Community Services Reimbursement Rate Commission

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CONTENTS

COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

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(Note: Biographical sketches are included as Appendix A.)

REPORTING REQUIREMENTS

On or before October 1 of each year the Commission shall issue a Report to the Governor, the Secretary, and, subject to paragraph 2-1246 of the State Government Article, the General Assembly that:

1. Describes its findings regarding:

(I) The relationship of changes in wages paid by providers to changes in rates paid by the Department;

(II) the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;

(III) the incentives and disincentives incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration and how the methodologies might be improved;

(IV) alternative rate setting methodologies that might improve the efficiency or effectiveness of the methods of payment to providers;

(V) how the quality of care offered by providers can be measured;

(VI) how incentives to provide quality of care can be built into a rate setting methodology; and

(VII) the adequacy of and methods used to determine the annual cost of living adjustment to the rates paid by the Developmental Disabilities Administration and the Mental Hygiene Administration.

2. Recommends the need for any formal executive, judicial, or legislative actions;

3. Describes issues in need of future study by the Commission; and,

4. Discusses any other matter that relates to the purposes of the Commission under this subtitle.

In addition, in the report due on or before October 1, 2002 the Commission shall include its findings regarding the extent and amount of uncompensated care delivered by providers.

EXECUTIVE SUMMARY

The State of Maryland desires an environment for citizens with developmental disabilities and mental illness that ensures quality, equity, and access to services and financial resources. The Commission believes that the State is committed to a system that provides quality care and that is fair to efficient and effective providers. As the human services and health care markets change and as changing demands are placed on the providers of services, it is important to ensure the continued successful operation of providers within a reasonable budgetary framework.

The Commission was established by the Maryland legislature in 1996, so has been in operation for 6 years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the sixth such Annual Report. The Commission consists of 7 members, appointed by the Governor, and with the advice and consent of the Senate.

Through July 1999 the Community Services Reimbursement Rate Commission (CSRRC) met monthly to address its charges as outlined in Senate Bill 685 (1996). These charges were modified by Senate Bill 448 (1999). At the July 1999 meeting the Commission decided that it would be more productive to establish Technical Advisory Groups (TAG) and to replace two thirds of the formal Commission meetings with TAG meetings. The first set of TAG meetings was held in August 1999, and this structure has proved to be quite productive so the Commission has continued to use it. The topics covered in the TAG meetings have included:

- design of wage surveys to collect wage rate and staff turnover information from providers, and the interpretation of the data collected by these surveys;
- the definition of uncompensated care, and the design of surveys to collect data on uncompensated care and related issues from providers, and the interpretation of the results of these surveys;
- the financial condition of the providers;
- the structure of updating systems; and,
- the measurement of quality and outcomes, and how incentives to improve quality can be built into the payment system.

The Commission devoted its December 4, 2000 meeting to quality issues in services for individuals with developmental disabilities, and its January 8, 2001 meeting to quality issues in mental health services, with presentations by invited speakers and discussions with providers. A paper discussing quality measurement and how to build incentives for quality into the payment system is being prepared, and drafts have been discussed with the TAGs.

Staff has prepared several briefing and issue papers, some of which are attached in Appendices Band C. This report also offers the Commission's observations with regard to funding and payment methodology, the adequacy of the rates and rate updates, new system transitions, social policy, provider efficiency, and quality and outcomes. The Commission remains committed to providing constructive recommendations to the Governor, the General Assembly, and the Secretary in a timely manner. It should be noted that the recommendations have been developed in a balanced manner; the report should thus be considered as a unit rather than as a set of individual recommendations. One of the required reports is on the subject of uncompensated care. The Commission has decided that it would be more appropriate to discuss uncompensated

care separately for different categories of provider, and in the context of their overall financial condition. As a result, the discussion of uncompensated care has been included in the papers on the financial condition of the providers.

Key findings from the past year include the following:

- Neither the DDA nor the MHA payment systems include systematic mechanisms to adjust rates for inflation and other factors. Such adjustment mechanisms should be developed and implemented.

- The salary levels paid by DDA providers and in a number of MHA community service employment categories are lower than the corresponding salaries of State employees, particularly when fringe benefits are taken into account.

- The collection of uniform data on an ongoing basis is needed to monitor, compare, and evaluate the present and new payment systems in the context of the Commission's statutory authority as well as DDA and MHA responsibilities to monitor the system.

- The measurement of quality of services and of outcomes are still at a developmental stage. It would be premature to base payments on specific measurements of quality and outcomes.

- The psychiatric rehabilitation providers paid by MHA and the providers paid by DDA have increased the wages for direct care workers over the past three years by more than the change in the rates they have received from MHA and DDA, respectively.

Both MHA and DDA have promulgated regulations requiring the submission of wage surveys and other data. The data that will be submitted pursuant to these regulations is expected to greatly assist the Commission in its analyses.

Social Policy Choices

The context in which social policy choices are made needs to be examined. For example, historically there have been lists of clients waiting to receive services, and providers are requesting higher rates to care for existing consumers and to make investments in quality. It was anticipated that, for DDA, this conflict between improving services to existing clients versus serving more clients would begin to be resolved by the Governor's waiting list reduction initiative. However, the waiting lists appear to be increasing again.

In MHA, the system was expanded to serve more individuals without Medicaid who are eligible for public subsidies for selected services, but there was no corresponding increase in the overall budget. Such expansions could risk jeopardizing quality and potentially reducing services to those most in need (populations historically targeted for services by the public mental health system). In fact, MHA is responding to ongoing budget overruns by cutting back on gray area eligibility. Choices such as covering new clients, dropping clients from coverage, or ensuring stability for existing providers need to be made consciously. MHA has described the context for

its decision making in the values set forth in its 5-year plans. DDA's planning efforts are directed by the goals of its self-determination project and its waiting list initiative.

The Commission will continue to look into these issues in the coming year.

The Financial Condition of the Providers

The bulk of the providers contracting with DDA and the psychiatric rehabilitation providers contracting with MHA appear to be in a stable financial situation. However, a majority of the outpatient mental health clinics (OMHC) are losing money, and have substantial cash flow problems. Their situation is sufficiently serious that access to care could be threatened in some areas of the state. The financial condition of the OMHCs will be exacerbated by reductions in gray area eligibility, and by reductions in Medicare payments rates for 2002.

RECOMMENDATIONS

Separate sets of recommendations are being made for MHA and for DDA related issues, although there is overlap between these two sets of recommendations. These recommendations are listed in priority order. Recommendations 2, 3 and 4 are similar to recommendations that were made in prior years, but that have not yet been implemented.

CSRRC Recommendations pertaining to MHA

1. The State is considering a variety of possible actions that would have the effect of reducing projected aggregate payments to providers, such as cutting the level of authorized services for community service providers, and cutting back on gray area eligibility in order to mitigate the budget shortfall. These reductions should not be made.

DHMH is projecting a substantial budget shortfall and in response to this shortfall is considering a variety of possible actions that would have the effect of reducing projected aggregate payments to providers, such as cutting the level of authorized services to be provided by community service providers and making the gray area eligibility criteria more restrictive. The financial condition of the providers, and particularly the OMHCs, is precarious, and the viability of some of the providers could be jeopardized by such cuts. Moreover, the savings in the MHA budget resulting from reductions in gray area eligibility should not be taken at face value, as they are likely to be offset by increased expenditures in other areas, for example, the criminal justice system, and increased emergency department and inpatient hospital utilization, including both general acute and state hospitals.

The Commission recommends that such cuts should not be made.

2. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to issue a joint report by July 1 of each year to the Governor and the Joint Chairmen of the legislative committees responsible for the MHA budget. The report should specify the level of updating recommended for the upcoming year for community services rates paid by MHA and the rationale for this level.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems, and should be developed and implemented for establishing the rates for MHA community services, and in developing the MHA budget. In addition, the base rate in the fee schedule should be reviewed for adequacy on a periodic basis.

The community services rates paid by MHA were increased in fiscal years 1999 and 2000. However, the MHA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs, so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be quite simple or relatively complex. It is difficult to understand why the State has not incorporated such a system for community services paid for by MHA.

In developing the update factors DHMH should take into account such factors as the differential in wage rates including fringe benefits between direct care workers who work in community service providers and the corresponding state workers, the inflation rate in relevant wages, the impact of inflation on the cost of the goods and services being purchased by the providers, changes in the nature of the services being provided, geographic differences in labor costs, and system-wide productivity improvements. Alternatively, the updated rates could be based on a re-evaluation of the rates being paid for the services by private payers, where this is applicable. The systematic approach would be established with factors to be used in calculating the update amount published several months prior to the fiscal year for which they will be applied in order to provide advance notice to the providers and allow for management responses to the anticipated changes. The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

The basis for the adjustment should be one of the nationally available indices of inflation, or a combination of such indices. Examples include the increase in the Baltimore or national Consumer Price Index (CPI), the increase in the medical care component of the CPI, or two thirds of the increase in service worker wages plus one third of the increase in the CPI. In addition, adjustments should be made to the inflation factor to account for unusual costs that impact the providers more or less than they impact the general inflation indices, changes in regulations that impose additional costs on providers, or reduce their costs, and expected productivity improvements.

MHA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

Because of the budget process in Maryland, and to assure the appropriate level of review, the Commission believes that the most appropriate approach is one in which the Governor receives advice on this issue, and that the approach should involve the Legislature. Therefore, the Commission recommends that the Governor direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to jointly issue a report by July 1 of each year specifying the level of updating recommended for the upcoming year for community services rates paid by MHA, and that this report be provided to the Governor and the Joint Chairmen of the legislative committees overseeing the MHA budget for their consideration in the budget process. The Commission believes that: 1) an examination of the appropriate level of updating and the rationale for that level; 2) a sharing of that analysis with the appropriate parties; and 3) interaction in the budget process, creates an environment that will achieve the best result.

3. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems. In addition, uncompensated care and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern, as are copayments for gray zone clients and uncompensated care for clients with private insurance. As a partial remedy the Medicaid payments for dual eligibles should be increased to result in total payments of the Medicaid fee schedule amount.

The Commission continues to be concerned about specific rates, for example, the PRP and OMHC rates for children given the large amount of service coordination they require. MHA does pay a higher rate for children's OMHC services, so the question there is whether that differential is sufficient to account for the higher staffing and/or greater amount of coordination that is required when providing services to children. PRP's do not receive a higher rate for services to children, although greater coordination is also required in that setting.

The high copayments required by Medicare are often raised as an issue, as are the low overall payment rates for clients who are eligible for both Medicare and Medicaid. The Commission's survey confirmed that both of these are sources of uncompensated care. A bill to provide increased Medicaid payments for dual eligible beneficiaries failed in the legislature last year. However, this is an important issue and the legislature should reconsider increasing the level of payments for Medicare copayments.

Uncompensated care is likely to become an even more important issue for providers with the cutbacks that are currently being made in gray area eligibility. This will adversely affect their financial performance.

4. MHA should monitor the financial condition of the providers, to ensure that financial issues are not likely to interfere with access to, or the continuity and quality of care. MHA should check on the financial status of providers who are reporting that they are in poor financial condition, and provide additional support on billing and other issues, as appropriate.

The Commission understands that MHA is already providing some consulting assistance to providers in need of such help and that providers may decline assistance that is offered. Never the less, the Commission believes that a more formalized systematic analysis and review with targeted assistance is appropriate and timely. The Commission would offer its assistance to work with MHA in the development of such a process.

Commission Recommendations pertaining to DDA

1. The State is experiencing budget problems and may consider a variety of possible actions that would have the effect of reducing projected aggregate payments to community providers. Such cuts should not be made.

