The Campaign to STRENGTHEN HUMAN SERVICES
IMPROVE CARE • RETAIN QUALITY STAFF
ENHANCE ECONOMIC IMPACT

May 14, 2012

Secretary JudyAnn Bigby, M.D.
Executive Office of Health and Human Resources
One Ashburton Place, 11th Floor
Boston, MA, 02109

Re: Chapter 257 Implementation and the Provider and Consumer Advisory Council

Dear Dr. Bigby:

We are writing as provider representatives appointed to the Governor's Provider and Consumer Advisory Council to assure you of our commitment to our collaborative work on this project, and to ensure that issues and suggestions we have communicated through a variety of forms are summarized in a manner which might be helpful to all as we begin this important endeavor.

First, we appreciate the Governor's appointment of the Council, and the personal outreach which you initiated to assure provider appointees that the Council will have a meaningful and a substantive role in shaping policy. We share your goals and commitment.

Secondly, we wanted to acknowledge actions over the past year which EOHHS and DHCFP have taken which indicate provider concerns are being heard. Examples include changes in methods for establishing selected rates for Chapter 257, such as: the use of salary levels which are higher than the average or median salaries in some rates; the provision for cost bases in some rates for relief coverage for direct care holiday, sick, vacation, and training time; the collaborative work done with providers to select and refine an objective assessment tool to assign intensity of service levels tied to different rates in some codes; and the phase-in process to allow providers to adjust to new rates. We have also been encouraged by the actions of Katie Mick to resolve provider appeals regarding proposed actions of one agency which reduced funding to a service code without reducing service utilization, which was effectively a rate cut. Providers saw this action by EOHHS to correct an apparent misinterpretation by an EOHHS agency as an important and visible commitment of the Department to honor the provisions of Chapter 257.

This letter is intended to reinforce the spirit of collaboration which has developed regarding Chapter 257 implementation, evidenced by the actions noted above.

Through a number of documents submitted as formal testimony, and informal position papers circulated among the provider community and EOHHS senior staff, the Collaborative and the provider organizations we represent have outlined a number of issues which we believe are critical to implementation of Chapter 257 in a manner which sets fair and reasonable rates. Several of these have been identified as issues to address by the Council in its draft charter.

The Collaborative, through the appropriate provider organization, has been reviewing proposed and final rate setting methodologies of individual service codes for conformance with the following principles. The Collaborative has also been tracking methods and cost bases for specific components of rates, in order to identify inconsistencies. If there are significant variances in the number or cost bases across codes, and if they impact these principles, the Collaborative

has decided to support the respective provider association by challenging the rates through testimony, negotiation, administrative appeal, or litigation.

To ensure that you and other members of the Administration involved in the Council understand our concerns and suggested positions on these key issues, and to ensure that we are all starting with a common understanding, we have taken the liberty of listing these in this letter, as follows.

1. **Adequate Funding**
    a. Providers should not expect all providers to be held harmless.
    b. Providers should expect that methods will not unfairly underfund costs in some categories to increase funds for other "below average" cost categories. Each component should be judged as fair or not.
    c. Suggested: Providers and EOHHS should identify criteria for identifying underfunded components of specific rate methodologies in order to develop alternatives.

2. **Determining Proper Cost Bases for Salaries and Benefits**
    a. Providers (and EOHHS verbally) have agreed that averages or medians of salaries in UFRs or existing contracts are unfair, as they have been artificially suppressed over time. However, methods for calculating salary components in rates published to date have varied significantly across codes.
    b. Suggested: Providers and EOHHS should identify some consistent benchmarks for salaries, such as:
        i. Using medians or averages with some added percentage.
        ii. Using external benchmarks for reasonable compensation (such as a broader market survey).
        iii. Using some percentage difference of provider versus state operated rates.

3. **Costs of Fringe Benefits**
    a. Just as with salaries, providers have reduced or suppressed benefits (e.g., eliminated or reduced pensions, increased staff health insurance contributions) in order to meet budget targets. In many reported examples, providers have adjusted benefits in EOHHS agency contracts downward to fit maximum obligations. This means that using averages does not reflect real costs. A review of published Chapter 257 rates reveals significant variances in the amounts and calculations of fringe benefits across service codes, which range from 19% of 2007 UFR data to 25.6% of 2010 contract data.
    b. Suggested: Providers and EOHHS should identify some consistent components and percentages for fringe benefits, such as:
        i. Using medians or averages with some added percentage.
        ii. Using external benchmarks for reasonable compensation (such as a survey of broader markets).
        iii. Using state operated benefits menus and rates for comparisons, and consider increases based on some percentage of that difference.

4. **Staffing Costs of Training and Benefit Time (Time Off)**
    a. Some EOHHS proposals to date have not included any costs for staff "benefit time" (holiday, sick, vacation) coverage, or training coverage, whereas some do. A review of rates published to date reveals variances ranging from none to 51 days.

b. Suggested: Providers and EOHHS should identify consistent components and percentages for relief and training coverage, such as:
    i. A targeted amount for benefit time based on actual provider experience and requirements such as required State holidays (for example, 14-15% added for every direct care FTE to cover sick, holiday and vacation coverage in residential care).
    ii. Propose a targeted amount of FTEs for training time.
    iii. Propose a factor for increasing training costs with intensity of needed training based on intensity of client need.

