan.*

4. What has been the impact of Chapter 257 on direct-care staff vacancies/turnover?

- Twenty-five providers (32%) indicated it that had a positive impact.
- Forty-three providers (55%) indicated that there had been no noticeable impact.
- Ten providers (13%) indicated that it had a negative impact.

A common response was that the rate increases helped somewhat in reducing vacancies and turnover; however, mean vacancies and turnover are still an ongoing issue, because a strong economy and low unemployment rate offer many potential and current hires better employment/economic options. Other comments included the following:

- *[Our] staff vacancy and turnover rates are the highest that they have ever been as a result of the low unemployment rate and low wages for staff.*
- *The ability to raise our starting salaries has made it easier to hire quality staff, but due to the current time of low unemployment, and the fact that we are located in a high cost of living area, we are still unable to pay as much as local fast food restaurants.*
- *Because Chapter 257 does not fund rates of pay consistent with state operated programs it is very difficult to attract and retain the best qualified staff, resulting in high turnover rates and a high percentage of overtime which is not adequately funded by the rates.*

5. How has Chapter 257 affected patient care?

- Forty-nine providers (63%) indicated that it had a positive impact.
- Twenty-five providers (32%) indicated that there had been no noticeable impact.
- Four providers (5%) indicated that it had a negative impact.

The vast majority of vendors felt that Chapter 257 had either a positive or a neutral effect on patient care. Specifically, vendors stated the following:

- *We have been able to improve the quality of services through more significant staff training. Everyone receives 20 hours of initial . . . training then an 8 hour annual refresher.*
- *Client care has improved as we have put into place more adequate monitoring, training, supervision and oversight.*

- *Patient care has been greatly improved as the organization is now able to provide a stronger management/administrative structure, improved staffed training, [and] improved internal capacity to support professional staff including nursing, case management, and clinical staff.*

6. Overall, have the Chapter 257 rates had any financial impact on your organization?

- Fifty-one providers (65%) indicated that they had a positive impact.
- Nineteen providers (24%) indicated that there had been no noticeable impact.
- Eight providers (10%) indicated that they had a negative impact.

The majority of vendors felt that the initial impact was positive because it resulted in a surplus cash flow. However, some vendors have recently seen surpluses and available cash flows decrease for expenses such as healthcare. Other comments included the following:

- *The introduction of Ch257 rates has had a significant impact on our financial position. In the first two years after Ch257 implementation, [we] could address a backlog of wage stagnation, eroding benefits, deferred maintenance and underfunded programming . . . substantially improving our agency's long-term financial viability.*
- *Without the Chapter 257 rate increases [we] may not be able to continue to provide residential services into the future.*
- *Only residential programs are funded sufficiently to provide positive operating results. . . . To avoid losing ground even the residential service rate setting process needs to be revamped in such a way as to specifically target and address the need for higher staff salaries . . . and the increased costs of health insurance.*

7. Did you participate in the rate-setting process, and if so, do you believe it was open and fair?

- Thirty-seven providers (47%) indicated that it was open and fair.
- Twenty-six providers (33%) indicated that they had neutral opinions on whether it was open and fair.
- Fifteen providers (19%) indicated that it was not open and fair.

Vendors' positions on this question were mixed. Although the majority felt that the process was open, vendors felt that the historical Uniform Financial Statement and Independent Auditor's Report (UFR) data used to set rates did not reflect the realities of the current labor market. In addition, rate reviews every two years have produced very low rate increases. Specifically, vendors stated the following:

- *The rate review process is supposed to be done absent of consideration for the state and/or departmental budgets but instead on an evaluation of fair and equitable pricing for the services that [the Executive Office of Health and Human Services, or EOHHS] is purchasing. The data and timelines have been inconsistent throughout this process.*
- *Inexplicably, ALTR direct care benchmark salaries are lower than any other service that has gone through Chapter 257 despite the challenge of having a workforce work 24/7. Other DDS / [Massachusetts Rehabilitation Commission] funded programs have direct care salaries at $1–2 more an hour [for] work with the same population of people.*
- *As providers raise questions about adequacy of the rates, a typical answer is "it's in there. . . ." I don't find that reassuring.*

