Special Commission on Governmental Restructuring

Working Papers, October 23, 1991

Committee on Health, Social Services and Economic Security

I. SUMMARY OF RECOMMENDATIONS

A. The Budget Process

1. Break the cycle of long-term service needs by investing in prevention and early intervention. Allocate year end surpluses in human service programs to this purpose.

2. Create a non-lapsing counter-cyclical fund to meet the growing demand for services that inevitably occurs during difficult economic times when revenues are least available.

3. Direct the Interdepartmental Council (with input from the Legislature and congressional delegation) to study categorical funding mandates and develop ways to increase flexibility so that existing funds may be better spent.

B. Organization of Services

1. Raise collaboration and coordination among departments and agencies to priority status by creating a strengthened Interdepartmental Council within the Office of the Governor and chaired by a high-level designee of the Governor with authority to coordinate, allocate resources, and resolve differences among departments.

2. Develop a universal Information and Referral System (I&R) for all health, human and educational services.

3. Abolish the present Department of Human Services and Department of Mental Health and Mental Retardation and replace with a Department of Children and Families and a Department of Health & Developmental Services, with services and programs organized along consumer lines with minimal categorical barriers.

4. Reduce duplication and fragmentation by establishing within each department unified case management, intake, licensing, evaluation and contracting systems.

5. Abolish the Division of Community Services and move its functions to other state agencies while continuing the "pass through" of federal funds to local Community Action Agencies.

6. Consolidate all services for the homeless and for those at risk of homelessness at the Maine State Housing Authority.

7. Move the Bureau of Rehabilitation services that relate to job training to the Department of Labor. If allowed under federal law, move all other functions to the Department of Health and Developmental Services.

8. Direct the IDC to convene a special task force (no longer than 3 months) to give immediate attention to the adequacy of services for youth in juvenile corrections and the proper placement of juvenile corrections within state government.

9. Consolidate advocacy services into an independent State Office of Advocacy.

C. Decentralization

1. Unify all health & social services regions into a common regional system with coterminous boundaries and share resources where possible. (Regional boundaries to be adopted in 1 year and implementation completed within 2 years.)

2. Use regional service systems to maximize coordination and collaboration at the local level rather than creating new mechanisms of regional governance.

D. Rationalizing Government

1. Establish a gubernatorial-level commission to identify technology investments that will improve efficiency and planning capability within and across departments, to promote the development of interdepartmental compatability and sharing of technology, and to encourage uniformity in data gathering.

2. Substantially reduce the number of advisory boards and commissions. Consider instead the creation of a single permanent commission for each department.

3. In order to optimize flexibility of service delivery, each State agency should review the services it delivers directly to assess whether they might be delivered by private contractors and service providers.

4. The IDC should study the development of public-private partnerships that reduce costs of services in such areas as insurance, group purchases of capital equipment and supplies, etc.

E. Other

1. If the Inspector General's audit concludes that the function of the Special Investigations Unit is valuable and effective, the function should be expanded to all areas and State government and not be limited to welfare programs.

2. Establish an ongoing process in the health and social services area to assess needs, establish priorities, review priorities regularly, balance needs with affordability, define and limit the role of government, and collaborate with the private sector.

II. INTRODUCTION

The Committee recommends major reorganization in the area of health and social services, but it is important to point out that it envisions more than a shuffling of boxes. Only functional integration of services will result in more effective and efficient services; they must not only be moved, but regrouped so that like functions are together.

The Committee analyzed the information it gathered in the context of the following strategic issues:

- Consumer Orientation of Services. Is the system "user friendly" for consumers? How difficult is it for consumers to gain access to services? How responsive is the system to consumer needs? Is the structure of government compatible with client needs and services?

- Use of Technology to Provide Services. Is the system using state-of-the-art technology? Could technological enhancement make the system more efficient and effective?

- Coordination of Services. To what degree are services coordinated across departments? within departments? between the state and regional and local levels? among local agencies?

- Use of Public-Private Partnerships to Provide Services. To what extent do private agencies provide services? Could private agencies provide some services more efficiently or effectively than government agencies? How can government collaborate with private agencies to improve efficiency and effectiveness?

- Impact of Economic Cycles on Services. How are services affected by swings in the economy? What counter cyclical mechanism can be developed to provide needed resources during difficult economic periods?

III. DISCUSSION, FINDINGS AND RECOMMENDATIONS

A. The Budget Process

1. Prevention and Early Intervention Programs

Discussion

Although we know that prevention and early intervention strategies in health and social services represent sound therapeutic and fiscal policy, they are consistently underfunded. This is attributable to at least 2 factors: 1) needs are always greater than resources in health and social services, and policy makers find serious immediate needs more compelling than prevention; and 2) the return on prevention and early intervention investments is generally longer than the budget and election cycles (2 years), making such programs difficult to support practically or politically.

In these very difficult times, departments tend not to have any year-end surpluses, but during the 1980s, lapsed funds in departments delivering human services ranged from $1 million to $5 million per year. In the future, year-end surpluses may offer a source of funds for prevention and early intervention programs. This may also be an area in which partnerships with the private sector could be developed.

Finding

Prevention and early intervention resources are inadequate. More often than not, a consumer's first exposure to the system is for relatively expensive treatment of a serious problem or condition. The continuum of services for any particular consumer group generally does not include prevention and early intervention because resources are not sufficient.

Recommendation

Provide incentive to State and private agencies by allowing them to apply year-end surpluses to prevention and early intervention programs. Encourage the development of partnerships with the private sector in this area. Focus on prevention activities that may reasonably be expected to break the cycle of long-term service needs. (Legislation required)

2. Demand for Services

Discussion

Difficult economic periods increase the demand for health, social and criminal justice services. Rising unemployment leads directly to increased demand for unemployment benefits, Aid to Families with Dependent Children (AFDC), fuel assistance, Medicaid, etc., and it is related to an increase in the incidence of domestic violence, child abuse, mental illness and a host of other health and social problems.

Maine currently has no mechanism to set aside funds during good times to meet basic human needs during bad times. The Rainy Day Fund is intended for projects that will "pump prime" the economy by funding capital projects.

Finding

The demand for health and social services increases dramatically as the economy worsens, placing fiscal strain on the State when it is least able to respond.

Recommendation

Create a non-lapsing counter cyclical fund to finance health and social services during difficult economic periods. Use of the fund should be governed by a strict formula. For example, one trigger might be periods when State revenues are growing at a rate that is 2 or more percentage points below the inflation rate. Allocation of the fund should require a 2/3 vote of the Legislature upon recommendation of the Governor. The fund would be created by setting aside an established percentage of General Fund revenue when they are growing by at least 2 percentage points above inflation. (Legislation required)

3. Flexibility of Funding

Discussion

In order to target funds to specific purposes, Congress has created several "categorical" programs that provide a specific benefit or benefits to a category of consumers. For example, a variety of community-based social services are available through the Medicaid "MR waiver," but a consumer must have mental retardation, meet income standards and be at risk of institutionalization in order to receive them. Even though people with other disabilities (head injuries, for example) could benefit from the program, they do not qualify. The State has also created categorical programs. For example, the Low-Cost Drugs for Maine's Elderly program provides certain prescription drugs to older consumers who meet income standards. Younger consumers could certainly benefit from the program, but eligibility is based in part on age.

