



PROVIDERS' COUNCIL

ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE

March 1, 2018

Executive Office of Health and Human Services
c/o D. Briggs
100 Hancock Street, 6th Floor
Quincy, Massachusetts 02171

Dear Ms. Briggs:

The Children's League of Massachusetts (CLM), the Association for Behavioral Healthcare (ABH) and the Providers' Council thank you for the opportunity to present our collective testimony regarding the proposed rates for **101 CMR 413.00: Payments for Youth Intermediate-Term Stabilization Services.**

Since the state launched Caring Together in 2012, we have learned a host of lessons. We are very appreciative of the Commonwealth's ongoing partnership with providers as we look to improve upon the Caring Together system, and for the many opportunities to provide input over the past six years. Our collective members remain committed to reaching the goals of the Caring Together model in order to better meet the needs of the children, youth and their families who are among our most vulnerable citizens in the Commonwealth.

Unfortunately, we also continue to have concerns around providers' ability to provide high quality services and care to children and adolescents through Caring Together when a number of issues previously raised by the provider community have not been addressed by the Commonwealth. In 2012 and 2016, our associations submitted joint testimony outlining specific concerns around rate adequacy, workforce challenges, acuity levels in residential programs, and program-specific concerns. We have attached our 2016 testimony, which details each of these concerns in great length.

While most of the concerns outlined in our 2016 testimony remain just as relevant, the following testimony will focus on our collective membership's most urgent concerns.

Rate Adequacy

While we are appreciative of the proposed cost adjustment factor (CAF) of 2.39 percent in the proposed rates, we remain concerned that flaws in the underlying methodology still being used for the majority of Caring Together rates have not been fully reviewed in accordance with Chapter 257, *An Act Relative to Rates for Human and Social Service Providers*. The law, passed unanimously by the Legislature, was created to bring fairness, adequacy and transparency to the Commonwealth's purchase-of-service system.

Rate adjustments made in 2016 were also simply a cost adjustment factor applied across most programs with a few programs receiving larger adjustments. As we explained in our 2016 testimony, a CAF does not address the underlying fact that Caring Together rates were originally set based on 2009 UFR data that was already outdated by the time initial Caring Together rates were established.

The provider community remains disappointed by the Commonwealth's failure to fully review the underlying methodology that was used to set rates for Caring Together services.

Furthermore, the law specifically notes that rates of payment must be adjusted to take into account the reasonable cost to social service program providers of any existing or new governmental mandates. The state, therefore, must consider *An Act Further Regulating Employer Contributions to Health Care* – a law passed and signed in August 2017 – when setting these human services rates.

The law creates a new governmental mandate that increases the EMAC contribution from 0.34 percent to 0.51 percent, costing each organization about \$26 more per year per employee. Additionally, organizations where non-disabled employees are electing to take MassHealth or a subsidized Massachusetts ConnectorCare program must pay an assessment of \$750 per employee per year – another new governmental mandate. We do not believe these costs have been built into the rates proposed for 101 CMR 413.00, and according to Chapter 257, they should be included, as they represent new governmental mandates.

Should the state wish to discuss the impact of these mandates and their effects on community-based nonprofits, our members would be willing to meet with you.

Workforce Challenges

Providers continue to face significant challenges around workforce recruitment and retention. Staff turnover represents one of the biggest challenges providers face as they strive to offer safe, quality services for the children they serve.

A significant factor in this turnover is that the current reimbursement rates for Caring Together services are not sufficient to allow providers to offer competitive salaries and benefits required for recruiting, training, and retaining staff. Our 2012 testimony noted that community-based human services organizations “are hard pressed to recruit and retain qualified staff” due to low reimbursement rates. In 2016, we stated that the starting salaries for Department of Children and Families employees “are significantly higher than the Caring Together clinical and line staff.”

While there have been modest increases to the rates over the past six years, the fact remains that dedicated caregivers working at nonprofits under Caring Together contracts remain severely underpaid compared to their state counterparts or those working in hospital and other health care settings. This does a disservice to the clients for whom we have been entrusted to

help, and it creates a two-tiered system of care, where our members frequently experience staff leaving for better paying jobs at the Department of Children and Families or other health care providers.

Take, for example, a recent survey done by Gallagher Benefit Services, Inc. to study the rates of pay for positions at community-based behavioral healthcare agencies versus hospitals. In most cases, hospitals pay significantly more – the overall “pay gap” for comparable jobs was 22.8 percent, though the differences do vary by job. For direct care counselors – one of the hardest positions to fill where workers need a bachelor’s degree – those in the community-based behavioral healthcare sector make an average of \$17.32 an hour, while those working in a hospital setting make \$24.49 an hour – a difference of more than 41 percent.

Other positions saw similar discrepancies. Licensed Clinical Social Workers (LCSWs) were paid an average of \$24.76 an hour by behavioral healthcare organizations and \$31.85 an hour by hospitals – a difference of nearly 29 percent. The gap only grows when looking at Licensed Independent Clinical Social Workers (LICSWs), who are paid \$26.46 an hour by behavioral healthcare organizations, while hospitals paid \$35.07 an hour – a difference of more than 32 percent.

