HOWARD CENTER RESPONSE TO GMCB FY16 BUDGET ANALYSIS & QUESTIONS:

January 8, 2016

1. **Describe the scope of client services and related demographics provided by the Howard Center. Describe major programs used to support clients. Is there a distinction between Designated and Specialized Services Agencies? Do other Designated Agencies provide a similar array of services?**

   Vermont's Agency of Human Services provides direct services by contracting with private, non-profit providers called Designated Agencies (DA). Per Statute Title 18 Chapter 207, DMH and DAIL:

   > *ensure that community services to persons with a mental condition or psychiatric disability and persons with a developmental disability throughout the State are provided through designated community mental health agencies. The Commissioner(s) ... designate public or private nonprofit agencies to provide or arrange for the provision of these services. Within the limits of available resources, each designated community mental health or developmental disability agency shall plan, develop, and provide or otherwise arrange for those community mental health or developmental disability services that are not assigned by law to the exclusive jurisdiction of another agency and which are needed by and not otherwise available to persons with a mental condition or psychiatric disability or a developmental disability or children and adolescents with a severe emotional disturbance in accordance with the provisions of 33 V.S.A. chapter 43 who reside within the geographic area served by the agency.*

   DAs are therefore responsible for ensuring needed services are available through local planning, service coordination, and monitoring outcomes within their region. Howard Center is the DA for Chittenden County as well as a preferred provider of substance use disorder services.

   As a designated agency, Howard Center, Inc. has a statutory responsibility to meet all of the developmental and mental health services needs of their region within the limits of available resources. In addition to the required core service and capacity provision, DAs engage in local planning processes to determine the state and regional System of Care Plans that inform additional service offering. Specialized Service Agencies (SSA's) provide a distinct approach to services or meet discrete, niche service needs.

   While each DA has the same statutory responsibilities, scope of services offered may differ as a result of local, regional, and state planning processes Howard Center services include:

   - 24 hour crisis response
   - Outpatient services for children and adults
   - Substance Abuse Treatment for adolescents and adults

- Case Management Services
- Developmental Services – Developmental Services, Choices for Care/Long-Term Care, Personal Care, Residential
- Mental Health Treatment – Children's and Adult Residential, Mentoring, Independent Schools, Severe Mental Illness
- Therapeutic school services – public schools and independent schools
- Employment Services
- Medical care (including nursing and psychiatry) and consultation
- Consultation for community partners

It is critical to note that in both statutorily mandated and other services it has been one or more designated agencies which have stepped in when the state has been confronted with natural and other private business disasters which requires the immediate assumption of often challenging and complex program and client support services. The unanticipated closure of The Vermont State Hospital and of a private medication-assisted treatment program with 170 patients left without care or notice are only two examples. It is this mutuality of mission and commitment which makes the designated agency and state relationship so meaningful.

2. **The Howard Center has a large number of buildings and offices to provide services to clients. Describe the scope and need for the offices. How does the Howard Center determine their service area?**

Howard Center currently owns 18 properties (149,931 square feet), has lease agreements for another 35 (110,135 square feet), and has agreements for another 10 locations all totaling 282,059 square feet. With the exception of two properties, all of these locations provide a base for service provision to clients. In addition to these locations, staff provide client services in over 50 local schools and childcare centers, the emergency room, on Church Street and surrounding areas, and in primary care offices. The array and quantity of individual locations reflect the array of what and where services are needed by clients including clinic based, court house, corrections, family centers, group homes, public schools, agency operated independent schools, and administrative offices.