2. A key financial metric indicates an initial positive effect from Chapter 257 pricing.

One of the purposes of Chapter 257 as stated in the report *Reforms to Strengthen and Improve Behavioral Health Care for Adults*, issued November 3, 2017 by EOHHS, was to improve the financial positions of service providers. To assess the initial effect of Chapter 257 in this area, we calculated the average operating results (ALTR program revenue less operating expenses) realized by the 89 human-service providers that operated in the ALTR program before and after they were required to use Chapter 257 pricing. As noted in the table below, the average operating results in this program increased significantly after Chapter 257 pricing for ALTR was implemented in fiscal year 2014. It should be noted that changes in program spending are affected by provider management decisions, which can vary from year to year and can affect a provider's net operating results.

	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012	Fiscal Year 2013	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017
Average Operating Results	$119,791	$115,749	$75,450	$14,093	$206,829	$600,375	$438,165	$404,007

3. Direct-care workers' salaries in Chapter 257–funded programs have only increased marginally.

One of the concerns raised by the Massachusetts Council of Human Service Providers' report *Help Wanted 2: Recruiting and Retaining the Next Generation of Human Services Workers in Massachusetts*, dated April 4, 2007, was that direct-care workers were not fairly compensated. Using the UFR data for fiscal years 2010 through 2017, we calculated the average direct-care worker salaries for the three

direct-care worker levels in the ALTR program. We then calculated the weighted average salary for all direct-care workers for each fiscal year from 2010 through 2017. We found that during this period, the average hourly rates paid exceeded the minimum wage, and the weighted average direct-care worker's salary increased by approximately 24% in total, or about 3.1% per year on average. According to the United States Labor Department, the rate of inflation increased by 2% on average during this same period, indicating that the salary increases that direct-care employees received in these programs only exceeded inflation by about 1% per year. Therefore, the increases likely did not have any material effect on improving the financial wellbeing of these direct-care workers.

	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012	Fiscal Year 2013	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017
Average Salary	$24,798.00	$25,033.00	$25,132.00	$25,573.00	$26,192.00	$28,773.00	$29,727.00	$30,705.00
Average Wage Per Hour	$11.92	$12.04	$12.08	$12.29	$12.59	$13.83	$14.29	$14.76
State Minimum Hourly Wage	$8.00	$8.00	$8.00	$8.00	$8.00	$9.00	$10.00	$11.00

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. The Executive Office of Health and Human Services has not established policies and procedures regarding the rate-setting process for programs subject to Chapter 257 of the Acts of 2008.

The Executive Office of Health and Human Services (EOHHS) has not established policies and procedures documenting how rates are developed for human-service providers' contracts under Chapter 257 of the Acts of 2008. As a result, there is no assurance that a consistent method is used to develop the rates paid to human-service providers. In addition, the lack of policies and procedures could make it difficult for new EOHHS staff members assigned to the rate-setting task to understand the method they should use.

Authoritative Guidance

Section 13D of Chapter 118E of the Massachusetts General Laws requires EOHHS to have a documented process regarding the establishment of reimbursement rates for human-service providers, stating that it "shall promulgate rules and regulations for the administration of its duties and the determination of rates."

Reasons for Issue

EOHHS asserts that it follows the statutory requirements for setting rates in accordance with Chapter 257; however, it did not have a policy in place during our audit period to establish a formal rate-setting process for programs subject to Chapter 257. Specifically, EOHHS's legal counsel wrote, in an email to us dated January 18, 2019,

> *In establishing social service program rates pursuant to the provisions of Chapter 257 of the Acts of 2008, EOHHS adheres to statutory requirements for promulgating regulations and regulatory amendments, and relies on the rate regulations themselves as a basis to obtain information by which rates are established. Specifically, M.G.L. c. 118E, section 13D, requires that rates for social service programs be established after public hearing. M.G.L. c. 30A requires a process by which regulations must be promulgated; and M.G.L. c. 30A, Section 2, details the procedures for promulgation of regulations after public hearing. Additionally, the Secretary of the Commonwealth publishes a regulations manual that provides rules of process in line with M.G.L. c. 30A, which EOHHS follows when promulgating rate regulations. As part of this promulgation process, EOHHS publishes a notice of public hearing containing a description of how proposed rates were developed. Further, at public hearing, EOHHS provides information in staff testimony detailing how each proposed rate was developed or updated.*