As noted, the pay disparity isn’t just between behavioral healthcare organizations and hospitals – it also exists between the community-based nonprofits and state agencies. A 2017 study by the University of Massachusetts Donahue Institute and UMass Dartmouth, *Who Will Care? The Workforce Crisis in Human Services*, demonstrated the pay gap by comparing wages of employees working under state contracts for nonprofit organizations and similar positions available directly with the Commonwealth.

One such example used a DCF “Social Worker I” in Pittsfield and a comparable community-based position – an “Outreach and Tracking Caseworker” at a Worcester human services provider. The DCF position was posted for between \$51,145.38 and \$69,855.24 annually; the community-based position paid \$14.50 per hour (with time-and-a-half for overtime) with an estimated annual salary of \$35,800. This represents nearly a 43 percent difference on the low-end or more than a 95 percent difference on the high-end.

This salary disparity doesn’t account for other benefits state workers receive, such as a pension. When including all factors, it is apparent that the community-based human services sector is in the midst of a workforce crisis, and unless benchmark salary amounts in model budgets created by EOHHS increase, it will only worsen.

While legislation is pending to eliminate the pay disparity between state employees and those caring for clients on behalf of the Commonwealth at community-based nonprofits (House Bill 3150 and Senate Bill 47), we ask the Executive Office of Health and Human Services to re-evaluate the benchmark salaries it is using to set rates for human services programs. Several of the direct care salaries being proposed by the Commonwealth for the Caring Together rates suggest paying employees an average of less than \$15 an hour. The state also proposes paying a direct care “peer mentor” position in a few of the Caring Together program models just \$11.83 an hour – barely more than minimum wage.

With more retailers and fast-food restaurants beginning to pay employees \$15 an hour, it has become increasingly difficult for providers to find individuals with bachelor’s degrees to provide critical care to clients. The state must ensure it is reimbursing providers at a high enough rate so

they are able to pay employees a fair and adequate wage commensurate with the services being delivered, or the exodus of workers from the field will continue until programs are unable to serve clients on the Commonwealth's behalf.

Acuity Levels

Community-based providers continue to report seeing higher acuity levels among children and adolescents throughout the Caring Together system of care. The increased acuity coupled with the inability to pay fair wages makes staff retention and client safety even more of a challenge for providers. Providers are staffing programs at higher levels than are required or funded in order to ensure safety. In our 2016 joint testimony, we explained, "These high levels of client acuity require Caring Together programs to commit staffing resources that substantially exceed the current/original model's staff to-client ratios. . . There is no reason why one provider should average four occasions per month when a child requires a psychiatric visit to the emergency department (ED) with staff accompaniment due to higher acuity than the program model is designed to handle." The increased acuity and increased incidents require increased managerial and administrative supports for debriefing, incident processing, oversight, supervision, outcomes tracking and training.

Program-Specific Challenges

Intensive Residential Treatment Program (IRTP):

For one of the most acute placement models, the following concerns need to be addressed to ensure providers are able to provide the best care possible for this population:

- We urge the Commonwealth to add an additional clinical position to the model budget. It is currently impossible to meet the clinical requirements of this level of care with only a Clinical Director and two clinicians. Given the acuity of children served in IRTPs, we recommend that the rate be adjusted to allow providers to hire a third clinician.
- The clients screened into IRTP level of care are presenting with higher acuity after shorter periods of stability in inpatient settings before being transitioned into IRTPs. As a result 1:1 and 2:1 staffing is a regular occurrence. We urge the Commonwealth to increase the staffing levels from 1:3 to 1:2.
- We request that salary levels used to set rates for IRTPs be increased to allow IRTPs to effectively compete for staff with state agencies, large hospital systems and other health care provider types. Current reimbursement rates force providers to offers salaries that are far below market rates.
- Program Management average salary (4.10 FTE's) of \$64,308 is significantly underfunded. Current actual average management salaries are \$75,000 which should be factored into the methodology.
- The Chapter 257 non-salary program reimbursement rate of \$25.44 per client is insufficient to cover costs of care. IRTP current costs are between \$35 and \$40 per day to cover meals, supplies, transportation and various support services which should be factored into the methodology.

Clinically Intensive Residential Treatment (CIRT) Program:

The move to a monthly accommodation rate in 2016 provided much needed financial stability within the model, allowing this highly specialized service to continue to exist for children and families when it is needed. With only one CIRT in the state, its existence is vital to the system of care for children and families in the Commonwealth.

While we are appreciative of the accommodation rate, we believe the CIRT program requires an increased funding level beyond that of the proposed CAF due to the uniqueness and specialized clinical treatment offered through this program. Providing a level of care equal to that found in hospitals, the program incurs the costs of what it takes to maintain and conduct Joint Commission accreditation - in addition to EEC licensing. The added costs for mileage – both for parents to come to the program and for staff to drive to the families – is also extremely significant. Maintaining a sufficient number of vehicles for transportation, vehicle maintenance, and insurance is costly and not sufficiently accounted for in these rates.