3. **Describe the performance measurement efforts to evaluate client outcomes and client satisfaction. Are national and/or regional peer measures used?**

Measuring the outcomes of behavioral healthcare treatment relies on a balance of objective standardized assessments and qualitative indicators. Behavioral health outcomes vary at times from traditional medical model outcomes in that for many of the challenges faced by clients, a stabilization of symptoms is a desired goal rather than a remission of existing conditions or symptoms. Our outcomes focus highly on improvement in client-assessed quality of life measures including: increased level of independent living, increased ability to maintain employment, reunification with family, success in school, and reduced dependence on substances. Howard Center outcomes data is tracked and analyzed utilizing a variety of tools and methodologies to include:

- Results-Based Accountability (RBA) evaluation framework. RBA has been adopted by the Agency of Human Services and utilization of this tool is a requirement in the DA Master Grant Agreement. RBA uses a data-driven, decision-making process that assists Howard Center with utilizing evaluation results for continuous quality improvement, problem solving and increased accountability. Federal, State and Local performance measures (including mandated data collection required by state or federal reporting requirements) are embedded within our evaluation framework. Specific examples of area standardized evaluation methods include the following:
    - Access to Services
    - Reduction in Clinical Symptoms
    - Confidential Consumer Satisfaction Surveys
    - Quality of Life Improvement Indicators
- National Core Indicators (DS)
- Achenbach System of Empirically Based Assessment (ASEBA) for assessment every six months while the client remains in service to track results of treatment (requirement of the Master Grant Agreement)
- Child Behavior Checklist (CBCL) is a requirement of the Master Grant Agreement for children referred to or in residential treatment or receiving Enhanced Family Services.
- Teacher Report Form (TRF), CBCL, YSR or Adult Self Report (ASR, for students 18+) data for clients receiving Success Beyond Six services (scored results submitted electronically to DMH)
- Self-Sufficiency Matrix assessment tool for adult mental health outpatient
- Several standards measurement expectations of CARF, an international accreditation organization, for our medication-assisted treatment programs.
- Substance Abuse specific measurements for ADAP are obtained during and after treating via client survey.
- Several National Council for Quality Assurance (NCQA) standards measures (NOTE: Howard was the first specialized substance abuse program in the country to be accredited by NCQA)

4. **Medicaid is easily the most dominant payer, representing over 80% of the DA's net revenues. Describe how Medicaid reimburses for different services. Distinguish key differences in rates or methods of reimbursement.**

Howard Center is funded by a variety of Medicaid streams that comprise traditional Fee-For-Service billing, per diem rates, monthly bundled rates, EPSDT funds and Medicaid Waivers.

Fee-For-Service: Fee-For-Service rates are standardized throughout the State and vary based on the type of service provided as well as the Medicaid payer source (ex. DMH or DVHA). Most bill

in 15 minute increments, but there is also a growing number of "encounter codes" that pay the same regardless of duration.
Examples: The Outpatient programs and Children's community services are largely funded with Fee-For-Service revenue. School based services draw down Fee-For-Service, monthly and daily Medicaid bundled rates.

Bundled and Per-Diem Rates: For programs funded by a bundle or per-member-per-month (PMPM) reimbursement model, the rate is set by negotiating with the associated state department to determine the annual cost to operate the program and dividing that amount by a utilization target (commonly clients served per month). However, when converting a funding stream from Fee-For-Service to a bundle model, prior year revenue generation is typically used to set the rate rather than budgeted program cost.

Per-Diem rates are often used in residential programs or programs that address a package of services that include living, vocational, clinical, and community-based supports. In a similar fashion to bundle models, the annual cost to run the program or serve the client is divided by an expected utilization target (often days in this case) to determine the reimbursement rate.

These bundle and per-diem models help to financially balance fluctuation in service volume, reduce the overall number of billing claims, and allow employees to spend less time tracking hours and more time focusing on client care.

Examples: Children's residential programs receive Private Non-Medical Institution Medicaid (PNMI) funds that are essentially three separate rates rolled up into one aggregate daily rate. Medication Assisted Treatment services are reimbursed via a bundled methodology.

EPSDT: Children's First Call Crisis program receives a portion of its funding from EPSDT Medicaid funds that is invoiced to the State and not directly billed to Vermont Medicaid.