With regard to the development of proposed rates, EOHHS follows the statutory requirements at M.G.L. c. 118E, sections 13C and 13D, related to the elements required to be considered in developing social service program rates. Specifically, EOHHS takes into account costs of applicable governmental mandates, relevant cost adjustment factors as appropriate, and applicable geographical differences. Additionally, as noted above, the social service program rate regulations contain provisions related to cost reporting requirements. The regulation at 808 CMR 1.00, a regulation promulgated by the Operational Services Division (OSD), provides detailed cost reporting standards and requirements attributable to human and social service providers, and which is referenced in the cost reporting requirements within the EOHHS rate regulations. These cost reporting requirements apply equally to all social service program providers, and enable EOHHS to establish rates of payment adequate to compensate for costs incurred by efficient and economically operated providers in line with statutory obligations.

Recommendation

EOHHS should establish written policies and procedures for the rate-setting process.

Auditee's Response

EOHHS agrees with the recommendation and will develop written policies and procedures on or before July 1, 2019, for its existing process for establishing rates for social-service programs.

Auditor's Reply

Based on its response, EOHHS is taking measures to address our concerns in this area.

APPENDIX

Program and Activity Codes Set by the Executive Office of Health and Human Services[7]

Initial Rates Set before June 30, 2017

Activity Code	Activity Name	Chapter 257 Regulation in the Code of Massachusetts Regulations (CMR)
2237	Substance Abuse Services	101 CMR 346
3315	First Offender Driver	101 CMR 346
3329	Tewksbury Stab and Trans	101 CMR 346
3380	Specialized Res Serv	101 CMR 346
3382	Youth Search	101 CMR 346
3385	Ambulatory Services	101 CMR 346
3386	Residential Treatment	101 CMR 346
3389	Triage, Engagement and Assessment	101 CMR 346
3395	Inpatient Detoxification	101 CMR 346
3397	Narcotic Treatment	101 CMR 346
3401	2nd Offender Residential	101 CMR 346
3434	Transitional Services	101 CMR 346
4912	Substance Abuse Legislative Earmarks	101 CMR 346
4919	Specialized Case Management for Families in TSL	101 CMR 346
4921	Statewide Treatment for Civilly-Committed Persons	101 CMR 346
4929	Office Based Opioid Treatment Services	101 CMR 346
4931	Clinically Managed Inpatient Detoxification	101 CMR 346
4935	Family Focused Intervention & Care Coordination	101 CMR 346
4936	Youth Intervention Programs	101 CMR 346
4956	BSAS Supportive Case Management	101 CMR 346
4958	BSAS Jail Diversion Program	101 CMR 346
3317	Early Intervention Services	101 CMR 349
2184	Competitive Integrated Employment Services	101 CMR 410
2885	M2 Employment Training and Ed	101 CMR 410
2886	M3 Employment Supports	101 CMR 410