5. **Defining Components for Specific Service Codes**
    a. Some published rate proposals have changed program models to remove funding for components of existing contracts. One example is DDS Community Based Day Services (CBDS) which removed costs of transportation to develop the rate. DDS then announced a clear method to allow providers to contract and bill these services separately for FY 2013. This is also an issue for other rates (such as DMH Clubhouse), in which a unit of service rate methodology threatens to define the program model, which allows for individuals to come and go without coercion as they engage in services. A related issue is a lack of clarity and lack of provider input in developing program models; the Clubhouse rates are again an example, in which costs were determined for two models of service defined by a number of enrolled individuals without clear explanation for the rationale.
    b. Suggested: Providers and EOHHS should identify a process for collaborating in model development, addressing issues such as:
        i. Model development should occur prior to rate development, with provider input, and should be "budget blind".
        ii. Quality and Outcome data, as well as Evidence Based practice standards should be considered in model development.
        iii. Regulations dictating staffing, credentials, and other compliance issues should be addressed in rates.
        iv. There should be a standard methodology for identifying and determining how components removed from but critical to a service code's program model (such as transportation) should be addressed in an alternative adequately funded code. The recent proposal for paying for transportation to and from DDS Community Based Day Services is a positive example of how this might work.
        v. For some service codes, case rates should be considered to allow providers the flexibility needed to serve clients in a responsive cost-effective manner. DMH Community Based Flexible Support and DMH Clubhouses are two examples.

6. **Utilization Factors**
    a. Utilization factors for proposed rates which provide for consumer absenteeism and vacancy have varied from 75% to 100%. Providers have been concerned that a required utilization of 100% is unfair, as in most codes staffing ratios and basic program services are still required costs but revenue would not support them. This utilization issue is more likely to produce adverse financial impact in models where program capacities are low, referrals take time to process to enrollments, and client choice is high.

b. Suggested: Providers and EOHHS should identify a consistent and reasonable methodology for determining percentages for utilization rates, such as utilization in the 85-95% range.

7. **Facilities / Occupancy Costs**
    a. Most published rate methodologies to date have used average costs per client to set occupancy costs. This penalizes providers for facility costs which are above "average" because of geography, purchasing timing, or because costs to maintain facilities at a reasonable standard are not reflected in the database.
    b. Differences in housing subsidies will impact rates in any contracts involving residential service codes.
    c. The survey and analysis being conducted by EOHHS regarding residential occupancy costs, while burdensome, suggests that EOHHS is also considering these issues.
    d. Suggested: EOHHS should consider developing rates with two tiers: one for program costs, and one for occupancy costs, which adjusts for actual costs and subsidies, with some caps. This requires more detailed cost reviews, but would be fairer.

8. **Negotiated or Objective Assignments of Intensity of Need and Services**
    a. In at least one published methodology, level of client intensity drives staffing ratios, which drive rates. Intensity levels could be set by negotiation with agency representatives or by objective assessments.
    b. Suggested: In order to properly allocate resources in EOHHS services in which the costs of services should match the intensity of client need, EOHHS and providers should work collaboratively to develop reliable and valid objective assessments, with adjustment factors for selected risk/safety factors (behavioral, forensic, medical).

9. **Administrative Costs**
    a. In rates published to date, administrative rates have varied between 9% and 15.6%. As with fringe benefits, there are many examples in which providers have reduced administrative costs in contracts in order to fit the contract total into an existing maximum obligation. Taking averages of the administrative costs within a service code to set rates therefore is adopting an artificially suppressed cost base. This has become increasingly problematic as changing regulations continue to require more administrative capacity. Examples include serving as representative payees for individuals, and the changes in the Medication Administration Program certification process over the past year.
    b. Suggested: EOHHS and providers should agree on a standard administrative cost base, such as the 12.5% allowed by OSD.

10. **Phasing in Rates**
    a. Recent rate methodologies have provided for reducing financial hardships for providers projected to lose significant revenue with new rate setting methods, by providing mitigation funding for "losers" and phasing in new rates over years. This is a positive development, but should be standardized.
    b. Suggested: EOHHS and providers should agree on a standard phase in strategy based on percentages of projected rate reductions.

11. **Cost Adjustments**
    a. A key issue for Chapter 257 was establishing a system which will adequately adjust costs for inflation. Rates proposed to date have included cost adjustment factors which have varied, and which have been explained as adjusting rates upward from the cost base used in calculations (e.g., a 2010 contract base) to the year of rate implementation. There are no published procedures for cost adjustments. Relying on annual cost report data to set the inflation factors will artificially suppress cost adjustments, as providers, in order to remain solvent, will work hard to keep costs under existing rates; using actual costs to set inflation factors will therefore produce year-over-year reductions.
    b. Suggested: EOHHS and providers should agree on a standard methodology which annually adjusts the initial rate base up by the annual OSD published rate for inflation. The date of the required review should be the date which the rate was originally required to be set. Also, we assume that rates set in a given fiscal year will be retroactive to the start of that year.

The broader issues behind Chapter 257 implementation are the continuing fragile financial condition of the EOHHS community provider system, the indefensibly low salaries paid to direct care and clinical staff, and the need for increased financial support of this system. Providers realize that developing a clear, fair, reasonable rate setting system is an important step in generating support for funding. We pledge to continue working with EOHHS through the Collaborative and through the Council to achieve the goals of full implementation of Chapter 257.

Thank you again for this opportunity. We are eager to begin.

Respectfully,

Bruce Bird, President and CEO
Vinfen Corporation

Deborah Ekstrom, President and CEO
Community Healthlink, Inc.

Bill Lyttle, President and CEO
The Key Program, Inc.

Bill Sprague, President and CEO
Bay Cove Human Services

Bill Taylor, President and CEO
Advocates, Inc.

Kathy Wilson, President and CEO
Behavioral Health Network, Inc.

cc: Catherine B. Mick, Chief Administrative Officer, EOHHS
Gary Blumenthal, President and CEO, ADDP
Vic DiGravio, President and CEO, ABH
Michael Weekes, President and CEO, The Provider's Council
Benjamin Fierro III, Lynch and Fierro, LLP