The obvious attraction of these programs is that they allow policy makers to target funds to a specific problem or consumer group, assuring affordability by limiting the number of consumers who will receive services. The major shortcoming is manifested when a particular consumer "falls between the cracks," and is subjected to countless eligibility processes in vain.

This is an area where policy makers should take care not to throw the baby out with the bath water. While enhanced flexibility would reduce bureaucracy and facilitate access for consumers, affordability must be considered as eligibility is broadened. Also, care should be taken not to diminish the effectiveness of services that are presently funded categorically.

Finding

Categorical funding at both Federal and State levels has created a maze of eligibility standards that presents a considerable barrier to consumers seeking services to address their particular needs.

Recommendation

The Interdepartmental Council (IDC) should study the issue of categorical funding and recommend ways to orient funding to consumers' functional needs rather than their categorical characteristics. The study should find ways to make existing funding more flexible without broadening eligibility or expanding services. The IDC should seek advice and assistance from the Legislature, the Congressional delegation and others as appropriate. (Legislation required)

B. Organization of Services

1. Coordination and Collaboration

Discussion

We recommend major organizational change in the areas of health and social services. Three existing State agencies are abolished and replaced with two new ones. We recommend this, however, with a keen awareness that the objective is not to rearrange the boxes, but to improve the effectiveness and efficiency of service delivery. To the degree that moving services will be a means to that end, we recommend it, but of paramount importance is the establishment of an effective communication and problem solving mechanism among services, regardless of their locations. Short of creating a billion dollar "mega-department," (which we reject as unwieldy) interrelated health and social services will continue to be offered by more than 1 State agency. An entity with authority is needed to foster collaboration that leads to more efficient and effective programs and to act on behalf of the Governor to settle disagreements among the agencies.

The present coordinating mechanism, the Interdepartmental Council (IDC), has had some successes but has relied on a consensus process that effectively gives veto power to any single participating agency. For example, if the four major departments (Human Services, Mental Health and Mental Retardation, Corrections and Education) are working out a fragile funding compromise that relies on contributions from each department, the agreement falls apart if one department withdraws its support. The chairmanship of the IDC rotates among agency heads, with the effectiveness of the chair depending upon that person's ability to persuade fellow IDC members. It is perhaps an indication of frustration with the present IDC process that staffing was reduced from four positions to one in the current biennial budget.

Finding

Regardless of the organization of State government, most consumers of health and social services have a variety of needs provided by more than 1 State agency, requiring high-level coordination among agencies. Despite good-faith efforts on the part of department heads, no interdepartmental coordinating mechanism exists that has the authority, staff and budget to provide leadership for extensive coordination and collaboration.

Recommendation

Raise coordination and collaboration to priority status. Use some of the savings found through the reorganization of health and social services to reconstitute the Interdepartmental Council (IDC) into an office of the Executive Department, with a director representing the Governor, an independent budget and staff, and authority to foster collaboration among departments and, when necessary, to represent the Governor to settle disputes and allocate resources among departments. This should be done regardless of the organization of State agencies. Examples of the collaboration envisioned for the IDC include three tasks given to them in this report: studying juvenile corrections issues, identifying ways to make funding more flexible, and identifying new public-private partneships in the health and social services area. (See Chart A) (Legislation required)

2. Fragmentation, Duplication and Responsiveness to Consumer Needs

Discussion

Fragmentation and duplication have been identified as major problems in the areas of health and social services dating at least as far back as the early 1970s when Governor Curtis proposed major changes in the organization of State government. More recent studies have identified these problems in everything from children's and family services (President's and Speaker's Blue Ribbon Commission on Children and Families, 1991; Governor's Task Force to Improve Services for Maine's Children, Youth and Families, final report pending, 1991) to long-term care (Commission to Study the Level of Services for Maine's Elderly Citizens, 1990) to housing (Interagency Task Force on Homelessness and Housing Opportunities, 1991) to mental health services (Systems Assessment Commission, 1991). Cutting across all service areas are duplication and fragmentation in licensing, contracting and evaluation, which not only waste money but lead to conflicting expectations of service providers. Duplication and fragmentation are inefficient, reduce the effectiveness of services, and create a nightmare of access problems for consumers. These symptoms lead to frustration and anger on the part of tax payers, undermining support for critical services.

Categorical funding streams, discussed earlier in this report, bear significant responsibility for creating these problems, but they need not be insurmountable barriers to solving them. Grouping related funding streams into single agencies for allocation will at least assure that one hand knows what the other is doing.

In attempting to study the area of health and social services, it quickly becomes clear that the sheer mass of needs and programs makes it very easy for them to overlap or fragment in different parts of the system. If one examines services from the perspective of existing organizational structures, it is easy to fall into the trap of fragmentation and duplication that one is trying to address. In an attempt to avoid that trap, the Commission identified the major consumer groups that receive health and social services and conducted its analysis from the point of view of consumers, rather than around existing departments or programs. Those groups are:

- Children, Youth and Families;
- People Who Abuse Substances;
- People Who are Homeless or Inadequately Housed;
- People Who are Unemployed or Underemployed;
- Older People;
- Abused and Neglected Adults;
- People with Mental Illness;
- People with Mental Disabilities;
- People with Physical Disabilities;
- People with Chronic Illness; and
- Consumers of Acute Care, Public Health and Disease Prevention Services.

Next, the Commission identified the services that are currently offered to each consumer group, as well as gaps that exist in the service delivery systems. The resulting matrix (See appendix 1) offers a visual representation of where services overlap, duplicate one another or do not exist.

Finding

As services evolve, they become fragmented and less responsive to consumers. This appears to be attributable in large part to categorical funding streams. Services are developed around those streams, creating formidable access problems for consumers who must face several eligibility processes in several agencies. This is most apparent for children and families, who may be receiving services from 6 or more major State agencies. Fragmentation has resulted in duplication or overlap of several services and functions, including case management, information and referral, advocacy and abuse investigations, licensing, management information systems, planning, contracting and evaluation, and adult protective services. Despite the duplication that exists in some areas, significant gaps exist in others, suggesting that a realignment of some functions will free resources for reallocation to unmet service needs.

Recommendations

Develop a unified information and referral system for all health, social, and educational services. (See chart B) (Legislation required)

Abolish the Department of Human Services and the Department of Mental Health and Mental Retardation. Realign services into a Department of Children and Families and a Department of Health and Developmental Services. Within each department, organize services along consumer lines to break down categorical barriers and facilitate access. (See Charts C and D) (Legislation required)

Establish unified case management, intake, contracting, licensing and evaluation systems within each of the new departments.