Furthermore, due to the specialized nature of services provided, this program requires highly skilled employees. The current pay scale prevents the ability to hire people at that level of skill set or to retain staff long enough to train them to that degree. For instance, retention of clinicians and Occupational Therapists remains a challenge for this program.

Short-term Assessment and Rapid Reintegration (STARR) Program:

The Stabilization, Assessment and Rapid Reintegration (STARR) Program is a 24-hour, 7-day-a-week residential setting for adolescents referred by DCF. A range of clinical, educational support, diagnostic and daily living services are provided for each youth in the program.

First and foremost, we extend our sincere appreciation to DCF for actively listening to the provider community and focusing on improving models to help support children in their care. As this program is redeveloped, it will be important for the rates to be re-evaluated to ensure STARR providers receive the appropriate level of funding to meet the program specifications to adequately serve children placed in their care.

The current use of the STARR program does not reflect that which was envisioned in the RFR; that is, a 45-day service with youth returning to a home setting with community supports in place. It has become not just a 45-day stay, but it is also a placement for hot-line youth needing a one to three day stay – a program for youth where no other viable placement is available. Given the challenges facing DCF, STARR providers have demonstrated their flexibility and responsiveness by adapting to these challenges. This responsiveness, however, has caused great stress on STARR program staff and the youth they serve. For example, there has been a significant increase in workers' compensation claims due to restraints and unprovoked assaults by clients on staff resulting in an increase in staff turnover, an increase in client on client incidents given presenting problems and age, and a dramatic increase in police intervention.

STARR Staffing and Safety:

- Current salary levels are grossly inadequate causing extreme difficulties in recruiting, hiring and retaining high quality staff for providers. STARR programs are experiencing a more rapid staffing turnover rate and higher vacancies than ever before. The turnover and backfilling of these positions (often at an overtime rate) also increases administrative and personnel costs for advertising, recruitment, training and relief staff.

- Children's safety should be of paramount concern when establishing staffing levels in rate methodologies. When discussing the proposed rate/program models and methodologies, providers are in agreement that more staff is needed during all shifts to maintain the safety of our children.

Program Specific Challenges Related to Current Rate Structure:

STARR providers face a critical shortage of staff at all levels of the program. Given the Commonwealth's low unemployment rate, low salaries for various staff positions within STARR, and providers' inability to compete with DCF social worker salaries, recruitment and retention of qualified staff is extremely problematic. The clinician staffing ratio used in Department of Youth Services (DYS) treatment programs is 1:4 compared to 1:6 in STARR programs.

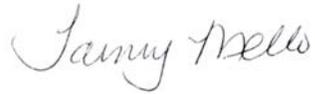
- A survey of STARR providers compiled last March showed there was a staff vacancy rate of 23 percent across STARR programs.
- Many of the children admitted to STARR programs have medical involvement and/or complications requiring multiple medical and dental appointments and follow up that goes well above the staffing levels enabled by the proposed rate. This is particularly difficult when beds are borrowed between DCF areas and the child's appointments are a long distances from the STARR program requiring staff to spend a significant amount of their time handling transportation issues.
- Prior to the procurement of Caring Together, STARR contracts included funding for an education position. This critical position was removed from STARR upon the implementation of Caring Together due to the expectation that youth would be in school. Data compiled by STARR providers last March indicates that 29 percent (174 of 600) of STARR youth were not attending school on a regular basis or not at all. Providers have testified on numerous occasions that this position needs to be reinstated. The position would provide educational structure, enable youth to earn credits while in placement, and ensure youth, where applicable, are enrolled in school.
- There are no differentiated STARR staff for youth within a specific population. For example, STARR programs serve youth with physical behavioral issues, youth on the autism spectrum, youth with complex medical needs, youth with self-harming behavior, and youth with gang involvement all within the current STARR model. In 2016, providers who represent 243 of the STARR beds made 547 calls to Mobile Crisis Intervention (MCI) team to help handle these youth with higher needs. There is a clear need for highly specialized STARR placement programs.

Inadequate salaries and high turnover throughout STARR programs and across the Caring Together System continue to compromise program stability and safety of both youth and staff. Direct care salaries proposed in the Caring Together model budgets must be brought up to a reasonable level so quality staff can be recruited, hired and retained.

We must ensure that our children are being served by safe programs that provide the highest quality of care. This starts by allocating adequate resources that will allow for the hiring and retention of skilled workers that can support the children in our Caring Together system and encourage them to thrive.

Thank you for your consideration of our above concerns. These concerns have come from lessons learned during the implementation of Caring Together over the past six years from our front line workers, program directors and CEOs.

Sincerely,

A handwritten signature in cursive script that reads "Tammy Mello".

Tammy Mello
Executive Director, Children's League of Massachusetts (CLM)

A handwritten signature in cursive script that reads "Vicker V. DiGravio III".

Vicker V. DiGravio III
President/CEO, Association for Behavioral Health (ABH)

A handwritten signature in cursive script that reads "Michael D. Weekes".

Michael D. Weekes
President/CEO, Providers' Council