DHMH is projecting a substantial budget shortfall and in response to this shortfall may consider a variety of possible actions that would have the effect of reducing projected aggregate payments to community providers. The financial condition of some of the providers could be jeopardized by such cuts. While the analysis of the financial condition of the providers shows them to be making a small profit, 25% of the providers were incurring losses, and reductions in rates would likely increase that percentage. As a result the Commission recommends that such cuts should not be made.

2. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to issue a joint report by July 1 of each year to the Governor and the Joint Chairmen of the legislative committees responsible for overseeing the DDA budget. The report should specify the level of updating recommended for the upcoming year for community services rates paid by DDA and the rationale for this level.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems and should be developed and implemented for establishing the rates paid for DDA community services, and accordingly used in developing the DDA budget.

The DDA budget for FY 1999 included funds to update the rates and to reduce the waiting list, and the FY 2000 budget included a cost of living adjustment for wages, a rate increase, and additional funds for the Governor's waiting list initiative. Rates were also increased for FY 2001 and FY 2002. In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers. However, there is no systematic approach to providing rate increases for the providers. Additionally, the weights used to calculate the Fee Payment System (FPS) payment have not been updated. If the weights are no longer appropriate, this could result in under- or overpayment for services. Consequently, underfunding could be confused with problems in the FPS payment methodology.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be relatively simple or quite complex. It is difficult to understand why the State has not incorporated such a system for community services paid for by DDA.

The community services budget of DDA was increased in fiscal years 1999, 2000, 2001 and 2002 partly for rate increases and partly to increase coverage. However, the DDA regulations

and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues. In addition, a systematic approach to the updating of rates is the only way to ensure the long term viability of these services.

In developing the update factor DHMH should take into account the inflation rate in relevant wages, the impact of inflation on the cost of the goods and services being purchased by the providers, changes in the nature of the services being provided, the funds being provided to increase direct care worker wages, and system-wide productivity improvements. The systematic approach would be established with the specific factors to be used in calculating the update amount published several months prior to the fiscal year for which they will be applied in order to provide advance notice to the providers and allow for management responses to the anticipated changes. The basis for the adjustment should be one of the nationally available indices of inflation, or a combination of such indices. Examples include the increase in the Baltimore or national Consumer Price Index (CPI), the increase in the medical care component of the CPI, or two thirds of the increase in service worker wages plus one third of the increase in the CPI. In addition, adjustments should be made to the inflation factor to account for unusual costs that impact the providers more or less than they impact the general inflation indices, changes in regulations that impose additional costs on providers, or reduce their costs, and expected productivity improvements.

DDA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

Because of the budget process in Maryland, and to assure the appropriate level of review, the Commission believes that the most appropriate approach is one in which the Governor receives advice on this issue, and that the approach should involve the Legislature. Therefore, the Commission recommends that the Governor direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to jointly issue a report by July 1 of each year specifying the level of updating recommended for the upcoming year for community services rates paid by DDA, and that this report be provided to the Governor and the Joint Chairmen of the legislative committees responsible for overseeing the DDA budget for their consideration in the budget process. The Commission believes that: 1) an examination of the appropriate level of updating and the rationale for that level; 2) a sharing of that analysis with the appropriate parties; and 3) interaction in the budget process, creates an environment that will achieve the best result.

3. The legislature should allow the providers some limited flexibility in the use of the additional funds to be provided to increase the wages being paid to direct care workers.

The Commission's wage survey confirmed that the wage rates of direct care workers, while greater than the nominal wage rates used by DDA to build up the payment rates, are substantially below the wages paid to corresponding state workers. The legislature, in the DDA budget language, required DDA to develop a plan to provide additional funds to the providers, with the

goal of increasing the wages being paid to direct care workers. The Commission believes that the providers require some flexibility in their use of these funds, and that the majority, but not all, of these additional funds should be devoted to increasing direct care worker wages and fringe benefits. For example, because these increased funds are not complemented by a system of updating of rates then some of the increased funding may be required to offset inflation in the costs of goods and services other than increases in direct care worker wages. The providers require flexibility to make logical pay scale and benefit adjustments, and may have to revise the structure of their pay scales, which will take some time to plan.

4. Data should be collected that allows for an assessment of outcomes and quality. DDA, the provider organizations, and the Commission should work together to design this data collection process to serve the varied information needs of the parties.

In addition to the consumer satisfaction surveys discussed above, DDA should consider collecting data which allows for a comparison of outcomes, both between providers and over time. The most effective manner to collect this data should be discussed - it may be through fields added to the cost report, or a separate report distributed by DDA. DDA, the provider organizations, and the Commission should work cooperatively to design the most efficient mechanism to accomplish this goal.

COMMISSION ACTIVITIES

Commission meetings and Technical Advisory Group (TAG) meetings are generally held the first Monday of each month unless that is a holiday. Commission meetings generally run from 1 p.m. to 3 p.m. The Mental Hygiene Administration TAG meetings runs from 1 p.m. to 3 p.m. and the Developmental Disabilities Administration TAG meetings from 3 p.m. to 5 p.m. The meetings are held at:

The Meeting House
Oakland Mills Interfaith Center
5885 Robert Oliver Place
Columbia, Maryland

Commission meetings were held on, or are scheduled for, the following dates:

January 7, 2002
February 4, 2002
June 3, 2002
September 9, 2002

Technical Advisory Group meetings were held on, or are scheduled for:

March 4, 2002
April 1, 2002
May 6, 2002
August 5, 2002

The Commission is scheduled to sunset at the end of September, 2002.

FUTURE ACTIVITIES

- The Commission will continue to schedule meetings in advance to fulfil its statutory charter, and will provide substantial advance notice of the issues to be considered at these meetings..

- The Commission will continue to monitor the financial condition of the providers, and their ability to operate on a solvent basis in the delivery of effective and efficient services in the public interest. Reports will be prepared using the audited reports being collected by MHA and DDA. These reports will include an analysis of the trends in financial condition.

- The Commission plans to continue to study and make recommendations on ways in which quality and outcomes can be measured, and how to improve the incentives to provide quality care.

- The Commission will examine the issue of rate system design, with a view to recommending changes to the payment structures and alternative methodologies to incorporate better incentives for efficiency and effectiveness.

- The Commission will review the methods used to update rates, and the level of these adjustments, and recommend changes as necessary.

- The Commission will review the relationship between the changes in wages paid by providers and the change in rates paid to providers by the Department, as well as soliciting ideas on how to reduce turnover of personnel. The results of these analyses will be included in the Annual Reports.

- The Commission will utilize Technical Advisory Groups as appropriate to deliberate on specific issues, such as, wage rates, turnover, measurement of quality and outcomes, and rate structures.

- The Commission shall study the DDA augmentation grant system and the start-up grant system and any other proposed changes to the system, and make recommendations as appropriate.

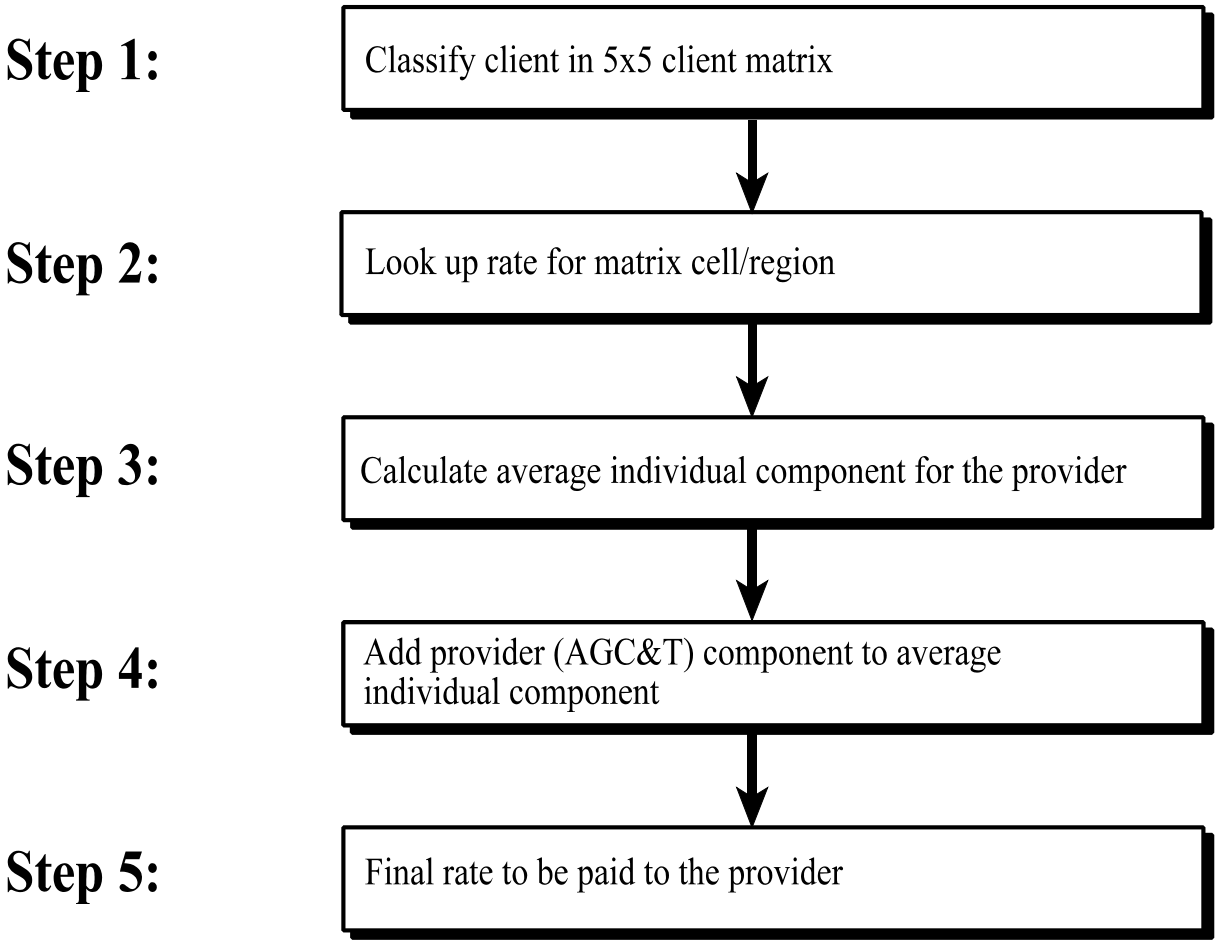
- The Commission will continue to receive public input and comment throughout the process. The Commission has been making its meeting schedule public 6 to 12 months in advance of the meetings. Detailed agendas have been made available closer to the meeting date in order to promote participation.

- Recommendations will be made to the Governor, the General Assembly, and the Secretary of the Department of Health and Mental Hygiene (DHMH) by October 1 each year. However, the Commission may issue an interim or other reports at other times as appropriate. The Commission currently plans to issue its Annual Reports in February of each year to make them more useful for the Department's budget process.

- The Commission plans to schedule additional briefings, hearings, and site visits to make itself knowledgeable about programs and services, as well as issues of concern to consumers and providers.

The Commission hopes to make recommendations relative to the above in a total package but will continue its policy of making interim recommendations as it deems appropriate.