Abolish the Division of Community Services and move its functions to other State agencies that already provide similar services, for administrative savings of approximately $250,000 per year. Administer the Community Services Block Grant "pass through" to Community Action Agencies through the contracting unit in the Department of Child and Family Services. (See chart E) (Legislation required)

Consolidate services for people who are homeless or at risk of homelessness at the Maine State Housing Authority. These include homelessness and heating assistance programs presently at the Division of Community Services, as well as homelessness programs presently at the Department of Economic and Community Development. (Legislation required)

Move Bureau of Rehabilitation services that relate to disabilities to the Department of Health and Developmental Services. Move Bureau of Rehabilitation job training and placement functions to the Department of Labor. (Legislation required)

The IDC should convene a task force to determine whether juvenile correctional services should remain part of the Department of Corrections or should be moved to the Department of Children and Families, and to recommend strategies to improve services for consumers of juvenile correctional services. The task force should include representatives from the Executive and Legislative branches and should last no longer than three months. Juvenile correctional services include juvenile detention, probation and parole, the Maine Youth Center, and community-based programs. (Legislation required)

3. Consolidation of Advocacy Services

Discussion

Advocacy organizations are presently sprinkled within and outside of State government, offering a variety of services at different levels of quality. Some are within State departments and receive their funds through the departments (e.g. Department of Corrections, Office of Advocacy), some are independent State agencies that receive an appropriation in their own right (Maine Committee on Aging), some receive federal funds (Long-term Care Ombudsman), some are non-profit organizations that contract with State agencies to provide advocacy (Legal Services for the Elderly) and others are non-profit organizations that receive direct appropriations from the Legislature (Pine Tree Legal Assistance). Size ranges from quite large (Pine Tree Legal Assistance) to single-person staffs (Maine Commission on Mental Health). Most include a board or commission that sets policy in its area.

Functionally, the organizations can be grouped into 2 major categories. One group serves a civil rights function. Organizations in this group are generally charged with the protection of individual rights, and have authority to investigate alleged violations (e.g. Maine Human Rights Commission). The other group serves a broader consumer advocacy function, and works to advance the causes of broad classes of people. Activities of this group often include public education, departmental oversight and lobbying (e.g. Commission on Mental Health).

Two major concerns need to be addressed in this area. First, most of these organizations have administrative expenses that, because of their size, are large relative to their program costs. A one-person organization needs an office, telephone, copying machine, etc. Many have boards that must be supported with staff time as well as funds for travel, meals, and other expenses. Joining several of them into an independent State agency (similar to the Finance Authority of Maine or the Maine Health Care Finance Commission) governed by a single representative policy board would sharply reduce administrative costs. It would also give greater autonomy to advocacy organizations that are presently within a department, such as the Office of Advocacy in the Department of Mental Health and Mental Retardation. For many consumers, this consolidation of resources would enhance rather than reduce advocacy efforts.

Secondly, many of the smaller organizations, though critically important, have become the target of budget cutters. Many are extremely vulnerable because they are perceived to be unnecessary frills with high administrative costs, and the number of them causes people to think that they are overlapping and wasteful. Ironically, many of them are most important to their constituents when budgets are being cut. Also, concerns have been expressed that the dispersed nature of the organizations makes it very difficult to gauge how much the State is spending on the function of advocacy. The Commission believes that consolidation is a win-win proposal because it will strengthen and protect advocacy and reduce costs.

Finding

Advocacy organizations serve a critical function in State government. They provide a voice for individuals and groups of people who would otherwise not be heard. Advocacy organizations are presently disbursed within and outside of State government, and operate at various levels of effectiveness and efficiency. In these times of fiscal stress, they have become vulnerable, even though their function is perhaps most critical when budgets are being cut.

Recommendation

To the greatest extent allowed under federal law, combine advocacy services into an independent State Office of Advocacy organized into a civil rights division and a consumer advocacy division. Eliminate existing advocacy boards and transfer staff to the Office of Advocacy. Transfer the Office of Volunteerism from the Executive Department to the Office of Advocacy to encourage volunteerism to benefit all consumer groups. The Office should be governed by an 11 member board that reflects the various consumer interests represented in the Office. Board members should serve staggered 3 year terms.(See chart F) (Legislation required)

C. Decentralization and Consistent Regional Approaches

1. Regional Service Delivery Areas

Discussion

Many State agencies are involved in the delivery of health or social services. The large, rural nature of the State makes regional service delivery critical. Unfortunately, the several State agencies that are involved in health or social services (Human Services, Mental Health and Mental Retardation, Corrections, Labor, Office of Substance Abuse, and Division of Community Services) all have different regional boundaries. This confuses consumers and presents an artificial barrier to sharing regional resources among departments. For instance, if boundaries were conterminous, departments could share office space and could integrate functions such as eligibility determination.

Finding

Each department has unique regional service delivery boundaries. The lack of uniform boundaries confuses consumers and hampers interdepartmental coordination of regional resources.

Recommendation

Unify all health and social service regions into one common regional system with conterminous boundaries and share regional service delivery resources wherever possible. Give health and social service agencies one year to agree on contermimous boundaries, and phase in implementation by the end of the second year. In determining regions, consideration should be given to natural boundaries, defined by where people from the region shop, go to school, etc. (Legislation required)

2. Regional Governance

Discussion

The Commission explored the question of regional governance as it relates to health and social services. Under a regional system, planning and allocation decisions would be made at the local level. A specific proposal currently before the Legislature would study the issue of regional boards in the area of mental health. Proposed by the Systems Assessment Commission, the study would consider the geographic boundaries of boards, the scope of their responsibilities, and the requirement that boards be controlled by consumers (at least 51% representation).

While the Commission acknowledges the advantages of local planning and control, particularly in the development of a comprehensive mental health system, it is concerned that regional governance may lead to a prohibitively expensive additional layer of government. Populous states, such as New York and California, rely heavily on county government to plan and allocate for social services, but the size of those states' populations requires decentralization. In a small state like Maine, it is not difficult for service providers to have access to central decision makers, and allocation decisions can be made centrally in a reasonably informed way. Also, regional structures could work against current recommendations to implement universal contracting, licensing, evaluation, etc.

Certainly, State agencies can learn much from local consumers, service providers, law enforcement personnel and elected officials. One example is involving local citizens in the development of regulations to assure that they make sense and are understandable. Much could be done to enhance local participation short of establishing an additional governmental or quasi-governmental structure. The development of conterminous boundaries would facilitate the participation process.

Finding

While many health and social services are delivered regionally in Maine, they are, for the most part, planned for and allocated centrally.

Recommendation

We recommend that State agencies use their regional service systems to exchange ideas and information with local consumers, service providers, law enforcement personnel and elected officials, encouraging local participation in the planning, development and implementation of services, including the adoption of regulations that are understandable and make sense to those who must implement them.

D. Rationalizing Government

1. Technology

Discussion

Enhanced technology, particularly in the area of information management, holds great promise for improved productivity and efficiency in the health and social services area. In many cases, federal grants would allow significant investments to be made at a relatively low cost to the State. For instance, a 90% federal match is available to enhance technology in the Medicaid program to eliminate paper claims and simultaneously create a data base for timely analysis. In the income maintenance area, a 90% federal match is available to automate eligibility functions. This would reduce the error rate, improve productivity and enable the State to move toward a single eligibility process.