Waiver: Developmental Services (DS) is funded almost completely by a Medicaid Waiver that has the capacity to provide up to 24 -7 care for an individual, depending on their level of need. The DS Waiver is paid in the form of a daily rate that is assigned to a given client by the State after an extensive review process. Currently, Howard Center provides services to 628 DS client on individual waivers. A similar form of Mental Health Medicaid Waiver is available to a limited number of children with intensive support needs. Services to adults with severe and persistent mental illness are funded through a separate Medicaid Waiver called the CRT Case Rate. We are paid a fixed monthly amount that may be adjusted bi-annually based on overall program utilization. CRT utilization is reported to the Department of Mental Health on the State data extract report known as the MSR (Monthly Service Report).

Rate Negotiations: Rate negotiations occur in a variety of ways. Legislature approved increases are often delivered via increases to Medicaid rates, however these are not inclusive of all streams or rates (for example PNMI). Also, these increases are gross and not reflected of match rates which increases annually and then increases proportionately to rate increases. The FY16 budget assumed of a 1.75% Medicaid increase 1/1/16 (.43% annualized) equating to $515k. The 0.22% rate increase received equates to $129,531 (0.15% total revenue increase). Reimbursement rates for Children's Residential programs are established via the Department of Rate Setting under PNMI rules. The rates are based on prior period actual costs within approved items/amounts. For example, the current FY16 rates are calculated based on FY14 actuals with a tie to inflationary indexes. There is no capacity for changes due to approved staffing or facility changes nor for changes to the bargaining unit contract or fringe expenses that differ from the established inflationary indexes. Rate negotiations for 3rd Party/Private Insurance are not performed on a regular basis to due lack of internal resources to dedicate to negotiating as well as insufficient IT and Data infrastructure to readily produce the data needed for successful negotiations.

5. **Staff, personnel contracts, and fringe represent over 75% of the DA's annual expenses. Describe the scope and type of positions that provide direct care. Describe recruiting issues that you are experiencing. Describe your overhead and administrative costs needed to support the agency.**

Howard Center utilizes a diverse work force to effectively respond to the service demand in our community and state. Direct service positions include staff holding an advanced degree (Masters or Doctorate) with many having or working toward independent licensure in psychiatry social work, counseling, psychology, nursing, substance use treatment and education. The remainder of the direct service positions require a Bachelor's degree in the respective field or relevant experience with the identified population. The majority of direct service positions are non-clinic based positions with expectations for community or home based work with non-traditional hours. Howard Center is especially challenged to recruit licensed and Masters level clinicians due in some cases to a limited number of specifically trained and experienced staff to address targeted needs and/or to lack of competitive hiring salaries driven by reduced funding to support staff salaries and the ability of other key employers, including the state, in our area offering 30+% more for positions requiring comparable credentials. (NOTE: They have this ability by virtue of their ability to cost shift, balance bill approved positions, or are affected by the Pay Act). The Bachelor's level direct service positions have become more difficult to recruit due to the low unemployment rate in the county, a related competitive human services/education recruitment environment and the limited number of individuals seeking to do this work at the same time the number of positions required continues to increase. In addition to recruitment, retention is also negatively impacted by a lack of diversified or controllable revenue streams which contribute to difficulty offering competitive salaries compared to hospitals, state positions and schools.

Aggregated funding COLAs for DAs/SSAs over the past 10 years trail the New England CPI by 13%. This directly impacts compensation where the disparity between Designated Agencies and state/hospital/education environments has grown to $16,000+ for bachelors level staff and $13,000 for masters level staff (data per Vermont Care Partners). As such, turnover rates average 27.5% with a vacancy rate of 10%. As of January 4, 2016, the agency has 104 unfilled positions.