Calculation of the Rate Under the DDA Fee Payment System



DEVELOPMENTAL DISABILITIES ADMINISTRATION

Reimbursement System

Description of the Current System

Community services for persons with developmental disabilities are delivered through community-based organizations. The majority of the service providers are nonprofit corporations. Approximately 20,000 individuals are served with a wide range of residential, vocational, and avocational support services. These services include family and individual supports that enable an individual to stay in his or her own home, day programs, supported employment, services coordination/case management, behavioral support services, medical day care, transportation, community-supported living arrangements, residential alternative living units, and residential group homes. Approximately $340 million of the Developmental Disabilities Administration's (DDA) FY 2000 budget was for community programs, $63 million was for institutional services, and about $6.4 million for administrative expenses. The $340 million in community services represented 84 percent of the agency's $407 million total budget. Approximately $100 million of this total budget was Federal funds received through the DDA's home- and community-based waiver, which provides Medicaid matching dollars for some services. Additional funds are raised by the community service providers through a combination of grants, contract revenue from sheltered workshops, contract employment, State and Federal set-aside contracts, fee-for-service (i.e., Division of Rehabilitation Services, Job Partnership Training Act, Welfare-to-Work), private pay, donations, and foundation support. The distribution of DDA expenditures is illustrated in Chart 1. Trends in the payments and volumes of service for these various components between 1997 and 2001 are shown in Charts 2 to 5.

The principal current DDA payment system is the Fee Payment System (FPS). $209 million is paid out under the FPS. The balance of payments for community programs are made through grants. The FPS has two components that address client need and service administration overhead, respectively. The individual (formerly called "client") component is for direct care and the rate paid is based on a matrix of 25 levels of client need. Reimbursement rates are partially determined by aggregate agency data related to the FPS Individual Matrix. Each agency submits reports on the functional severity levels and corresponding support requirements of its client mix. Reimbursement is based on an average matrix score. The FPS includes regional rate adjustments that increase the individual portion of the formula for certain high-cost areas. The provider component of FPS pays for administrative, general, capital and transportation costs. There are two provider rates, one for day services and one for residential services, which are being phased in over time and the phase-in will be complete in fiscal year 2002. These rates are paid per day, and do not vary across the state. A payment is made to cover transportation costs for clients who use wheel chairs. In addition, augmentation payments are made for clients with particular needs.

In fiscal year 2001 DDS commenced a rate based system for community supported living arrangements (CSLA). This system pays for services based on the hours and service needs identified are being required by the individual in their individual service plan.

Quality and outcomes

The Commission has continued to study the issues of quality of care and improvement in outcomes of care. To that end, the staff of the Commission prepared an extensive reading list of articles and studies on the definition and measurement of quality and outcomes. The Commission held a Forum to discuss these issues on October 5, 1998 and another to update its understanding of the issue on December 4, 2000. The first part of each Forum consisted of presentations from several invited speakers on the subject. The second part consisted of discussions among the attendees. A more complete summary of the 1998 Forum was provided in Appendix B-10 of the Commission's July 1999 Annual Report. A summary of the December 2000 Forum was attached as Appendix B-3 to the February 2001 Annual Report.

Regulations issued by DDA in 1998 address the issue of quality of care. In addition, the Maryland Association for Community Services (MACS) is working with the Council on Quality and Leadership to extend the role of the Council in reviewing agencies providing services to individuals with developmental disabilities in Maryland. Currently agencies have little incentive to obtain accreditation, since doing so involves incurring some expenses, while there is no tangible reward for being accredited. The Commission encourages providers to obtain accreditation from a recognized accrediting agency.

The self-determination project can be considered to be a positive step in advancing quality of care and positive outcomes, as the clients and their care managers will be provided more flexibility in deciding which services are worthwhile, and which are not worth the expense, and will be able to decide which providers to purchase services from.

The Technical Advisory Group on DDA issues is discussing the available and potential measures for quality and outcomes, and how improved incentives to provide quality of care can be built into the rate setting methodology.

Fairness and Equity

The fairness and equity of the payments are major concerns of the Commission. A consideration of fairness and equity involves an examination of (1) the rate structure and the incentives that the structure embodies, and (2) the level of the rates and whether that level is adequate. In 1998 the Commission requested preparation of a paper, Appendix B-1 of the Commission's July 1999 Annual Report, discussing incentives in rate structures. As a first step toward assessing the fairness of the level of payments, the Commission examined the wage rates being paid by DDA providers as compared with the wages paid to comparable State employees. The results of this analysis were summarized in the paper that was attached as Appendix B-2 of the Commission's July 1999 Annual Report. The conclusion reached was that the wage rates of the DDA providers were substantially lower than the comparable salaries of State employees, particularly when fringe benefits and job security were taken into account. This survey and analysis were repeated in fiscal years 2000 and 2001, with similar conclusions.

A comparison of overall expenditure levels on individuals with developmental disabilities with the corresponding expenditures in other States was made. A summary of this analysis is provided later in this section.

Wage rate increases compared with rate increases

One of the charges of the Commission is to compare the change in the wage rates paid by providers to changes in rates paid by the Department. Wage surveys performed by the Commission on an annual basis are intended to collect the data necessary to fulfill this charge. The analysis performed on the data reported in the surveys demonstrates that the wage increases have been greater than the increases in rates provided by the Department. A report on the results of the wage surveys is attached as Appendix B-2 to this report.

Updating Rates

There are two aspects to updating rates:

1. Updating of the rates to take account of inflation, regulatory changes, and other factors that influence the costs of the providers and are not within their control; and

2. Changes to the relative rates paid for different services to account for differences in the way that services are provided and that change the relative resource requirements for the different services as well as changes in the service needs of the clients.

The systems used by Medicare to update rates for inpatient payments, and the updating system used by the Health Services Cost Review Commission, were discussed in Appendix B-1 of the April 2000 Annual Report. This Appendix also discussed the issue of updating of rates more generally, and listed some of the factors that should be taken into account in designing an updating system. The Commission has recommended in each of its Annual Reports that an updating system should be developed and implemented, but to date the Department has not taken action on this recommendation.

1. System for rate adjustments

A major concern is that there is no systematic adjustment to the individual component of the rate for inflation and other factors influencing provider costs. Increases are provided if and when the State budget allows for them, and this has been rather sporadic over the past several years. The direct care wage rate used in the FPS (and formerly in the PPS) increased from $5.40 in 1992 to $5.87 for residential services and $5.99 for day services in 1998, and for 2001 was $6.89. Inflation in the economy impacts DDA providers, but there is no system for ensuring that rates are adjusted to account for that impact. This can be contrasted with some other health care payment systems that do include systematic adjustments to rates, for example, the Medicare payment systems for ambulatory surgery and inpatient hospital care and the Medicare physician fee schedule. Also, the Health Services Cost Review Commission (HSCRC), which sets the rates for all the general acute care hospitals in the State as well as the private psychiatric hospitals, has a systematic inflation adjustment system that allows most hospitals to receive an annual adjustment for the impact of inflation, productivity/intensity changes, and other factors outside of the control of the hospitals. In contrast, rate adjustments are made to the DDA payment rates based on the situation of the State budget. The lack of a systematic adjustment results in major uncertainties for the providers in their budgeting process and means that they are subject to

reductions in the resources available as inflation erodes the purchasing power of the payments being made to them. This is a major concern and should be corrected.

2. Relative rates

The DDA payment system has individual rates for 25 different levels of care, for residential and for day services, in addition to some add-ons for specific services. The relative weights of the 25 categories[1] were presumably developed on the basis of relative costs of caring for clients in these categories. These weights have not been changed much since the inception of the PPS (now the FPS) in the 1980s, however, and the Commission has a concern whether the relative weights continue to be appropriate.

Expenditure Levels Compared with Other States

The comparison of expenditure levels with those of other States was the first step in the evaluation of the reasonableness of the payments. An evaluation of relative State expenditure levels on services to developmentally disabled individuals was done based on the literature on this subject. A Commission paper discussing the results was attached as Appendix B-4 of the Commission's July 1999 Annual Report. The principal results reported are:

- Fiscal effort was defined to be public spending on mental retardation/developmental disabilities services as a percentage of State personal income. In FY 1996, Maryland ranked 30th out of 51 States.[2] This was down from 28th in 1992 and 23rd in 1988.

- In some areas the expenditures in Maryland were above the national level. Family support programs were reported to have an enrollment of 3,985 in Maryland, with an average expenditure per enrollee of $2,840, compared with a U.S. average of $1,858. Supported employment was reported to have an enrollment of 2,728, with an expenditure of $8,556 per enrollee in Maryland, compared with a U.S. average of $4,511. Supported living and personal assistance was reported to have an enrollment of 269, with a per enrollee expenditure of $32,184, compared with a U.S. average of $12,301.

- Maryland has been less successful in reducing the number of institutions as patients have been discharged from institutional settings.

- Maryland ranks fairly high on its care for individuals in community settings, and has been relatively successful in shifting patients from institutional to community settings.

[1] The individual component of the rate for a client using a day program in Baltimore varies from $7.19 for a client with the lowest level of needs to $32.33 for a client with the heaviest level of care needs on both the health/medical and supervision/assistance dimensions.

[2] For this purpose "States" includes the District of Columbia.

Geographic Variation in Rates

The individual component of the rates varies by region of the State, with the regions being:

Baltimore Metropolitan area: Baltimore City and Baltimore, Harford, Howard, Carroll, and Queen Anne's Counties

Washington, D.C., Metropolitan area: Calvert, Frederick, Prince George's, Montgomery, and Charles Counties

Rural: St. Mary's, Garrett, Caroline, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester Counties

Pittsburgh Metropolitan area: Allegany County

Wilmington Metropolitan area: Cecil County

Hagerstown Metropolitan area: Washington County

The provider component of the rates, which pays for administration, general, capital and transportation costs (AGC&T), is paid on a flat per diem, with no variation across the state. There are two different per diem rates, one for day services and one for residential services.

System modifications for fiscal year 1999 and subsequent years

On February 13, 1998, DDA issued proposed regulations to modify its system. The changes made in these regulations are improvements in the payment system, but the Commission has a concern that the changes do not go far enough. The major changes included: (1) the payment for the provider component of the rate was changed from being based on the actual costs of the individual provider with limits to flat rates for residential and day services, and (2) the individual component of the rates of the rural areas was increased to the Baltimore level. The first change improved the incentives embodied in the payment system, making it a management decision to determine to what extent AGC&T costs and other costs should be substituted for one another[3].

Detailed concerns were raised by the Commission in a letter to DDA providing comments on the proposed regulations, and this letter was attached as Appendix B-5 of the Commission's July 1999 Annual Report. The major issues raised in that letter were: (1) lack of a systematic method to update the rates and weights, (2) packages of services to be provided require more precise definition, (3) rationale for having no regional adjustment to the AGC&T component, and (4) additional payments are made for individuals who require wheelchairs, but there may be other individuals who have similar transportation costs who are not eligible for the add-on. The

[3] It should be emphasized that it is not necessarily bad to increase AGC&T costs if that increase provides benefits in terms of reduced costs elsewhere, improved collections, or improved quality of care.

administration is studying the issue of additional payments for individuals with other physical functional impairments.

Design Framework

The move from a cost-based payment for the provider component of services to flat fees for the provider component of residential and day care, i.e., for AGC&T, improves the incentives in the payment system by making providers more accountable for their cost levels. However, questions have been raised concerning the lack of any regional adjustments to the provider component of the rates to take account of regional differences in costs.

The individual component framework should be reexamined. The DDA payment system was designed in the mid-1980s. Since then the ideas underlying the provision of services to persons with developmental disabilities have changed dramatically, to a more client-centered approach, and with more self-determination on the part of clients. This suggests that it is time to revisit the overall system design and make it more appropriate to the current service delivery philosophies.

Transition

The changes to the system were phased in over a 3-year period. This appears to be a reasonable time period over which to spread the changes, and it gave time for providers to modify their cost structure to respond to the changes in their payment stream. The Commission has analyzed the impact of the changes on providers and a summary of the impact of the change in the payment system was attached as Appendix B-5 of the Commission's July 1999 Annual Report. The Commission will be monitoring the financial condition of the providers annually, and will respond rapidly if there are any undesirable changes in those financial conditions.