7. All text in this appendix is quoted from a spreadsheet provided by the Executive Office of Health and Human Services.

Activity Code	Activity Name	Chapter 257 Regulation in the Code of Massachusetts Regulations (CMR)
3180	Comprehensive Integrated Employment Services	101 CMR 410
5100	VR CIES Components	101 CMR 410
5200	CIES Component Procurement	101 CMR 410
5300	Partnership Plus	101 CMR 410
2142	Shared Living Services	101 CMR 411
2230	Shared Living	101 CMR 411
2509	Specialized Foster Care	101 CMR 411
2510	Detention Diversion	101 CMR 411
3150	Placement Services	101 CMR 411
AMSS	ADOPTMGMT	101 CMR 411
FNFO	Foster Care	101 CMR 411
FOS0	Foster Care	101 CMR 411
FOSC	Complex Medical and Family Residential	101 CMR 411
4624	Emergency Shelter	101 CMR 412
4625	Housing Stabilization	101 CMR 412
4626	Domestic Violence Substance Misuse and Trauma	101 CMR 412
2500	Hardware Secure Treatment	101 CMR 413
2503	Staff Secure Treatment	101 CMR 413
2505	Revocation	101 CMR 413
2506	Residential Services Blanket	101 CMR 413
2514	Day Reporting Center	101 CMR 413
2516	Trans. Indep. Living Program	101 CMR 413
3061	Transition Aged Youth Service	101 CMR 413
3075	Child/Adol Group Homes	101 CMR 413
3079	Child/Adol Residential Service	101 CMR 413
3080	Intensive Residential Treatment	101 CMR 413
3091	Individualized Support, Residential Schools	101 CMR 413
3470	Youth Residential	101 CMR 413
CTC0	Caring Together	101 CMR 413
CTT0	Caring Together Teen Parent	101 CMR 413
2124	Respite Care	101 CMR 414
2403	Flexible Family Support	101 CMR 414

Activity Code	Activity Name	Chapter 257 Regulation in the Code of Massachusetts Regulations (CMR)
3066	Individual Flexible Support Service	101 CMR 414
3700	Family Support Navigation	101 CMR 414
3701	Respite in Recipient’s Home—Day	101 CMR 414
3702	Respite in Care Giver’s Home	101 CMR 414
3703	Individualized Home Supports	101 CMR 414
3707	Adult Companion	101 CMR 414
3709	Community Family Training / Residential Family Training	101 CMR 414
3710	Behavioral Supports and Consultation Family Training	101 CMR 414
3712	Stabilization in Caregiver’s Home	101 CMR 414
3716	Community Peer Support / Residential Peer Support	101 CMR 414
3731	Respite in Recipient’s Home—Hour	101 CMR 414
3735	Children’s Respite in Care Giver’s Home—Hour	101 CMR 414
3759	Adult Site Based Respite Facility	101 CMR 414
3760	Non-Waiver Services	101 CMR 414
3770	Family Support Centers	101 CMR 414
3771	Cultural Linguistic Family Support Centers	101 CMR 414
3772	Autism Support Centers	101 CMR 414
3773	Intensive Flexible Family Support Services	101 CMR 414
3774	Medically Complex Programs	101 CMR 414
3775	Planned Facility-Based Respite Programs for Children	101 CMR 414
3776	Family Leadership Program	101 CMR 414
3781	Financial Assistance Administration	101 CMR 414
6700	Family Support Navigation AWC	101 CMR 414
6701	Respite in Recipient’s Home AWC	101 CMR 414
6703	Individualized Home Supports AWC	101 CMR 414
6704	Individualized Day Supports AWC	101 CMR 414
6707	Adult Companion AWC	101 CMR 414
6753	Agency w/Choice Admin Fee	101 CMR 414
6780	Financial Assistance AWC	101 CMR 414
FBSR	Recreation/Camp	101 CMR 414
FNSS	Fam Networks Supp & Stab	101 CMR 414
FRCF	Resource Centers Full Time	101 CMR 414