Overhead and administrative costs needed to support the agency include executive administration, finance and accounting, billing, communications, information technology and information management (including electronic health records, health information, privacy, and security), human resources, and compliance. Costs are reported and allocated per the State of Vermont Department of Mental Health and Department of Disabilities, Aging, and Independent Living Audit Guide for Community Mental Health Centers. FY16 budgeted agency administrative costs are 8.9% of total expenses with IT/IM comprising 46% of those costs. Despite IT costs that have increased 80% over the last 10 years, the current infrastructure does not provide adequate network, storage, EHR, and/or data analytics capabilities. According to the HIMSS Analytics® Database, the average IS operating expense as a total expense for U.S. hospitals in 2013, was 3% while sources such as CIO.com's 2008 study or HIS Pros indicate health care and education/non-profit entities running between 4.0 – 6.2% . HC IT expenses are currently running 1.7% of budget with IM (EHR, clinical informatics, records management) running at 2%. It is also worth noting that while costs are reported and allocated per state guidelines, not all revenue streams fund full costs including some Medicaid funding streams which artificially limit administrative costs to 5%.

6. **Discuss the financial health of your organization. Discuss the rationale for adopting a budget with no operating margin. Are there opportunities to achieve a surplus?**

If the organization were at optimum financial heath, we would be able to achieve three key goals: (1) market level compensation, (2) adequate capital investments in infrastructure and (3) sufficient operating cash. These key foundational areas in turn result in a stable, skilled workforce that provide services in appropriate and supportive facilities while utilizing efficient and productive systems and technology platforms. Meeting these goals will positively impact service delivery and Howard Center's ability to meet the needs of our clients and community.

As we strive for this vision, we struggle with how to best utilize resources that are not sufficient to maintain the current level of service and programming offered. To ensure consistent and quality service provision, we must attract and retain qualified staff. Compensation is the organization's top priority. Tools to achieve include: minimizing other costs, increasing expectations on staff, assessing the feasibility of terminating inadequately funded services and programming and exploring entrepreneurial opportunities that have the potential to generate net revenue and at the same time is consistent with our mission.

The rationale for adopting a budget without an operating margin is both cultural and financial. Historically, a perception has been that a budgeted gain provides sufficient grounds for reduced funding in subsequent years. Additionally, given insufficient reimbursement trends, budgeting a gain would be done at the expense of staff compensation and aging infrastructure. Lastly, DA budgets are not built from a cost basis with a mechanism for negotiating rates but rather from perspective of how to make the available funding work to cover the services provided.

7. **Discuss the scope and trends of bad debts and free care in the organization. Describe your free care policy.**

   Howard Center provides care regardless of ability to pay and/or follow through on payments. We offer a sliding fee scale based on income. A quantitative response is challenging given system and data analytic inadequacies. Historical charges are based on reimbursement rather than cost, and we do receive some grants to support the cost of un/under-insured. Current estimates indicate as much as $7 million annually in uncompensated care.

8. **Describe the latest projections for your 2016 budget.**

   Four months into the fiscal year we are performing with a 1.6% (457k) operating gain. This gain is primarily due to vacancy savings. These vacancies create additional burden and caseload for current staff as well a situation where we are unable to respond to community need or accept and fulfill new contracts that have the potential to be net positive. As such, an off-cycle compensation increase for primarily direct service staff was agreed to by the bargaining unit and was implemented in the last week of December. The estimated annual cost is $1.5M. The FY16 cost will be covered by the above referenced vacancy savings. The FY17 budget will need to indicate continued changes in programming and/or service delivery to fund the increase for next year as well as the anticipated additional increases we anticipate will be needed as a result of bargaining unit negotiations which will begin in the spring. Even with this increase, salaries will remain significantly below our regional market.

9. **Describe your capital budget planning process.**

   Given cash constraints, trends in funding, and the constant uncertainty of future funding, the capital planning process is relatively unsophisticated and is performed annually to assess immediate/short term needs for the coming year. The capital budget is approximately 28% repayment of long term debt, 36% technology, and 36% property, plant and equipment. The FY17 capital process will begin to take a 3-5 year view.

10. **Describe your health care reform efforts around delivery system and payment reform.**
    - OneCare member and representative on the Board of Managers.
    - CHAC member
    - VHCIP Payment Model Design and Implementation Work Group representation.
    - CEO on VHCIP steering committee and GMCB advisory committee
    - DA/SIM/APM Workgroup representation.