Efficiency and Effectiveness / Financial Status of Providers

The enabling statute of the Commission mentions efficiency and effectiveness in two contexts, requiring the Commission to consider:

- The ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest.
- The incentives and disincentives incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration.

Currently available data do not allow for any detailed analysis of the efficiency and effectiveness of the providers. However, the Commission has done analysis of the financial situation of the providers using Audited Financial Reports (AFR) filed by the providers with DDA. The analysis was done on the AFRs for fiscal years 1997, 1998, 1999, and 2000. In fiscal year 1997 overall profit margins of the providers were positive, at 2%, but a large percentage of the providers, 36%, had negative margins. The financial situation of the providers improved in fiscal year 1998, with the median margin increasing to 4.6%, and the percentage with negative margins dropping to 22%. In fiscal year 1999 the median margin was 3.1%, but with far more providers included in the analysis, and a smaller percentage of providers, only 20%, had negative margins.

Fiscal year 2000 showed a similar median margin of 3.2%, with 25% of the providers having negative margins. The Commission's report on these financial analyses is attached as Appendix B-1.

The Commission also plans an analysis of the data submitted in the Cost Report for an assessment of relative efficiency and effectiveness.

Turnover and wage levels

Based on input and advice from the Technical Advisory Group on DDA issues a wage rate and turnover survey was been developed and mailed to providers in the Fall of 2000. A report summarizing the results of that survey was attached as Appendix B-5 to the February 2001 Annual Report. The survey was sent out twice more to providers that did not respond and responses were received from 122 providers after combining the different mailings. The analysis of these survey responses once again showed that direct care workers are paid substantially less than corresponding state workers, particularly when fringe benefits are taken into account. Turnover rates have increased and are now around 50% for aides overall, and higher for aides in residential services.

Wage rates of direct care workers increased over 7% between fiscal year 2000 and fiscal year 2001, but are still well below the wage rates of comparable state positions.

Uncompensated care

Based on the survey completed in 1999 non-reimbursable expenses[4] comprised 1.2% of total expenses. Only 14 providers (of the 51) reported a non-zero amount for non-reimbursed expenses, and for these providers the total non-reimbursed expenses comprised 3.76% of the total expenses. Several providers commented that their non-reimbursed expenses were low because they did not provide services that the state did not pay for. A revised survey on uncompensated care and related issues was sent to the providers early in 2000. The results of this survey were similar to those reported above, with overall uncompensated care reported to be just under 1% of revenue. Uncompensated care is discussed in more detail in the papers on the financial condition of the providers.

Uncompensated care does not appear to be a major problem for the providers contracting with DDA.

Future system

The Commission will continue to review changes to the FPS, and to the system used for augmentation grants, and will comment as appropriate.

[4] After consultation with MACS it was determined that this is the term that would be best understood by the providers.

RECOMMENDATIONS

1. The State is experiencing budget problems and may consider a variety of possible actions that would have the effect of reducing projected aggregate payments to community providers. Such cuts should not be made.

DHMH is projecting a substantial budget shortfall and in response to this shortfall may consider a variety of possible actions that would have the effect of reducing projected aggregate payments to community providers. The financial condition of some of the providers could be jeopardized by such cuts. While the analysis of the financial condition of the providers shows them to be making a small profit, 25% of the providers were incurring losses, and reductions in rates would likely increase that percentage. As a result the Commission recommends that such cuts should not be made.

2. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to issue a joint report by July 1 of each year to the Governor and the Joint Chairmen of the legislative committees responsible for overseeing the DDA budget. The report should specify the level of updating recommended for the upcoming year for community services rates paid by DDA and the rationale for this level.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems and should be developed and implemented for establishing the rates paid for DDA community services, and accordingly used in developing the DDA budget.

The DDA budget for FY 1999 included funds to update the rates and to reduce the waiting list, and the FY 2000 budget included a cost of living adjustment for wages, a rate increase, and additional funds for the Governor's waiting list initiative. Rates were also increased for FY 2001 and FY 2002. In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers. However, there is no systematic approach to providing rate increases for the providers. Additionally, the weights used to calculate the Fee Payment System (FPS) payment have not been updated. If the weights are no longer appropriate, this could result in under- or overpayment for services. Consequently, underfunding could be confused with problems in the FPS payment methodology.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be relatively simple or quite complex. It is difficult to understand why the State has not incorporated such a system for community services paid for by DDA.

The community services budget of DDA was increased in fiscal years 1999, 2000, 2001 and 2002 partly for rate increases and partly to increase coverage. However, the DDA regulations and the budget process do not include any systematic approach to updating of rates from year to

year. Wages are a substantial portion of provider costs so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues. In addition, a systematic approach to the updating of rates is the only way to ensure the long term viability of these services.

In developing the update factor DHMH should take into account the inflation rate in relevant wages, the impact of inflation on the cost of the goods and services being purchased by the providers, changes in the nature of the services being provided, the funds being provided to increase direct care worker wages, and system-wide productivity improvements. The systematic approach would be established with the specific factors to be used in calculating the update amount published several months prior to the fiscal year for which they will be applied in order to provide advance notice to the providers and allow for management responses to the anticipated changes. The basis for the adjustment should be one of the nationally available indices of inflation, or a combination of such indices. Examples include the increase in the Baltimore or national Consumer Price Index (CPI), the increase in the medical care component of the CPI, or two thirds of the increase in service worker wages plus one third of the increase in the CPI. In addition, adjustments should be made to the inflation factor to account for unusual costs that impact the providers more or less than they impact the general inflation indices, changes in regulations that impose additional costs on providers, or reduce their costs, and expected productivity improvements.

DDA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

Because of the budget process in Maryland, and to assure the appropriate level of review, the Commission believes that the most appropriate approach is one in which the Governor receives advice on this issue, and that the approach should involve the Legislature. Therefore, the Commission recommends that the Governor direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to jointly issue a report by July 1 of each year specifying the level of updating recommended for the upcoming year for community services rates paid by DDA, and that this report be provided to the Governor and the Joint Chairmen of the legislative committees responsible for overseeing the DDA budget for their consideration in the budget process. The Commission believes that: 1) an examination of the appropriate level of updating and the rationale for that level; 2) a sharing of that analysis with the appropriate parties; and 3) interaction in the budget process, creates an environment that will achieve the best result.

3. The legislature should allow the providers some limited flexibility in the use of the additional funds to be provided to increase the wages being paid to direct care workers.

The Commission's wage survey confirmed that the wage rates of direct care workers, while greater than the nominal wage rates used by DDA to build up the payment rates, are substantially below the wages paid to corresponding state workers. The legislature, in the DDA budget language, required DDA to develop a plan to provide additional funds to the providers, with the goal of increasing the wages being paid to direct care workers. The Commission believes that the

providers require some flexibility in their use of these funds, and that the majority, but not all, of these additional funds should be devoted to increasing direct care worker wages and fringe benefits. For example, because these increased funds are not complemented by a system of updating of rates then some of the increased funding may be required to offset inflation in the costs of goods and services other than increases in direct care worker wages. The providers require flexibility to make logical pay scale and benefit adjustments, and may have to revise the structure of their pay scales, which will take some time to plan.

4. Data should be collected that allows for an assessment of outcomes and quality. DDA, the provider organizations, and the Commission should work together to design this data collection process to serve the varied information needs of the parties.

In addition to the consumer satisfaction surveys discussed above, DDA should consider collecting data which allows for a comparison of outcomes, both between providers and over time. The most effective manner to collect this data should be discussed - it may be through fields added to the cost report, or a separate report distributed by DDA. DDA, the provider organizations, and the Commission should work cooperatively to design the most efficient mechanism to accomplish this goal.

MENTAL HYGIENE ADMINISTRATION

Current Reimbursement System

Description of the Current Payment System

Community services for individuals with severe and persistent mental illness are provided by community agencies, which are mostly nonprofit corporations. Over 60,000 individuals are served with a wide range of providers and services including outpatient clinics, psychiatric rehabilitation and residential rehabilitation programs, mobile treatment, crisis residential treatment, and other services.

Chart 6 shows the distribution of MHA expenditures by type of service, and Charts 7 though 9 show the changes in MHA expenditures between fiscal years 1998, 1999, 2000 and 2001. It is of interest that the expenditures on state hospitals have been steadily increasing, in spite of declining volumes of service. This is the same pattern that was observed in the State Residential Centers funded by DDA, and contrasts with the MHA outpatient services, expenditures on which have been steadily declining. Expenditures on psychiatric rehabilitation services have been growing, as have the expenditures on services coordination.

The Public Mental Health System (PMHS) funds a broad range of services provided by various types of individual providers, including physicians, psychologists, social workers, nurse psychotherapists, and professional counselors. Until July 1, 1997, MHA reimbursed providers through grants and Medical Assistance payments. However, this changed when the Maryland Medical Assistance Program (Medicaid) obtained an 1115 waiver from the Health Care Financing Administration (HCFA). With the implementation of the waiver, mental health benefits were carved out and are provided through the PMHS. The PMHS funds services for Medical Assistance recipients as well as "gray area" consumers (individuals not eligible for Medicaid, but eligible for publicly subsidized services) of mental health services. Under the new system the reimbursement methodology has changed from grants to fee-for-service for most services. The fee schedule was modified effective July 1, 1998, with some codes being added, and substantial increases in the payments rates for some of the clinic services. A new fee schedule, with some substantial additional increases, was implemented in March 2000.

MHA is using an administrative services organization (ASO), Maryland Health Partners (MHP), to help administer the new system. MHP provides 24-hour screening and helps determine if the individual is eligible for publicly funded services. MHP also refers individuals to service providers, preauthorizes nonemergency care, conducts utilization review, collects data, and processes billing claims and payments. Utilization review is intended to ensure that all services are clinically appropriate. The Core Service Agencies (CSAs) continue to have the responsibility for planning and monitoring services at a local level.

The current payment methodology represents a significant change from the way MHA did business in the past (i.e., prior to July 1, 1997) and from the way providers were accustomed to being reimbursed.

Subsequent to the changes made on July 1, 1997, there were major problems with accumulating bills, paying based on these bills, and reporting on the services provided and amounts paid to providers for these services. These problems appear to have been largely resolved.

Quality and outcomes

The current payment systems do not include rewards for high quality and good outcomes or penalties for the converse. While the assessment of these variables is difficult and work on this subject is still at a developmental stage, there is much activity on this front, with an emphasis on examining the impact of services on the welfare, independence, and lifestyle of clients rather than on the process by which care is delivered. The Commission has studied the literature on quality and outcomes, has met with agencies responsible for quality evaluation, and held a Forum on Quality and Outcomes on October 5, 1998. A summary of the results of that Forum were provided in Appendix B-10 of the Commission's July 1999 Annual Report. The Technical Advisory Group on MHA issues has started discussion on this issue, and a second meeting devoted to MHA quality and outcome issues was held on January 8, 2001. A summary of that meeting was attached as Appendix B-4 to the February 2001 Annual Report.

MHA has sponsored a consumer satisfaction survey, which is an important component of the measurement of quality of care. The results of that survey are summarized in "Report on Maryland Public Mental Health System: Consumer Satisfaction and Outcomes 1998", February 1999, by Maryland Health Partners and R.O.W. Sciences, Inc. This study found that a large majority of the respondents (76% child/family, 78% adult) were satisfied with the mental health services they received.

The Commission intends to continue to monitor the tools available to measure quality and outcomes, and to make recommendations on their use when appropriate. A paper on the measurement of quality and outcomes is currently in preparation and will be issued in 2002.