Finding

Technology used by many State agencies is outdated and incompatible with applications in other State agencies. In addition to not having adequate technology, departments do not collect data uniformly, limiting the usefulness of existing data in policy making. Although technological enhancements offer the greatest promise of improved productivity and efficiency, inadequate investment is made in this area. This is true particularly in times of fiscal stress, when technology enhancements tend to get cut out of budget requests.

Recommendation

Establish a gubernatorial-level commission to identify technology investments that will improve efficiency and planning capability within and across departments, to promote the development of interdepartmental compatability and sharing of technology, and to encourage uniformity in data gathering.

2. Advisory Boards

Discussion

In the general area of human resources, the State supports over 400 advisory boards and commissions. Those bodies generally referred to as "advisory" actually fall into 3 distinct categories, as follows:

- Those whose primary function is advocacy;
- Those that are technical or regulatory in nature, offering expert advise, adopting rules, etc. These serve particular functions that are needed, but it may be possible to consolidate their functions into fewer boards; and
- Those that oversee or assist with the development or administration of a program or service. These are purely advisory in nature, are the greatest in number, and offer the greatest potential for cost savings through elimination or consolidation. Advisory boards are generally formed in response to a problem or an identified need for greater citizen participation. Often, the boards continue to exist long after the problem is resolved, but they become difficult to abolish because they represent specific constituencies which interpret abolishment as an attack on the worth of their programs or needs.

Finding

Hundreds of advisory boards exist in the health and social services area, costing well in excess of $1 million per year in direct costs, State agency staff time and reduced efficiency of program operation. Though many of these boards provide an important opportunity for citizen participation, that opportunity must be balanced with affordability. Many advisory boards continue to exist long after their mission has been fulfilled.

Recommendations

Boards that serve primarily an advocacy function should be considered for transfer to the Office of Advocacy. (Legislation required)

Boards that serve a technical or regulatory function should be reviewed with an eye toward consolidation and administrative savings.

Apply staggered repeal dates to all statutory health and social services advisory groups that are not required by federal law and do not carry out any technical or regulatory functions. Direct each department head to engage the advisory groups that report to the department in a joint review process and to submit legislation to lift the repeal for any group that is justified as necessary. The joint review should be based upon the following criteria:

- Does the board have a clearly defined focus, mission, goals, objectives and action plan?
- Does the mission of the board continue to be relevant? Does it continue to achieve the purpose for which it was established? Is the board active? Does it average 75% attendance at meetings?
- Can the board accomplish its mission within a specified time period? Could it be an ad hoc committee?
- Is the board's size and membership, frequency of meetings, etc. appropriate to the mission? Can reductions be made without compromising effectiveness?
- What is the amount of staff time (both board staff and staff time spent by State agencies) required to support the board in carrying out its mission? How does it compare with current staffing levels?
- Are there other boards with similar missions or with similar membership? Could they be merged?
- Is the board required by federal or state mandate?

(Legislation required)

To balance citizen participation with affordability, consider creating a single permanent commission for each major department to replace the varied functions that are now carried out by numerous boards and commissions.

3. Flexibility of Service Delivery

Discussion

With a few notable exceptions, Maine's health and social services are delivered by private contractors. Social services as diverse as group homes, family planning, supported employment, fuel assistance and day care are provided through contracts with for-profit and non-profit organizations. Medical services are provided almost exclusively by private health care practitioners; the State determines eligibility, establishes reimbursement policy and pays the bills.

The exceptions include the mental health system, which still relies heavily on the State institutions (Augusta and Bangor Mental Health Institutes) for in-patient services. Mental retardation services are far more likely to be provided by private contractors, but the State still operates Pineland Center in Pownal, (approximately 275 consumers) and the Aroostook Residential Center in Presque Isle (13 consumers). The State also provides many types of case management, in programs ranging from income maintenance to rehabilitation.

Some have suggested that the State should not deliver any programs directly. They argue that funding and oversight are appropriate roles for the State, but adding service delivery to the mix produces conflicts-of-interest and reduces innovation because State agencies are slower to adapt to change than are small private agencies. They also argue that private agencies can provide services at a lower cost. Others argue that certain services must be provided by the State because no one else will deliver them, or because the State must offer citizens with a last resort, should private agencies not be able to meet their needs. They also argue that reduced costs in the private sector can often be traced to reduced quality.

Many opportunities exist for the State to enter into partnerships with its private contractors. For instance, the Department of Administration, Division of Risk Management presently self-insures liability coverage for foster home and respite care providers who have contracts with the Department of Human Services and the Department of Mental Health and Mental Retardation. If the State were to reimburse those providers to obtain their own coverage, they would obtain less coverage for as much as 5 times the cost. Similar partnerships could be established in the areas of health insurance, group purchasing, etc.

Finding

Although most health and social services are provided through contracts with private agencies in Maine, the State does provide services directly in some key areas. While innovative public-private partnerships exist, many more could be developed.

Recommendation

In order to optimize flexibility of service delivery, each State agency should review the services it delivers directly to assess whether they might be delivered by private contractors and service providers. The assessment should be based upon the following criteria:

- Can the private sector offer the same or better services at a reduced or similar cost?
- Is it essential that the State be a provider of last resort for this service?
- What is the impact on State employees, and what investment would be required to assist their transition to the private sector?
- Do legal or moral issues require a dominant State role in the service?

The IDC should identify public-private partnerships that reduce costs in the areas of insurance, capital equipment, supplies, etc. and submit enabling legislation to implement them by January, 1993.

E. Other

1. Special Investigations Unit

Discussion

The Special Investigations Unit exists within the Department of Human Services, Bureau of Income Maintenance, to ferret out fraud and abuse in Maine's welfare programs. The program has a long and colorful history, having been first established in 1972 within the Department of Audit. Later, it was moved to the Department of Human Services' Legal Division, then to the Bureau of Income Maintenance, where it was operated as a free-standing division until 1989, when it was placed under the supervision of the Division of Support Enforcement (still within the Bureau of Income Maintenance). When the long-time head of the Unit retired in 1990, that person's position was lost, and the Department asked the Legislature to restore the position in the current biennial budget. The Legislature agreed to fund a project position (temporary in nature), but asked the Commission to review how the function of the Unit should be carried out.

The Department asked the federal Inspector General's Office to audit the overpayment recovery function of the Special Investigations Unit. The audit was completed in the summer of 1991, but a written report will not be available for some time.

At issue is whether this function can be carried out effectively within the Department, or whether it should be located outside the Department.

Finding

The effectiveness of the Special Investigations Unit is unknown at this time. The results of the Inspector General's audit will provide information critical to assessing the Unit's effectiveness.

Recommendation

If the Inspector General's audit concludes that the function of the Special Investigations Unit is valuable and effective, the function should be expanded to all areas and State government and not be limited to welfare programs.