- First Hub in the state's Hub & Spoke System
- ABA services bundled payment pilot with CIGNA and BCBS (BCBS agreement ended)
- Initial planning as D.A. pilot for Feedback Informed Care (FIT) for BCBS
- Shifting from Fee For Service to Bundled Payments (JOBS, School Social Work, etc.)
- Dialoguing with state to conceptualize a value-based payment system

11. **Discuss the differences between "mandated services vs. non mandated"?**

    All clients served by Howard Center participate voluntarily. That said and depending on the program, they may have external pressures from judicial, educational, or familial/social/employment contexts that incents their participation. For example, clients wishing to have their driver's license reinstated after (or in anticipation of) a DUI conviction may enroll in CRASH services; individuals may receive consideration for judicial consequences by agreeing to attend and participate in clinical counseling services .

12. **How does the Howard Center define client/patient needs as part of determining budget resources?**

    In addition to participating in and receiving data from formalized community needs assessments conducted by both United Way of Chittenden County and UVMMC and our own formalized System of Care Planning Process, community and client surveys, and invitations for feedback and statements of need we have four programming area advisory committees composed of direct recipients of care, their families, staff and board members who meet monthly throughout the year to review services and provide feedback on needed services and budget priorities. This information is then combined with available financial resources to determine budget.

Technical Questions:

13. **The balance sheet shows over $4 million in investment funds. Are these funds invested and if so, where is that accounted for in the budget?**

    The investment funds reflected on the balance sheet represent private donations accrued over many years and are board-designated endowment funds. The initial focus has been on growing the endowment base, thus no distributions have yet been made and none are budgeted.

14. **How is bad debt and free care accounted for? How much is it and how many cases or clients are there?**

    Current systems and processes are insufficient to accurately account for bad debt and free care. We estimate bad debt and free care values are approximately 10% of annual revenue.

- Published rates – Published rates (i.e. the chargemaster) typically reflect Medicaid reimbursement rates rather than being calculated on a cost basis. This factor alone causes under-reporting of bad debt and free care.
- Self-Pay – Self-pay comprises 0.3% of agency revenue. Approximately 4% of Howard Center clients are self-pay. Of these, 39% are on a sliding fee scale. The sliding fee scale charges a proportionate amount of the published rates. Collections for self-pay clients are poor, with 22% collection rates. In FY15, $461,943 of self-pay revenue was uncollected due to write-offs and sliding-scale discounts.
- 3rd Party / Private Insurance – 3rd party represents 1.4% of agency revenue. 78% of services provided are not covered services by 3rd party/private insurance. Of covered services, $1,163,014 / 46% was written off in FY15 (74% contractual allowances, 11% credentialing/authorizations, 15% write-offs).
- Medicaid – Just under $6 million dollars was uncollected in FY15 primarily due to contractual allowances. Lapses in Medicaid coverage also result in provision of free care.
- Revenue offset – ADAP provides resources to support provision of services to un/under-insured clients ($1.2M in FY14).

15. Can you provide some utilization metrics that describe scope and changes in services?

Economic factors at the time of the budgeting process provided limited opportunities for program growth. Many programs made budgetary concessions to merely maintain service capacity. There were also some targeted capacity reductions to minimize financial losses.

Specific metrics include:

- Increased DS clients served from 588 in FY14 to 609 in FY15
- Medication Assisted Treatment capacity growth from 617 clients in FY14 to 950 clients in FY15
- Increased capacity (clients served) in children's Autism Spectrum program by 16
- Reduced capacity in children's residential beds (12 to 6)
- Reduction of 3.8 School Social Worker FTEs in public schools

16. Is any benchmark or peer comparison information available?

Financial metric comparisons of the Designated Agencies are compiled annually by both the Vermont Care Partners CFO Group as well as auditor firm Kittell, Brangan and Sargent.

Standard outcome measures are gathered via Vermont Care Partners staff and the VCP Outcomes Group.

SAMHSA Uniform Reporting System includes national and state data.
http://www.samhsa.gov/data/sites/default/files/URSTables2014/Vermont.pdf