The Commission received a great deal of information on the measurement of quality and outcomes through its public forums and from literature surveys done by its technical consultant. Based on this information the Commission concluded that the measurement of quality of services and of outcomes are still at a developmental stage. It would be premature to base payments on specific measurements of quality and outcomes. However, there are some national accrediting organizations working on refining the measurement of quality and outcomes and on the credentialing of mental health workers. Currently providers have little or no incentive to become accredited by these organizations as they would incur costs in going though the accreditation process, but would not receive any tangible benefits from being accredited. The process of becoming accredited causes providers to critically examine their processes and systems, and to establish measures they might not otherwise consider.

MHA could consider a program to help providers defray the costs of accreditation, and the costs they, or their employees, incur in the process of credentialing employees.

In addition to the consumer satisfaction surveys discussed above, the MHA should consider collecting data which allows for a comparison of outcomes, both between providers and over time. The most effective manner to collect this data should be discussed - it may be through a

cost report, data collected by the fiscal intermediary, a separate report distributed by MHA, or in association with billing data. MHA, the provider organizations, and the Commission should work cooperatively to design the most efficient mechanism to accomplish this goal.

Fairness and Equity

As was mentioned in the discussion of the DDA payment system, the fairness and equity of the payments are major concerns of the Commission. A consideration of fairness and equity involves an examination of (1) the rate structure and the incentives that the structure embodies, and (2) the level of the rates and whether that level is adequate. A paper, Appendix B-1 of the Commission's July 1999 Annual Report, was prepared discussing incentives in rate structures. In 1998, as a first step toward assessing the fairness of the level of payments, the Commission examined the wage rates being paid by the MHA providers as compared with the wages paid to comparable State employees. The results of this analysis were summarized in a paper that was attached as Appendix B-2 of the Commission's July 1999 Annual Report.

The Maryland Association of Psychiatric Support Services (MAPSS) conducted studies of wage levels in 1998, 1999, 2000 and 2001 and summaries of the results have been included in prior Annual Reports. A summary of the results of the fiscal year 2001 study is attached as Appendix C-3 of this Annual Report. The conclusion reached is that, after the differences in fringe benefits are taken into account, the wage levels paid by the community providers are 10 to 20% below the wages paid by the state for corresponding positions.

The Commission prepared a survey of the financial condition of providers which the Core Service Agency (CSA) Directors revised and sent out to their providers. 24 responses were received to this survey. A report on the results of that survey was attached as Appendix B-6 to the February 2001 Annual Report. Many of the OMHCs are in very poor financial condition, with major losses. This problem is sufficiently widespread that it could result in access problems. This report has been expanded based on additional information and is attached as Appendix C-1 to this report. The additional information has simply confirmed the financial weakness of the OMHCs, and suggests that there may be closures of additional clinics if action is not taken to improve their financial position. The financial problems of the public clinics are so severe that they cannot be addressed solely by the management of the OMHCs, rate increases will be required to stabilize the system.

Geographic Variation in Rates

There is a single rate schedule for the State, with no adjustments for wage level or cost-of-living differences in different parts of the State. The Commission questions the rationale for having no difference in payment rates across the State, given that there are regional differences in costs being incurred by providers. The analysis of the financial status of the providers, discussed later in this report, was done by region in order to determine whether the differences in costs are resulting in differences in financial performance. However, the results of this analysis were not conclusive.

Updating of Rates

There are two aspects to updating rates:

1. Rate adjustments to take into account inflation, regulatory changes, and other factors that influence the costs of the providers and are not within their control, and

2. Changes to the relative rates paid for different services to account for differences in the way that services are provided and that change the relative resource requirements for the different services, as well as changes in the service needs of the clients.

1. System for rate adjustments

A major concern was that there was no systematic adjustment to the rates for inflation and other factors influencing provider costs. Increases are provided if and when the State budget allows for them, and this was rather sporadic over the past several years. Inflation in the economy affects the MHA providers, but there is no system for ensuring that rates are adjusted to account for that impact. This can be contrasted with some other health care payment systems that do include systematic adjustments to rates, e.g., the Medicare payment systems for ambulatory surgery and inpatient hospital care and the Medicare physician fee schedule. Also, the HSCRC, which sets the rates for all the general acute care hospitals in the State as well as the private psychiatric hospitals, has a systematic inflation adjustment system that allows most hospitals to receive an annual adjustment for the impact of inflation, productivity/intensity changes, and other factors outside of the control of the hospitals. In contrast, rate adjustments are made to the MHA payment rates based on the situation of the State budget. The lack of a systematic adjustment results in major uncertainties for the providers in their budgeting process and means that they are subject to reductions in the resources available as inflation erodes the purchasing power of the payments being made to them. This is a major concern and should be corrected. When increases were provided they were often tied to the cost-of-living adjustments provided for state employees. While this adjusted for wage increases, it did not take account of the impact of inflation on the other costs incurred by the providers.

2. Relative rates

Because of the way in which the rates have been developed, the relativity of the rates does not appear to be a major issue under the new fee schedule. However, the Commission will continue to observe the impact of the fee schedule. Attention should be paid to the relative rates as the rates are updated in the future. In particular, the Commission has received some complaints from providers that the rates for children are too low.

The Commission invited speakers from the Health Care Financing Administration and the Health Services Cost Review Commission to explain the methods these agencies use to update payment rates. A summary of these presentations, together with a discussion of some of the key issues that should be taken into account in the design of an updating system, as included in Appendix B-1 of the April 2000 Annual Report. The Commission has discussed this issue with MHA and intends to continue its work on updating.

Turnover and wage levels

The Commission carried out a survey on staff turnover rates. The year for which data were requested was fiscal year 1998. 20 providers responded to the survey. The Commission's findings from the survey were:

- Nationally turnover for direct care staff was around 20%.
- In Maryland the turnover of direct care staff was 29%.
- Turnover in Maryland was higher than that reported in the literature, so it is important to address the issue.
- There is a correlation between pay levels and turnover, and low wages and poor benefits are reported in the literature and by survey respondents to be major reasons for turnover.

The complete report on the survey was attached as Appendix B-7 of the Commission's July 1999 Annual Report.

An expanded wage survey was designed with input from the Technical Advisory Group on MHA issues, and was mailed to OMHC providers in January 2000. However, so few responses were received that no meaningful analysis was possible.

MAPSS carried out wage surveys in the falls of 1999 and 2000. A summary of the results of the 1999 survey was attached as Appendix B-2 to the April 2000 Annual Report and a summary of the fall 2000 survey (FY 2001 data) is attached as Appendix C-3 to this report.. The Commission is required to compare the increases in the rates paid to providers with the increases in the wage rate paid by providers. The results of the survey show that over the past three years the psychiatric rehabilitation providers have provided wage increases for their direct care workers which are substantially higher than the rate increases they have received over the same time period.

Uncompensated Care

Uncompensated care was one of the issues included in a survey of the PRP providers mailed early in 2000. For those PRP providers that reported an amount for uncompensated care the uncompensated care was 3.45% of total revenue.

Uncompensated care, i.e., bad debts and charity care, are major concerns. Commission staff have discussed the issue of uncompensated care with several of the provider organizations to obtain an understanding of the nature of the care that is uncompensated. To a large extent the uncompensated care appears to be services that do not appear on the fee schedule, but which the providers consider they have to perform to adequately care for their clients. Case management was an issue that recurred in these discussions. While there is a fee for case management, it is only paid for intensive case management, and there are less intensive case management services that do not qualify for payment but do absorb staff time. MHA is aware of this issue and is working to address it. The fee schedule implemented in the spring of 2000 increased the payment for intensive case management. An allowance for lower levels of case management is built into some of the other rates in the fee schedule. Medicare copayments appear to be a source of uncompensated care.

The directors of the Core Service Agencies (CSA) modified a Commission survey which had received an inadequate response rate, and sent to it their associated agencies in the summer of 2000. They succeeded in achieving a response rate of about 25%, and the results of the analysis of the responses was attached as Appendix B-6 to the February 2001 Annual Report. The results of this survey suggest that about half the OMHCs are losing money, and that these losses are compounded by high levels of accounts receivable. Uncompensated care is relatively high and is a major contributing factor to the losses being incurred. There are three major components to the uncompensated care:

- unpaid Medicare copayments
- the low level of payment for dual eligible Medicare/Medicaid beneficiaries
- unpaid charges for clients with insurance

Efficiency and Effectiveness / Financial Status

Provider efficiency presents a different challenge under a fee-for-service payment system than under a grant-based system. With the advent of the new payment system on July 1, 1997, MHA stopped requiring that cost reports be filed by the providers. This makes it difficult to assess the relative efficiency of providers in their production of services without engaging in an expensive and time-consuming data collection effort. The efficiency of utilization of services may be able to be studied once sufficient billing data are available under the new payment system. The Commission will continue to monitor the status of the billing and payment for services with a view to using the billing data for analysis once sufficient reliable data are available.

The Commission will be looking at alternative rate structures that provide greater incentives for effective treatment, while keeping in mind the current lack of quality review mechanisms to counterbalance the incentives to underserve that might be embodied in a payment system with more highly aggregated units of payment.

The Commission has done an evaluation of the financial status of the psychiatric rehabilitation providers using Audited Financial Reports (AFR) of the providers. For fiscal year 1997 the median margin for the Psychiatric Rehabilitation providers was only 0.5% and 41% of the providers in the sample has negative profit margins. In fiscal year 1998 the situation was much improved, with a median margin of 7.8%, and 22% of the providers showing negative profit margins. A repeat of the study using data for fiscal year 1999 produced similar results, but with fewer providers, only 18%, having negative profit margins. A complete discussion of the study, together with discussion of other financial indicators, was provided in Appendix B-7 of the February 2001 Annual Report. The financial condition in FY 2000 is probably similar to that reported for 1999, but changes for the worse are expected in the current year due to reductions in gray area eligibility, constraints on the frequency and duration of care, and the impact of inflation in wages and other goods and services purchased by the providers, in the absence of any rate update.

The survey of OMHCs discussed in the previous section shows that the providers responding were generally in very poor financial condition. A more recent survey performed by Council on Behavioral Health (CBH) shows that the financial condition of the OMHCs continues to be poor, and a study of the public OMHCs commissioned by MHA shows their financial condition to be

dire. A paper discussing all these results is attached as Appendix C-1 to this report. With the collection of audit reports by MHA the Commission expects to be able to carry out a much more comprehensive analysis of the financial condition of the providers in the coming year. The Commission has reported on the financial condition of the psychiatric rehabilitation providers in previous Annual Reports. Appendix C-2 is short summary and update of the previous results. A more extensive analysis of the financial condition of the psychiatric rehabilitation providers is planned for the spring of 2002.

The MHA has experienced budget shortfalls in recent years, and it is anticipated that a budget shortfall will occur again in the current fiscal year. These shortfalls appear to have been due to an underestimate of the volume of services that was provided. It appears that the volume of service being provided is flattening out, so this may not be a problem in the future. This year, in response to these shortfalls, reductions are being made in gray area eligibility. In addition, other required changes in the payment system have been overshadowed by the budget shortfalls, for example, the need for a systematic updating system for rates, and additional payments for Medicare copayments for dually eligible clients.

Data

The Commission would like to be able to track utilization for purposes of assessing provider relative efficiency and effectiveness and to examine differences and trends in treatment. The paucity of billing and payment data available for analysis has been a major problem for the Commission in doing this. Data from periods prior to July 1, 1997, are no longer relevant, given the dramatic changes in the payment system that occurred at that time. The Commission hopes and anticipates that sufficient accurate data will become available in FY 2002 to allow for a meaningful analysis.

Integration of Payment Modalities

The current payment system does not provide good financial incentives to control utilization or direct clients to the most appropriate modality. The control of utilization is entirely dependent on administrative review by the ASO and the system has limited financial incentives for provider efficiency and effectiveness. The Commission conducted a literature review on the available systems which provide more comprehensive incentives for efficient and effective provision of care and has had some discussion on this issue at its public meetings. In these deliberations the Commission is aware that incentives to provide care efficiently may also be incentives to underserve, and that quality review mechanisms are required as a counterbalance. The development of good quality review and outcome measures for behavioral health is still at the developmental stage.