Activity Code	Activity Name	Chapter 257 Regulation in the Code of Massachusetts Regulations (CMR)
FRCM	Resource Centers Micro	101 CMR 414
2144	Community Based Day Supports	101 CMR 415
2251	MRC Community-Based Day Supports	101 CMR 415
3163	Community Based Day Supports	101 CMR 415
3777	Nursing Facility Active Treatment	101 CMR 415
3034	Clubhouse Services	101 CMR 416
8005	Money Management Assistance	101 CMR 417
8006	Home Care / Respite Care Purchased Services	101 CMR 417
8010	Guardianship	101 CMR 417
8014	Home Care / Respite Care Case Mgmt & Adm	101 CMR 417
8015	Supportive Senior Housing	101 CMR 417
8017	Congregate Housing Services Coordination	101 CMR 417
8042	Protective Service Casework	101 CMR 417
8060	Enhanced Community Options Program Case Management	101 CMR 417
8061	Enhanced Community Options Program Purchased Services	101 CMR 417
2501	Hardware Secure Detention	101 CMR 418
2502	Assessment	101 CMR 418
2507	Alternative Lock-Up	101 CMR 418
2517	Support Services	101 CMR 418
2522	Staff Secure Detention	101 CMR 418
4928	Youth Stabilization	101 CMR 418
2115	Supported Employment Services	101 CMR 419
2248	Rolland Non-Residential	101 CMR 419
3168	Supported Employment Services	101 CMR 419
3181	Group Supported Employment	101 CMR 419
2225	MRC Non-Residential / MRC Supported Employment	101 CMR 419
2143	Adult Long Term Care	101 CMR 420
2226	MRC—Residential	101 CMR 420
2234	TAC Assigned Chpt 688 VR & CL	101 CMR 420
2245	Rolland Waiver Residential	101 CMR 420
2247	Rolland Residential	101 CMR 420
3153	24 Hour Residential Services	101 CMR 420

Activity Code	Activity Name	Chapter 257 Regulation in the Code of Massachusetts Regulations (CMR)
3182	Emergency Stabilization Residence	101 CMR 420
3753	Occupancy for Adult Long Term Residential Svs.	101 CMR 420
210L	Adult Long Term Care Occupancy	101 CMR 420
3040	Outreach & Engagement	101 CMR 421
3041	Stabilization Services	101 CMR 421
3042	Housing First	101 CMR 421
3043	Homeless Program Support	101 CMR 421
3049	Adult Residential Services—Contracted	101 CMR 421
2103	Diagnostic & Eval—Medicaid	101 CMR 422
2119	Homemaker	101 CMR 422
2121	Mobility—Nonmedicaid	101 CMR 422
2218	Assistive Technology Independent Living	101 CMR 422
2220	Home Care Assistance	101 CMR 422
2405	Deaf Blind Community Access Network	101 CMR 422
2406	Mobile Eye Clinic Services	101 CMR 422
3253	Visually Impaired Service	101 CMR 422
2199	Financial Assistance	101 CMR 423
2216	Independent Living / Supported Living	101 CMR 423
2227	Community Supports	101 CMR 423
2402	Residential Supports	101 CMR 423
3798	Individual / Community Supports	101 CMR 423
210R	Adult Foster Care	101 CMR 423
2128	Day Hab Supplement	101 CMR 424
2222	Transitional to Adult Hood	101 CMR 424
3165	Adult Day Health Services	101 CMR 424
3170	Clinical Team	101 CMR 424
3274	Corporate Rep Payee	101 CMR 424
3285	Day Habilitation Supplement	101 CMR 424
3664	Day Habilitation Services	101 CMR 424
2833	ESP—Young Parents Program	101 CMR 425
CSSE	CTR Comprehensive Emer Svcs	101 CMR 427
RESS	Res Shelter	101 CMR 427

Initial Rates Set on or after July 1, 2017

Activity Code	Activity Name	Chapter 257 Regulation
3054	Community Based Flexible Support	101 CMR 426
3056	Individual Support	101 CMR 426
3059	Community Rehabilitative Support	101 CMR 426
3438	Teen Challenge Fund	101 CMR 427
CSSI	CTR Protective Investigations	101 CMR 427
FBSC	FBS Clinical	101 CMR 427
FBSS	Suptv Prev Prog	101 CMR 427
2208	VR Independent Living	101 CMR 428
2451	Independent Living Service	101 CMR 428
3014	Recovery Learning Community	101 CMR 428
3361	Sex Assault Prev. & Surv.	101 CMR 429
4627	General Community-Based Domestic Violence	101 CMR 429
4628	Supervised Visitation	101 CMR 429
4629	Children Exposed to Domestic Violence	101 CMR 429
4630	SDV Equity	101 CMR 429
3486	Intimate Partner Abuse Educational Services	101 CMR 429
3031	Program of Assertive Community Treatment	101 CMR 430
3048	Respite Care Services	101 CMR 431
FNLA	Family Network Lead Agency	101 CMR 432