2. Promoting Rational Government

Discussion

In order to promote rational government, the State must have a mechanism that prevents the proliferation of government. In the health and social services area, an ongoing process is needed to assess needs, establish priorities, review priorities regularly, balance needs with affordability, define and limit the role of government, and collaborate with the private sector.

Maine's health and social service departments are complex in their bureaucratic structure, containing multiple bureaus and divisions engaged in overlapping functions. The number of boards and commissions is staggering, with many lacking a clear mission and focus or overlapping with one another. A major cause of this complexity and duplication is the process by which programs and services are created and funded. The present legislative process is impacted by and seeks to respond to interest groups and citizen demands for specialized services. In the absence of a procedure or mechanism to stem the future proliferation of government bureaucracy, the work of the Commission will not be lasting.

Finding

A systematic approach to creating and funding services and programs is needed in order to stem the future proliferation of government.

Recommendation

Establish an ongoing process in the health and social services area to assess needs, establish priorities, review priorities regularly, balance needs with affordability, define and limit the role of government, and collaborate with the private sector.

IV. SAVINGS RESULTING FROM COMMITTEE RECOMMENDATIONS

The Committee emphasizes that all of its recommendations are geared to short- or long-term savings in State expenditures. Savings will be found, as follows:

A. Short-Term Savings

1. Reduce administrative costs by eliminating the Division of Community Services.

    - 3 State positions and 1 Federal position eliminated, for savings of approximately $250,000 per year

2. Streamline service delivery by reorganizing health and social services into a Department of Children and Families and a Department of Health and Disabilities.

   - Duplication is reduced:
     - each new department implements a single case management system and unifies contracting, evaluation and licensing
   - Effectiveness is enhanced:
     - child and family services are consolidated (from 6 or more agencies presently)
     - the link between physical and mental health is acknowledged and utilized

3. Take advantage of existing expertise by dividing the Bureau of Rehabilitation's functions and reassigning them to the Department of Labor and the Department of Health and Disabilities.

   - Job placement expertise at Labor and rehabilitation expertise at Health and Disabilities are utilized; duplication of functions is reduced

4. Enhance collaboration and reduce time consumming interdepartmental disputes by reconstituting the Interdepartmental Council into a strong organization with authority.

5. Consolidate several existing information, referral, and intake services into a unified service.

6. Consolidate advocacy agencies into a single agency.

7. Balance the need for public participation with affordability. Eliminate advisory boards that are not essential.

B. Long-Term Savings

1. Enhance long-term collaboration between departments through a strong Interdepartmental Council.

2. Break the cycle of long-term need by focusing on prevention and early intervention programs.

3. Reduce need for future staff increases and improve productivity of current work force through technological enhancements.

4. Reduce the need for regional infrastructure by implementing conterminous regional boundaries.

5. Reduce growth through the development of a monitoring mechanism to stem the proliferation of State agencies.

6. Review existing services to optimize flexibility in service delivery.

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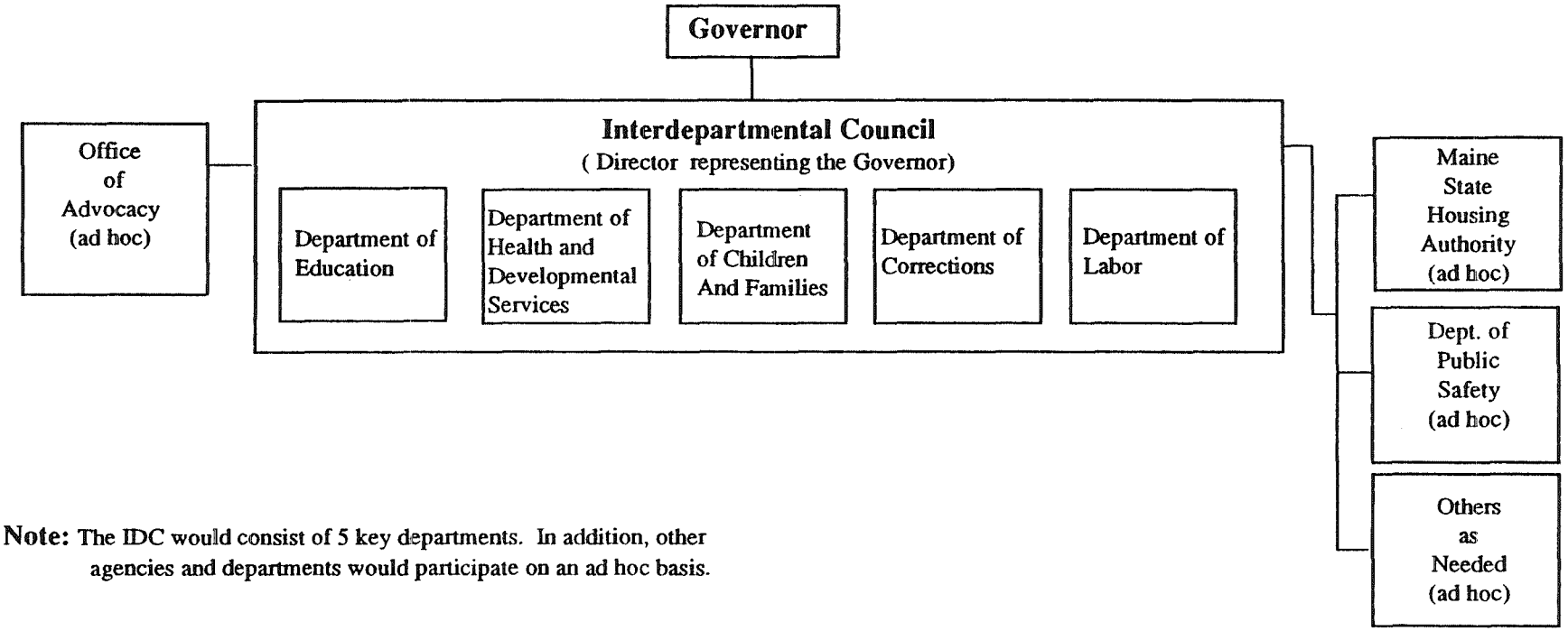
CHART A