Future System

Integration with Section 1115 Waiver

The Section 1115 Waiver applies to the majority of physical health Medicaid payments and pays for most of these services under a capitation payment system, as well as behavioral health, which is paid under a separate fee-for-service system. Many States have followed this model of separating the payments for physical and behavioral health under managed care programs. Reasons for adopting this approach include: (1) a desire to ensure that savings on behavioral health are retained in the behavioral health area rather than channeled into physical health; (2) protecting the integrity of services; (3) retaining the traditional providers who would not have qualified as capitation providers; and (4) having the State retain the risk for service utilization rather than transferring the risk to a profit-making entity. The incentives to control utilization embodied in the capitation payment system for physical health are much stronger and more comprehensive than those embodied in the payment systems for behavioral health currently in use in Maryland. However, some States that have moved to capitation payment systems for behavioral health have experienced problems with access to care and with administration of the system, but these problems may be the result of poor implementation rather than intrinsic in the payment structure. Accordingly, the Commission does not advocate a capitation payment system for behavioral health at this time, but believes it may be desirable to move the payment system(s) for behavioral health in the direction of more coordinated mental health and primary care, with stronger incentives to utilize services effectively and achieve consumer outcomes, provided adequate quality control mechanisms are available.

The Commission will observe the performance of the "capitation" pilot demonstration[5] currently taking place in Baltimore City and take the results of that demonstration, as well as the results of innovative payment systems in other States, into account in developing recommendations on the direction that should be taken.

New Payment Structure Evaluation

One of the first papers prepared for the Commission was a discussion of the incentives that are embodied in rate structures and how the design of the rates influences those incentives and therefore affects provider behavior patterns. The Commission wishes to see the payment systems move toward greater aggregation of services and more comprehensive incentives to provide high-quality care as effectively and efficiently as possible. An example of a payment structure to accomplish this might be a system involving case rates for selected packages of services, but with limits on gains or losses on any client.

RECOMMENDATIONS

[5] This demonstration uses case rates for a limited, intensely ill, population.

1. The State is considering a variety of possible actions that would have the effect of reducing projected aggregate payments to providers, such as cutting the level of authorized services for community service providers, and cutting back on gray area eligibility in order to mitigate the budget shortfall. These reductions should not be made.

DHMH is projecting a substantial budget shortfall and in response to this shortfall is considering a variety of possible actions that would have the effect of reducing projected aggregate payments to providers, such as cutting the level of authorized services to be provided by community service providers and making the gray area eligibility criteria more restrictive. The financial condition of the providers, and particularly the OMHCs, is precarious, and the viability of some of the providers could be jeopardized by such cuts. Moreover, the savings in the MHA budget resulting from reductions in gray area eligibility should not be taken at face value, as they are likely to be offset by increased expenditures in other areas, for example, the criminal justice system, and increased emergency department and inpatient hospital utilization, including both general acute and state hospitals.

The Commission recommends that such cuts should not be made.

2. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to issue a joint report by July 1 of each year to the Governor and the Joint Chairmen of the legislative committees responsible for the MHA budget. The report should specify the level of updating recommended for the upcoming year for community services rates paid by MHA and the rationale for this level.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems, and should be developed and implemented for establishing the rates for MHA community services, and in developing the MHA budget. In addition, the base rate in the fee schedule should be reviewed for adequacy on a periodic basis.

The community services rates paid by MHA were increased in fiscal years 1999 and 2000. However, the MHA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs, so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be quite simple or relatively complex. It is difficult to understand why the State has not incorporated such a system for community services paid for by MHA.

In developing the update factors DHMH should take into account such factors as the differential in wage rates including fringe benefits between direct care workers who work in community service providers and the corresponding state workers, the inflation rate in relevant wages, the

impact of inflation on the cost of the goods and services being purchased by the providers, changes in the nature of the services being provided, geographic differences in labor costs, and system-wide productivity improvements. Alternatively, the updated rates could be based on a re-evaluation of the rates being paid for the services by private payers, where this is applicable. The systematic approach would be established with factors to be used in calculating the update amount published several months prior to the fiscal year for which they will be applied in order to provide advance notice to the providers and allow for management responses to the anticipated changes. The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

The basis for the adjustment should be one of the nationally available indices of inflation, or a combination of such indices. Examples include the increase in the Baltimore or national Consumer Price Index (CPI), the increase in the medical care component of the CPI, or two thirds of the increase in service worker wages plus one third of the increase in the CPI. In addition, adjustments should be made to the inflation factor to account for unusual costs that impact the providers more or less than they impact the general inflation indices, changes in regulations that impose additional costs on providers, or reduce their costs, and expected productivity improvements.

MHA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

Because of the budget process in Maryland, and to assure the appropriate level of review, the Commission believes that the most appropriate approach is one in which the Governor receives advice on this issue, and that the approach should involve the Legislature. Therefore, the Commission recommends that the Governor direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to jointly issue a report by July 1 of each year specifying the level of updating recommended for the upcoming year for community services rates paid by MHA, and that this report be provided to the Governor and the Joint Chairmen of the legislative committees overseeing the MHA budget for their consideration in the budget process. The Commission believes that: 1) an examination of the appropriate level of updating and the rationale for that level; 2) a sharing of that analysis with the appropriate parties; and 3) interaction in the budget process, creates an environment that will achieve the best result.

3. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems. In addition, uncompensated care and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern, as are copayments for gray zone clients and uncompensated care for clients with private insurance. As a partial remedy the Medicaid payments for dual eligibles should be increased to result in total payments of the Medicaid fee schedule amount.

The Commission continues to be concerned about specific rates, for example, the PRP and OMHC rates for children given the large amount of service coordination they require. MHA does pay a higher rate for children's OMHC services, so the question there is whether that differential is sufficient to account for the higher staffing and/or greater amount of coordination

that is required when providing services to children. PRP's do not receive a higher rate for services to children, although greater coordination is also required in that setting.

The high copayments required by Medicare are often raised as an issue, as are the low overall payment rates for clients who are eligible for both Medicare and Medicaid. The Commission's survey confirmed that both of these are sources of uncompensated care. A bill to provide increased Medicaid payments for dual eligible beneficiaries failed in the legislature last year. However, this is an important issue and the legislature should reconsider increasing the level of payments for Medicare copayments.

Uncompensated care is likely to become an even more important issue for providers with the cutbacks that are currently being made in gray area eligibility. This will adversely affect their financial performance.

4. MHA should monitor the financial condition of the providers, to ensure that financial issues are not likely to interfere with access to, or the continuity and quality of care. MHA should check on the financial status of providers who are reporting that they are in poor financial condition, and provide additional support on billing and other issues, as appropriate.

The Commission understands that MHA is already providing some consulting assistance to providers in need of such help and that providers may decline assistance that is offered. Never the less, the Commission believes that a more formalized systematic analysis and review with targeted assistance is appropriate and timely. The Commission would offer its assistance to work with MHA in the development of such a process.

ACRONYMS

AGC&T: Administrative, General, Capital, and Transportation

ASO: Administrative Services Organization

CBH: Council for Behavioral Health (formerly MAPSS and MCCMHP)

CMS: Center for Medicare and Medicaid Services (formerly HCFA)

CPT-4: Current Procedural Terminology, fourth edition

CSA: Core Service Agency

CSRRC: Community Services Reimbursement Rate Commission

DDA: Developmental Disabilities Administration

DHMH: Department of Health and Mental Hygiene

DRG: Diagnosis-related Group

FPS: Fee Payment System

HCACC: Health Care Access and Cost Commission

HCFA: Health Care Financing Administration

HSCRC: Health Services Cost Review Commission

MACS: Maryland Association of Community Services

MAPSS: Maryland Association of Psychiatric Support Services

MCCMHP: Maryland Council of Community Mental Health Programs, Inc.

MHA: Mental Hygiene Administration

MHCC: Maryland Health Care Commission

MHP: Maryland Health Partners

OMHC: Outpatient Mental Health Clinic

PMHS: Public Mental Health System

PPS: Prospective Payment System

GLOSSARY OF TECHNICAL TERMS

Administrative Services Organization (ASO): An organization retained to provide administrative services, such as utilization review, preauthorization of services, and payment of claims.

Augmentation grants: Grants to pay for additional services provided to clients who have needs that are in excess of those typically experienced.

Capitation payment: A payment for a defined range of services for a defined period of time that may vary with the characteristics of the client. Normally, the capitation payment is expressed as a set amount per member per month. These rates are normally not affected by the number or type of actual services provided to the client.

Case rates: Payment rates that are based on the characteristics of the client and cover all of a defined range of services for a defined period of time. These rates are normally not affected by the number or type of actual services provided to the client.

Copayment: A portion of a bill that is the responsibility of the patient and that applies when certain services are rendered. The amount usually varies by the nature of the service and the amount of the bill. This payment supplements the payment that is made by a third-party payer.

Core Service Agency (CSA): A county-level agency responsible for planning and monitoring services at the local level.

CPT-4 codes: Current Procedural Terminology, fourth edition. A standardized system for numerically encoding health care procedures.

Fee-for-service: A payment system in which payments are made for individual services provided using a preset fee schedule.

Fee Payment System: The principal payment system used by DDA. This is the successor to the DDA PPS.

Gray-area individuals: Individuals who are not eligible for Medicaid, but who are eligible for publically subsidized services.

Health Care Access and Cost Commission (HCACC): An independent State of Maryland commission responsible for, among other things, collecting and disseminating data on health practitioner payments.

Health Care Financing Administration (HCFA): The Federal agency responsible for, among other responsibilities, administering the Medicare and Medicaid programs. Now renamed to Center for Medicare and Medicaid Services (CMS).

Health Services Cost Review Commission (HSCRC): An independent State of Maryland commission responsible for setting the rates of the hospitals in Maryland.

Home- and community-based waiver: A waiver provided to the State by the Federal Government allowing the Medicaid program to pay for services in the patient's home or in the community, rather than requiring that the services be provided in an institutional setting.

Individual (or client) component: The portion of the payment rate that is based on the requirements of the individual client.

Maryland Health Care Commission: The State agency formed by the combination of the Health Care Access and Cost Commission and the Health Resources Planning Commission.

Medicaid: An alternative name for the Medical Assistance Program.

Medical Assistance Program: A State-run program that pays for health care and long-term care services to individuals who satisfy certain qualifying criteria, particularly including income limits. This program is jointly funded by the State and Federal Governments.

Medicare: A Federal program that pays for acute health care services, including but not limited to inpatient hospital, outpatient, and physician services, for elderly or disabled individuals.

Prospective Payment System (PPS): A payment system in which the payment rate is established in advance of the provision of services and is not altered based on the actual costs incurred by the provider.

Provider component: The portion of the payment rate that is intended to pay for administrative services and overhead. Specifically, this portion of the payment covers administrative, capital, general, and transportation costs.

Section 1115 Waiver: A waiver of Medicaid regulations provided by the U.S. Department of Health and Human Services to a State allowing for a managed care program for all or part of the Medicaid beneficiary population.

Supported employment: The provision of services related to helping a client find work or retain employment.

Transition plan: A plan to alleviate the immediate impact of the change in the payment system by phasing in the impact over a period of time.

APPENDIX A

Biographical Sketches of Community Services Reimbursement Rate Commission Members

Lloyd T. Bowser, Sr., B.S.
Lloyd T. Bowser, Sr. is self-employed as a Human Resources Consultant for the public and private sectors. He has a B.S. in Business Management. During Mr. Bowser's diverse federal career, he worked in a wide variety of capacities in the human resources and budgetary areas. He served in two branches of the military, and, over the years worked for six federal agencies. Mr. Bowser recently retired from a career in the federal service as a Senior Level Executive after having served a lengthy career in progressively responsible administrative and executive positions. For the 18 years prior to his retirement he was an Area Manager for the U.S. Office of Personnel Management.

For the past 30 years, Mr. Bowser has pursued a second career as a volunteer in a number of different arenas. He served as chairman of the Baltimore Federal Executive Board's Human Resources Council. He also chaired the FEB's Focus on the Drug Picture Program, which received national and international acclaim. Mr. Bowser was appointed by Baltimore's mayor to three consecutive terms on the Baltimore city School Board. He chaired the personnel and credentials committee the Board's only standing committee. He is presently active on a number of boards including the American Red Cross. Mr. Bowser has received numerous professional and civic awards including citations from the President, the Governor and several mayors. He was honored with a Maryland Senate Resolution and Proclamation for his community service accomplishments. He received a citation from the principals of the three Career and Technology senior high schools in Baltimore City for his support and contributions for their schools' vocational education programs.

Joan Petersen Clement, M.S.W., R.P.R.P.
Joan Petersen Clement has more than 25 years' experience in working with programs, organizations, and individuals in the field of psychiatric rehabilitation. She served as the Executive Director of St. Luke's House, Inc., a nonprofit, comprehensive mental health and psychiatric rehabilitation program in Bethesda, Maryland, serving adult and young adult consumers with mental illness from 1980 to May 1998. She was Chief Program Officer of the International Association of Psychosocial Rehabilitation Services from 1998 to 2001.

Ms. Clement earned her M.S.W. from Ohio State University and is a Registered Psychiatric Rehabilitation Practitioner.

Jean Marie Frank, B.S.

Jean Frank worked for more than 27 years for the Social Security Administration (SSA). Her experience at SSA included work in disability operations and disability systems. She retired while holding the position of Director of the Division of Planning and Control in the Office of Systems Requirements. Ms. Frank received a B.S. in Social Studies from the Johns Hopkins University and a B.S. in Food Science from the University of Maryland, College Park.

Theodore N. Giovanis, FHFMA, M.B.A.
Theodore Giovanis is President of T. Giovanis & Company, a consulting firm specializing in legislative, regulatory, and strategic consulting with an emphasis on health care policy. He has served as a technical resource for congressional staffs and the Administration. In addition to extensive consultant experience in health care financing, regulation, and policy, he has served as Director of the Health Care Industry Services of Deloitte & Touche, Director for Regulatory Issues of the Healthcare Financial Management Association, and Assistant Chief of the Maryland Health Services Cost Review Commission.

Mr. Giovanis received an M.B.A. in management from The University of Baltimore and is a fellow in the Healthcare Financial Management Association (HFMA). He is also certified in managed care.

Alan C. Lovell, Ph.D.
Alan C. Lovell is currently the Chief Executive Officer of CHI Centers, Inc., "supporting people with disabilities since 1948," a multi-purpose, community-based organization serving children and adults with disabilities. He has served in numerous leadership positions, including President and Chair with the Maryland Association of Community Services, the Maryland State Developmental Disabilities Council and the Montgomery County Interagency Coordinating Committee for People with Developmental Disabilities (InterACC/DD).

Dr. Lovell received his Ph.D. in public administration from Kensington University.

Jerry Lymas, B.A., J.D.

Jerry Lymas is currently the President of the Justin Development Group, Inc., a Neighborhood development firm specializing in neighborhood real estate development, construction management, facilities management, and development for churches through the Justin Development Group 50 Churches 50 Corners Program. Prior to that he was Special Assistant to The Honorable Parren J. Mitchell on matters relating to housing and development. He served in the U.S. Army, reaching the rank of First Lieutenant.

Mr. Lymas received his B.A. from Morgan State University in history, and his J.D. from the University of South Carolina Law School.

John Plaskon, B.S., M.S.

John Plaskon is currently the Executive Director of Crossroads Community, Inc., a position he has occupied for 13 years. He also serves on the Boards of The Maryland Association of Non-Profit Organizations, The Upper Shore Community Mental Health Center, Shore Leadership, and the Queen Anne's County Local Management Board. Previous experience includes having been a Developmental Disabilities Coordinator on the Eastern Shore, Program Director for Channel Marker, and a Rehabilitation Counselor in New Jersey.

Mr. Plaskon received his B.S. in meteorology from Rutgers University , and an M.S. in educational psychology from Texas A&M, as well as a certificate in administrative practice from UMBC.

LIST OF MEMBERS OF THE TECHNICAL ADVISORY GROUPS

The Commission wishes to express is sincere appreciation to the following members of the Technical Advisory Groups who have given of their time and expertise and made a valuable contribution to the work of the Commission:

Technical Advisory Group on MHA issues

Lloyd Bowser - Commissioner, Chair
Joan Clement - Commissioner
John Plaskon - Commissioner
Richard Bayer - Upper Bay Counseling and Support Services
Herb Cromwell - Community Behavioral Health
Phyllis Goldberg - MCCMHP
Lori Doyle - ReVisions
Tim Santoni - MHA
Bob Pitcher / Frank Sullivan - MACSA
Theodore Giovanis - Commissioner (ex-officio)

Technical Advisory Group on DDA issues

Jean Frank - Commissioner, Chair
Alan Lovell - Commissioner
Dianne Hutto McComb - MACS
Scott Uhl - DDA
Tim Wiens - Jubilee
Theodore Giovanis - Commissioner (ex-officio)

APPENDIX B

This appendix includes the following papers recently produced by the CSRRC on issues concerning providers contracting with DDA, and the report submitted by DHMB to the Joint Legislative Chairmen regarding wage and fringe benefit parity.

B-1. The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997, 1998, 1999, and 2000

B-2. Wage Rate Survey of DDA Providers - 2001

B-3 DHMH Report to the Joint Chairmen

APPENDIX B-1

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997, 1998, 1999 and 2000

Introduction

The enabling statute of the Community Services Reimbursement Rate Commission (CSRRC) requires that the Commission, in its evaluation of rates, consider "the existing and desired ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest". The analysis reported here is intended to examine the financial status of the providers of community services to individuals with developmental disabilities for the fiscal years 1997, 1998, 1999, and 2000.

A number of caveats need to be made to avoid reading too much into this data. The first is that there is no single financial measure that gives a complete picture of the financial situation of a provider. Therefore, it is necessary to examine several indicators to obtain an overall picture. The second caveat is that the payment systems have undergone substantial changes over the past couple of years, and these changes are likely to have caused some of the differences observed between the years reported here. A third is that the expenses and payments are not just those associated with services paid for by the state, so this is not simply an analysis of the impact of the DDA payment system. Another caveat is that the set of providers reporting is not the same in each year.

The Commission is required to report on the extent and amount of uncompensated care delivered by providers. The nature and extent of the uncompensated care varies greatly between the different types of providers under the Commission's purview, and so the Commission has decided that it would be best to provide the discussion of the extent and amount of uncompensated care within each of the papers produced concerning the financial condition of the providers, rather than producing a single paper on that issue. As a result, this paper includes a section on the extent and amount of uncompensated care delivered by the providers.

Data sources

The data used for this analysis were extracted from the fiscal year 1997, 1998, 1999 and 2000 Audited Financial Reports. Reports for 55 providers (out of about 110 providers contracting with DDA) were available in the files of the Developmental Disabilities Administration (DDA) for fiscal year 1997, 46 for fiscal year 1998, 84 for 1999, and 89 for 2000. Providers were required by regulation to provide their Audited Financial Reports. Of the 89 providers used for the 2000 analysis, 32 were from the Central Region, 13 from the Eastern Region, 27 from the Southern Region, and 16 from the Western Region.

The following data fields were extracted from the Financial Reports (definitions of the terms is included in Attachment 1):

Total expenses

Total revenues
Current assets
Total assets
Current liabilities
Long term liabilities
Total liabilities

In addition, for fiscal years 1998, 1999, and 2000 "contributions" were extracted in the reports in which they were identified, but this variable should be interpreted with caution as it is probably not consistently defined and reported.

Financial ratios calculated

The Commission's statute focuses on solvency. A literal interpretation of solvency is that sufficient cash is available to pay all just debts. Data on cash flows is not generally available from providers on a consistent basis, if at all. The accounting profession has traditionally used various financial ratios to measure the condition and performance of organizations and the Commission believes that legislature intended an examination of financial condition rather than literal solvency. Accordingly, the Commission has used the data available from Audited Financial Reports to construct financial ratios for use in evaluating the financial condition of the providers.

The data were used to calculate four financial ratios or indicators that are generally considered to be indicative of the financial health of a provider. These were:

Profit margin: (Total revenues - Total expenses)/Total revenues

Current ratio: Current assets/Current liabilities

Return on total assets: (Total revenues - Total expenses)/Total assets

Asset turnover: Total revenues/Total assets

Net assets: Total assets - Total liabilities

Several providers had large profits, but only a small proportion of their business is with Maryland DDA. In order to adjust for this in FY 2000 the mean ratios were calculated weighting the results by the total Maryland DDA payments to the provider. These payments included CSLA, FPS, and grants. Consideration was given to dropping from the analysis providers whose revenue was largely from sources other than Maryland DDA, but it was found that weighting by DDA payments provided similar results for the ratios, and shows a more complete picture of the financial condition of all the providers.

Results

Profit Margin

The term "profit margin" is used as it is generally understood. However, it should be noted that

while most of the providers are "not-for-profit" organizations, all organizations require some level of profit in order to sustain their existence and build up funds to replace their buildings and equipment. In addition, the revenues reported by some providers included grants that were used to pay for capital acquisitions rather than for operating expenses.

The margin (profit margin) is probably the most important indicator of the financial health of an industry (and an individual company), as it shows whether the industry is covering its costs and has the capacity to accumulate reserves for future investment. Weighting by the expenses of the provider the mean margin of the providers of community services reporting to DDA was 1.4% in FY 1997, 3.8% in FY 1998, 3.2% in FY 1999, and 3.5% in FY 2000. The spread of the margin is shown in Table 1.

Table 1: Mean Profit Margins	FY 1997	FY 1998	FY 1999	FY 2000[1]
Upper quartile	7.0%	7.8%	8.3%	8.1%
Median	2.1%	4.4%	3.1%	3.2%
Lower quartile	-2.7%	1.2%	0.0%	0.0%
Mean	2.1%	3.8%	3.2%	3.5%

Of the providers of community services reporting to DDA 20 of the 55 providers (i.e., 36%) had negative margins in FY 1997, 10 of the 46 providers (i.e., 22%) had negative margins in FY 1998, 17 of the 83 providers (i.e., 20%) had negative margins in FY 1999, and 22 of the 89 had negative margins in FY 2000 (i.e., 25%). Of the 22 providers with negative margins in FY 2000, 7 of these also had negative margins in FY 1999.

For each of the years the margins were not correlated with the size of the provider, although the small providers had the greatest range in their margins, with both the highest percentage losses and the highest percentage profits.

Profit margins by region of the state

Table 1A shows the mean profit margins (DDA revenue weighted for 2000) for the providers located in the 4 DDA regions of the state for FY 1997, 1998, 1999 and 2000 and the median for 1999[2] and 2000. These profit margins should be interpreted with caution as the number of providers involved is quite small.

[1] Weighted by DDA payments.

[2] The mean can be moved substantially by one or two outlier values, but the median (the middle value when the values are arranged in order) is less affected by outliers, and so is also reported here.