The Interdepartmental Council Process

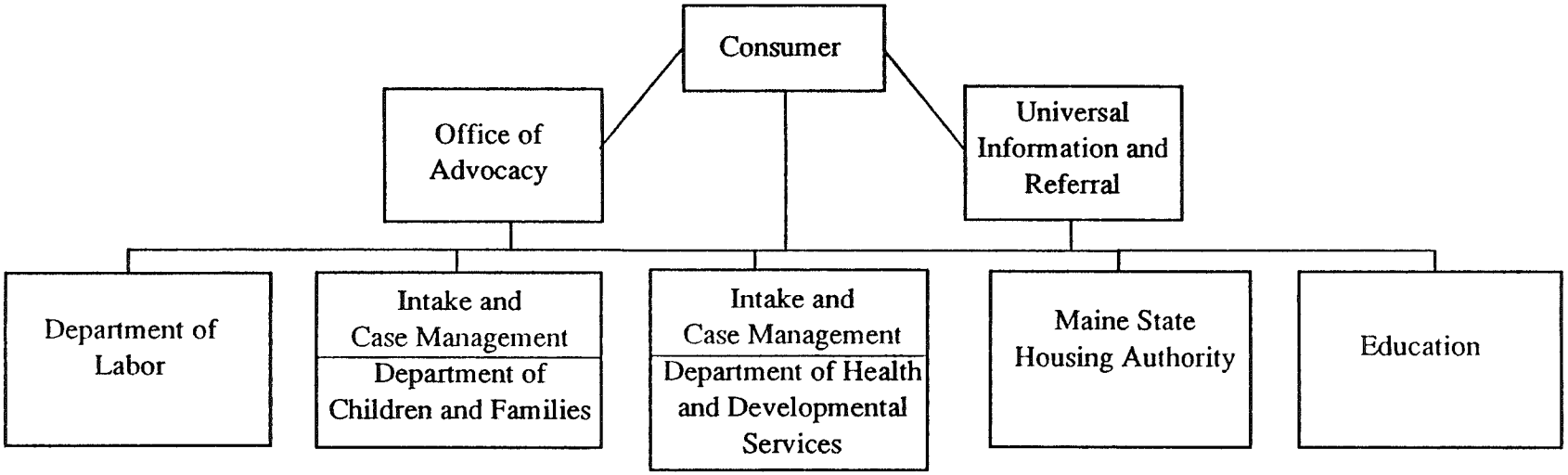


Note: The IDC would consist of 5 key departments. In addition, other agencies and departments would participate on an ad hoc basis.

October 21, 1991
Prepared by the Office of Policy and Legal Analysis and State Planning Office
for the Commission on Governmental Restructuring
IDC.PM3

CHART B

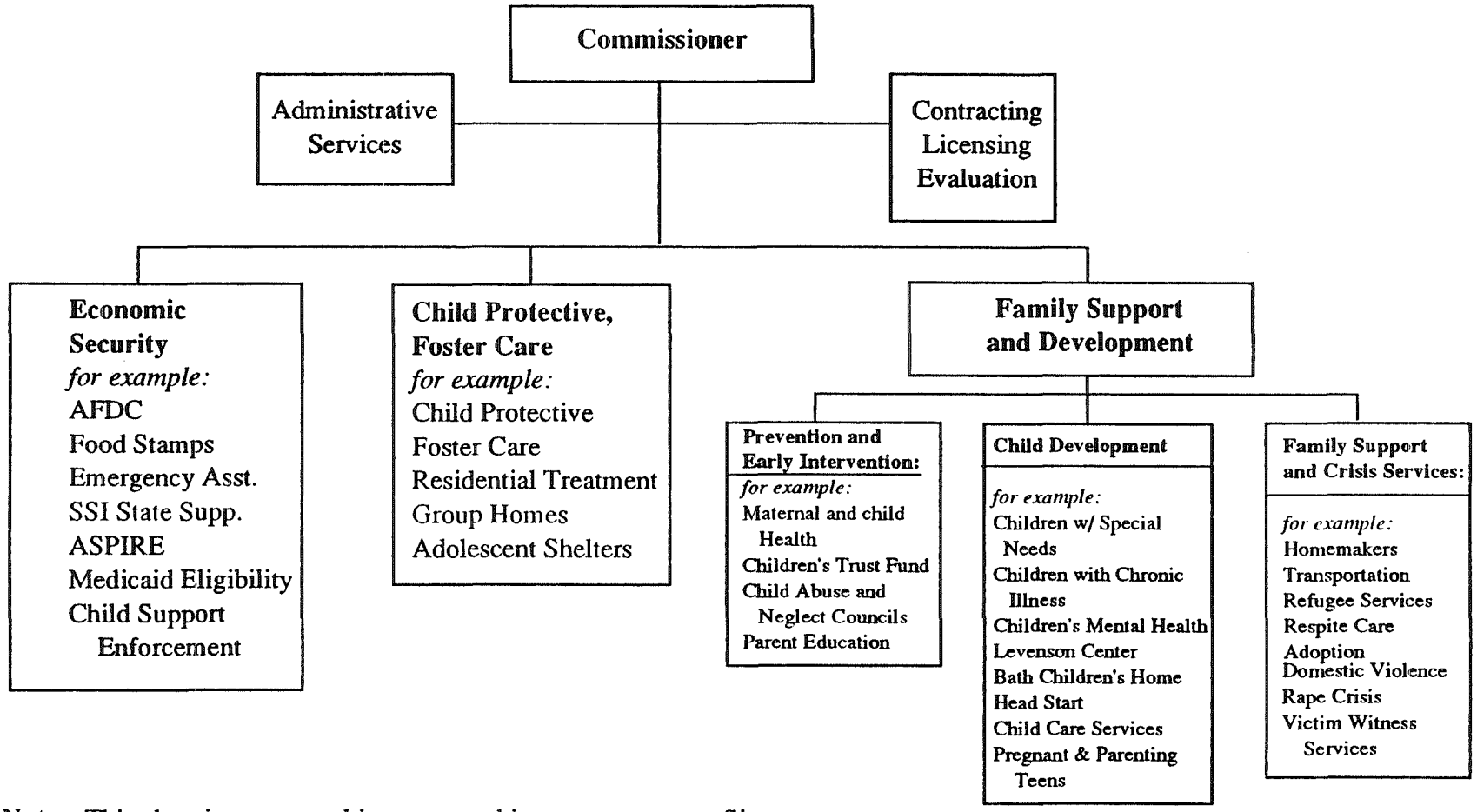
Universal Information and Referral System; Unified Intake and Case Management for Each Department



October 21, 1991
Prepared by the Office of Policy and Legal Analysis and State Planning Office
for the Commission on Governmental Restructuring
Univ.PM3

CHART C

Department of Children and Families

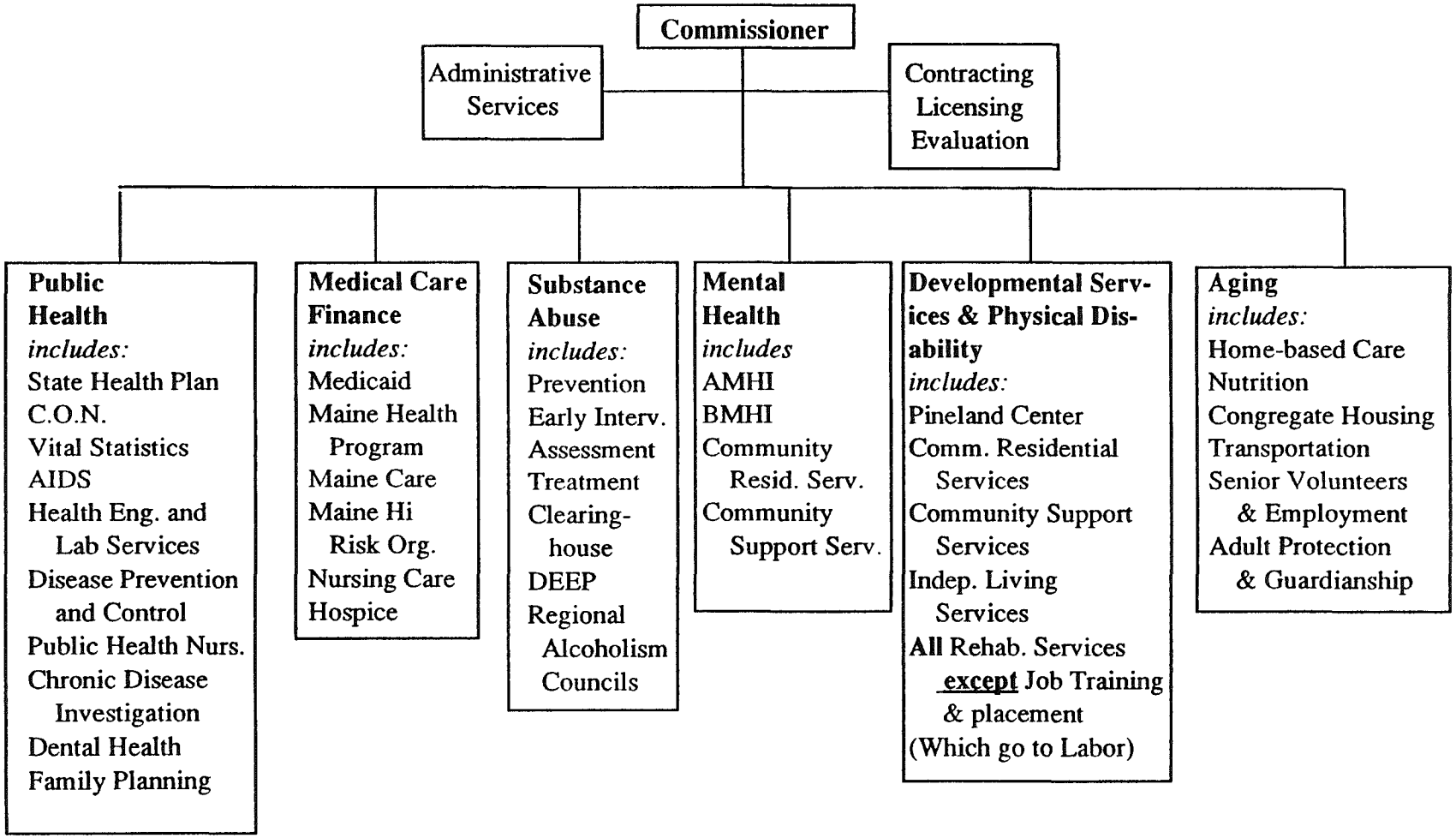


Note: This chart is conceptual in nature and is not meant to conflict with more detailed organizational charts presented by the Departments.

October 21, 1991
Prepared by the Office of Policy and Legal Analysis and State Planning Office
for the Commission on Governmental Restructuring
CHILD.PM3

CHART D

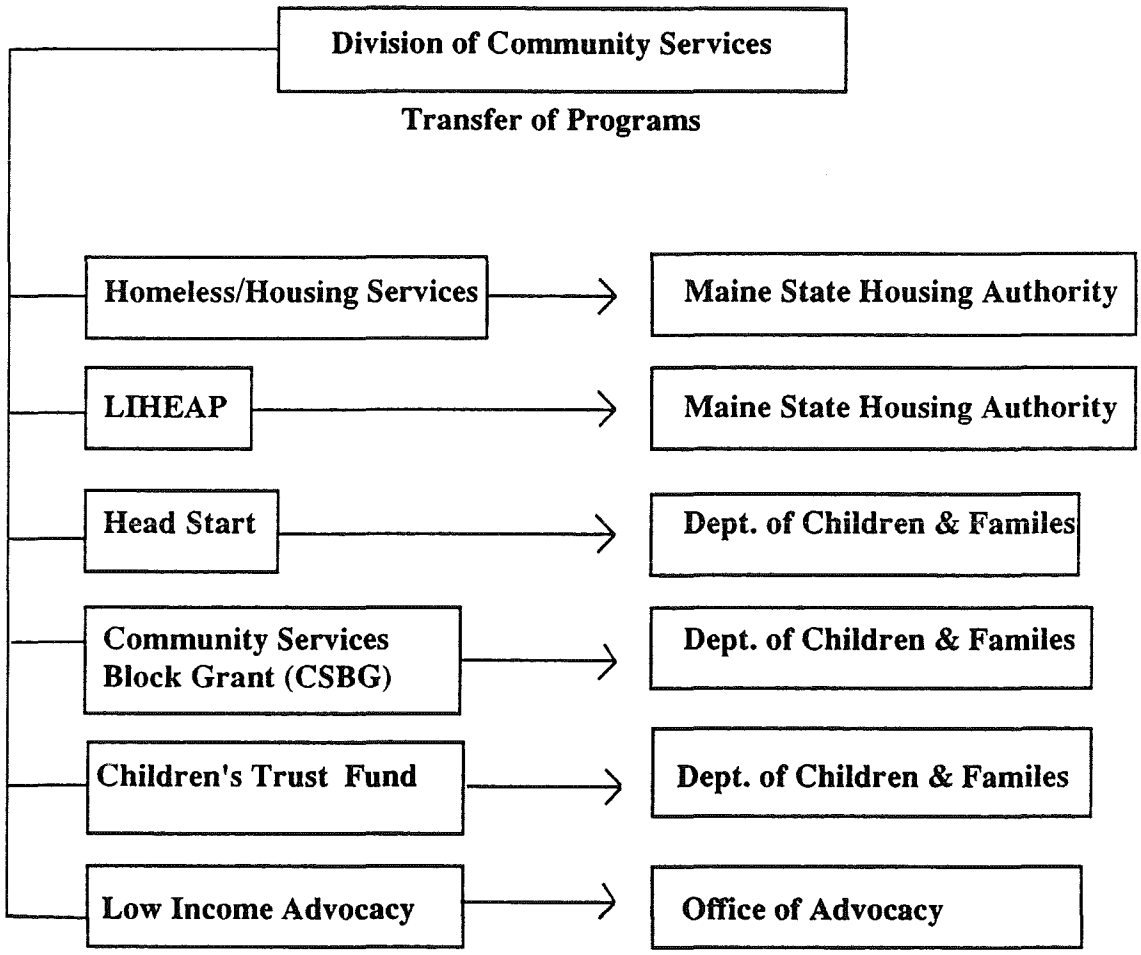
Department of Health and Developmental Services



Note: This chart is conceptual in nature and is not meant to conflict with more detailed organizational charts presented by the Departments.

October 21, 1991
Prepared by the Office of Policy and Legal Analysis and State Planning Office for the Commission on Governmental Restructuring
Health.PM3

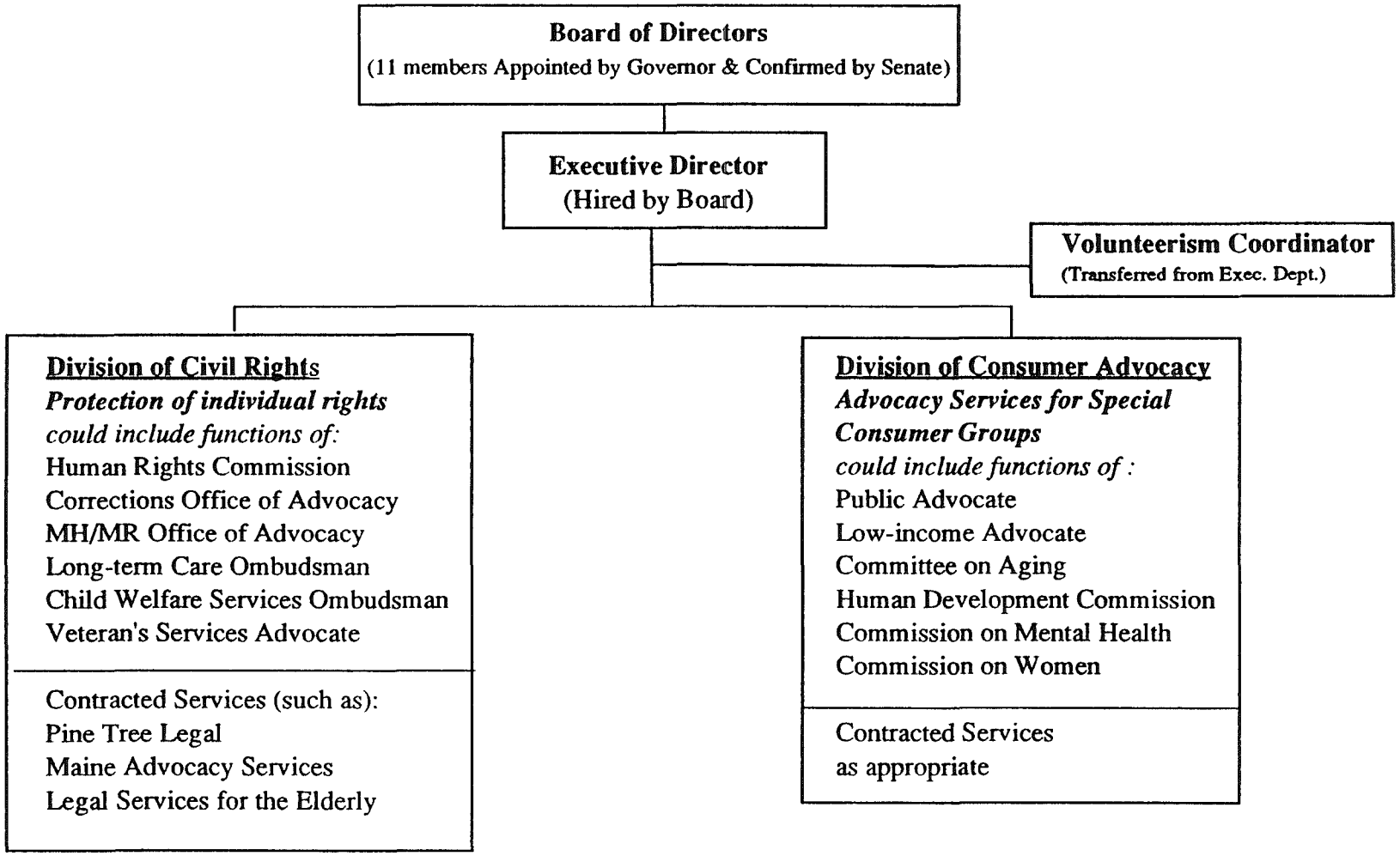
CHART E



October 21, 1991
Prepared by the Office of Policy and Legal Analysis and State Planning Office
for the Commission on Governmental Restructuring
DCS-TRF.PM3

CHART F

Office of Advocacy



October 21, 1991
Prepared by the Office of Policy and Legal Analysis and State Planning Office
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ADVOC.PM3

APPENDIX I

(Oversized service matrix goes here)

APPENDIX 2

Committee on Health, Social Services and Economic Security

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SHS #11

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Bureau of Child & Family Serv.
SHS #11

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SHS #153

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Jamie Morrill
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SHS #73

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Appendix 3

LIST OF REPORTS FOR WHICH EXECUTIVE SUMMARIES WERE MAILED TO COMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY, 8/5/91

Additional Support for People in Retraining and Education Program: An Evaluation According to Legislative Requirements - February, 1990

AFDC Caseload Characteristics in January 1989

Affordable Housing in Maine, A Study of the Obstacles to - December 1, 1989

Aid to Families with Dependent Children and Medical Assistance Payment Programs, Report of the Task Force to Study the - May 15, 1991

Aid to Families with Dependent Children Need and Payment Standards, Final Report of the Commission to Evaluate the Adequacy of the - February, 1990

Aid to Families with Dependent Children, Proposal to Adequately Address the Housing Needs of Recipients of - Recommendations

Alcohol and Drug Abuse Planning Committee, Program and Audit Committee Review

Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services, First Report of the Commission to Study the - 1989

Child Support Enforcement Program, Maine Emergency Medical Services, Program and Audit Committee Review - 1990-1991

Child Welfare Services - 1986 Program and Audit Committee Review

Child Welfare Services, Maine Emergency Medical Services, Program and Audit Committee Review - 1989-1990

Children's Mental Health System, Building a: A community Based Crisis Stabilization and Diversion System - February 25, 1991

Children at the Augusta Mental Health Institute: Prevention Strategies and Ideal Discharge Plans - June, 1989 - June, 1990

Children, Youth and Families, Governor's Task Force to Improve Services for Maine's - May 22, 1991

Early Intervention System, Historical Perspectives on Maine's 0-5 Interdepartmental

Elderly Citizens, Commission to Study the Level of Services for Maine's - December, 1990

General Assistance, Final Report of the Special Select Commission on the Financing and Administration of - May, 1987

Health Care Expenditures, Blue Ribbon Commission on the Regulation of - January, 1989

Health Information Recording System, Study of the Necessity and Feasibility of Establishing a - December, 1988

Implementation Plan for Settlement Agreement to Consent Decree *(Paul Bates, et al, v. Robert Glover, et al (Civ. 89-88))* - January 1, 1991

Maine Health Program, Report of the Task Force to Evaluate and Revise the - Phase 2 - May 31, 1991

Medicaid Financing of Services for Maine's Citizens with Mental Retardation: A Follow-Up Report - March 15, 1991

Medicaid Report, Annual - State Fiscal Year 1990

Mental Health and a Healthy Society: Transforming Maine's Mental Health System by the Year 2000 - January 25, 1991

Mental Health Systems Reform in Selected States - November, 1990

Smoking or Health, Governor's Commission on - Final Report and Recommendations - January, 1990

#2953LHS