Table 1A: Mean profit margin by region	1997	1998	1999	1999 (median)	2000[3]	2000 (median)
Central (Baltimore & area)	0.1%	2.4%	3.0%	2.9%	2.0%	1.4%
East (Eastern Shore)	4.5%	7.8%	8.2%	6.7%	5.5%	3.6%
South (Washington suburbs & South)	2.0%	4.3%	2.3%	2.5%	5.2%	6.2%
West (Western Maryland)	1.4%	2.9%	3.2%	2.6%	3.5%	2.2%
State	2.1%	3.8%	3.2%	3.1%	3.5%	3.2%

In FY 2000 contributions made up 3.1% of the total revenue of all the providers in the study[4], so a substantial portion of the margin can be attributed to contributions. This was also the case in FY 1999.

Current ratio

The current ratio is an indication of how much cash and other liquid assets (receivables and marketable securities) a provider has available, as compared with their current liabilities, i.e., it is one indicator whether the provider has funds to pay its bills on time. Generally, the higher the ratio, the better the situation of the provider. The spread of the current ratio is shown in Table 2.

Table 2: Current ratio	FY 1997	FY 1998	FY 1999	FY 2000
Upper quartile	2.42	3.24	3.36	3.08
Median	1.77	1.66	1.87	1.42
Lower quartile	0.96	0.88	1.03	0.98

The providers of community services reporting to DDA experienced an increase in their current ratio from 1997 to 1999, but a drop in 2000.

[3] Weighted by DDA payments.

[4] The reporting of contributions is not done consistently in the Audited Financial Reports, so this estimate of the contributions may underestimate the total amount of donations and contributions.

FY 2000 median current ratio by region:

Table 2A: Current ratio	Central	East	South	West
Median	1.21	1.88	1.42	1.46

Return on assets (ROA)

The ROA expresses the profit as a percentage of the total assets of the provider. It indicates whether the provider is generating a reasonable return given the amount of money that is tied up in its assets. A higher ratio is generally better, although it should be kept in mind that a high ratio may be reflective of low assets.

The spread of the ROA is shown in Table 3.

Table 3: Return on assets	FY 1997	FY 1998	FY 1999	FY 2000
Upper quartile	8.3%	8.9%	10.3%	11.7%
Median	2.9%	5.2%	4.4%	4.72%
Lower quartile	-3.4%	0.5%	0.1%	0.33%

Return on assets improved between FY 1997 and FY 1998 and the median dropped slightly from 1998 to 1999, but increased again to FY 2000.

FY 2000 median return on assets by region:

Table 3A: Return on assets	Central	East	South	West
Median	2.5%	4.94%	10.90%	1.88%

The high return on assets in the Southern region is partly due to a low reported assets value relative to revenues and partly due to the level of the margin in the Southern region.

Asset turnover

Asset turnover looks at the total revenues as a proportion of the total assets. In general a higher ratio is good, as it indicates that more revenue is being generated per dollar in assets.

The spread of the asset turnover is shown in Table 4.

Table 4: Asset turnover	FY 1997	FY 1998	FY 1999	FY 2000
Upper quartile	1.86	2.34	2.04	1.71
Median	1.39	1.56	1.44	1.39
Lower quartile	0.88	0.83	0.92	0.94

FY 2000 asset turnover by region:

Table 4A: Asset turnover	Central	East	South	West
Median	1.45	1.32	1.53	1.00

Net assets

Of the community service providers reporting to DDA, 4 had negative net assets in FY 1997, 4 had negative net assets in FY 1998, 3 had negative net assets in FY 1999, and only two had negative net assets in FY 2000. There is some difficulty in tracking the providers across years as the set of providers for which Audited Reports were available changed from year to year. Of the three providers with negative net assets in 1999, two had substantial positive margins in 2000, and so their net assets had increased from 1999. For one of these providers the improvement was sufficient to turn the net assets positive. Data were not available in FY 2000 for the third of these providers.

Summary

The ratios examined are in a reasonable range for fiscal years 1998, 1999 and 2000. These ratios indicate that there was an improvement in overall financial condition between fiscal year 1997 and fiscal year 1998, with fiscal years 1999 and 2000 being similar to fiscal year 1998.

	1997	1998	1999	2000
% with negative margins	36%	22%	20%	25%
% with positive margins	64%	78%	80%	75%
% with current ratio < 1	25%	22%	23%	26%

In FY 1997 20 of the 55 providers (36%), in FY 1998 10 of the 46 providers (22%), in FY 1999 17 of the 84 providers (i.e., 20%), and in FY 2000 22 of the 89 (25%) had negative margins. This

is generally a favorable trend, and suggests that fewer of the providers are in financial jeopardy. In total the margins were positive, and 35 of the 55 (64%) providers operated with positive margins in FY 1997, 36 of the 46 (78%) in FY 1998, 67 of the 84 (80%) in FY 1999, and 67 of 89 (75%) in FY 2000.

In FY 1997 25% of the community service providers reporting to DDA had current liabilities greater than their current assets, in FY 1998, in FY 1999 23% had current liabilities greater than current assets, and in FY 2000 26% had current liabilities greater than current assets. This could be indicative of a number of conditions, such as the existence of a short term working capital loan, and should be investigated. Overall the current ratio declined from FY 1999 to FY 2000, which is an undesirable movement.

The data for fiscal year 1998 showed an improvement in financial position compared with FY 1997. Changes were made in the payment systems for fiscal year 1999, with the impact of the redistributive changes spread over 4 years. Rates were increased generally. These changes appear to have reduced the proportion of providers with losses, and the number with negative net assets. DDA should be monitoring the financial status of the providers and providing technical assistance if it is clear that a provider is becoming financially unstable. DDA should also be examining whether such issues as client mix, location of the agency, and the age of the agency, are affecting the financial status.

The mean margin in FY 2000 was 3.5%, but this includes 3.1% of contributions.

Uncompensated care

Uncompensated care consists of two components, bad debts and charity care. Charity care is care that is provided with no expectation of payment, because of the financial condition of the recipient of care. Bad debts are the costs of services which were unpaid, but where payment was expected when the services were rendered. The line between charity care and bad debts is often not clear, and providers may lump all unpaid care into bad debts. The accounting treatment of bad debts and charity care is different. Charity care is treated as a deduction from revenue in audited financial reports, while bad debts are treated as a cost.

Data sources

The providers contracting with DDA have been relatively responsive to the Commission's surveys, so the analysis of their uncompensated care is based on the surveys, which allow for an analysis of the components of the uncompensated care.

Analysis

48 providers responded to the Commission's wage and uncompensated care survey for fiscal year 1999 and the uncompensated care reported was less than 1% of the total revenue. Only 9 of these providers reported any uncompensated care, and for these 9 providers the uncompensated care was less than 3% of their total revenue. Uncompensated care is clearly not an important factor for these providers. Providers taking on clients that will be uncompensated know this when then enroll these clients.

A related issue that is frequently raised by the providers is the costs associated with unfunded mandates. These are requirements imposed by the state and federal governments that impose additional costs on the providers, but with no corresponding increase in payments. It is difficult to estimate the additional costs resulting from such mandates, as they accumulate over time, and often expand or formalize activities that some providers are already engaged in. Recent unfunded mandates in requirements for the use of Certified Nurse Aides, and the use of nurses for particular services. One way to ensure that the costs associated with such regulatory changes are included in the rates would be to recost the packages of services included in the rates, using current costs and staffing levels.

Conclusions

Uncompensated care levels are relatively low among the providers contracting with DDA. Thus, uncompensated car is not a major issue for these providers, and it does not appear that any action need be taken by the state on the uncompensated care issue at this time. The Commission will continue to monitor the level of bad debts at these providers using data available from audited financial reports, and will reopen this issue if any substantial deterioration in the uncompensated care situation is observed. A related issue of greater concern to the providers is unfunded mandates. i.e., requirements imposed by the state or federal governments that increase the costs of providing services, but for which no allowance is made in the rates. The cost impact of such mandates is difficult to quantify, but the Commission shall continue to monitor such mandates, and review their impact on the overall financial condition of the providers. In interpreting the

financial analysis it should be kept in mind that the costs associated with uncompensated care and unfunded mandates are included in the total costs, and so the margins presented take these costs into account.

Attachment 1: Definitions of terms

Total expenses: The total costs incurred by the provider during the year. These costs include labor, supplies, maintenance, contracts, depreciation of buildings and equipment.

Total revenues: The total payments received by the provider. These include payments from the state, payments from other payers, interest and investment income, donations.

Current assets: Assets that are available in the short term. These include cash, receivables, and marketable securities.

Total assets: All assets including the current assets, and long term assets such as buildings and equipment (after taking out accumulated depreciation).

Current liabilities: Payment due from the provider in the near future. These include payables and current mortgage payments.

Long term liabilities: Amounts due in the long term. These generally include mortgage payments (beyond the present year's portion) and other long term debt.

Total liabilities: The sum of the current and the long term liabilities.

APPENDIX B-2

Wage Rate Survey of DDA Providers - 2001

Introduction

The Community Services Reimbursement Rate Commission (CSRRC) is required by its enabling statute to compare the increase in the wages paid by providers of community services that contract with the Developmental Disabilities Administration (DDA) with the rate increases provided in the rates paid by DDA. In order to comply with this requirement the CSRRC designed a survey instrument, obtained a list of community services providers from DDA, and carried out a survey of these providers. The survey instrument asked for information on wages paid during a pay period in October 2000. Surveys were sent to over 100 providers. The survey was sent again to non-respondents in February and then again in September, 2001. Responses were received from 122 of the providers and 116 of these were used for the analysis reported below.

This paper reports the results and conclusions from the survey, providing information on wage rates, fringe benefit percentages, staff turnover rates, and vacancy rates.

Design and testing of the survey instrument

The first step in the design of the survey instrument was a review of survey instruments previously used to collect data from these providers. The design of the survey instrument was done in conjunction with the Technical Advisory Group on DDA issues, who reviewed the instrument and suggested changes. The instrument used in FY 2000 had been field tested by two providers, and modified based on their input prior to its use. Based on the response to that survey additional changes were made to the FY 2001 survey form, particularly on the issue of turnover. The survey was then mailed to over 100 providers. The Maryland Association of Community Services (MACS) for Persons with Developmental Disabilities followed up with providers who had not responded and encourage them to complete the survey. DDA promulgated regulations requiring the submission of the data, with the possibility of financial penalties for failure to respond. DDA remailed the survey in September, 2001 to providers who had not previously responded to the previous surveys with a cover letter that was more strongly worded, pointing out that responding to the survey was a legal requirement.

Results of the survey

The survey found the following state-wide full time base wage rates (excluding fringe benefits):

Wage category	Base hourly rate - 2000*	Base hourly rate - 2001*	% change
Aide	$7.44	$8.64	16.1%
Service worker	$8.57	$9.15	6.7%
First line supervisor	$13.44	$14.83	10.3%
Driver - CDL	$8.61	$9.45	9.8%
Driver- non-CDL	$8.08	$8.86	9.7%

* The set of providers responding differed between the two years, with 47 providers included in the 2000 analysis, compared with over 115 in the 2001 analysis. This difference in the set of providers responding may explain part of the change in wage rates between the two years.

Staff turnover rates

The turnover rates for the employees categories for all services were:

Aides	48%
Service workers	35%
First line supervisors	29%
Drivers CDL	33%
Drivers - non-CDL	132%

Residential aides (not live-in) had a 64% turnover rate, while residential aides (live-in) and day service aides experienced turnover rates of just under 30%.

These high turnover rates are similar to those found in prior years. The turnover rates of state employees are less than a fifth of those experienced by the providers.

Staff tenure

76 providers included data on staff tenure. The average tenures of staff and the percentages of the direct care employees in each category were:

Category of employee	**Average tenure**	**% of direct care workers in category**
Aides	26 months	36%
Service workers	29 months	50%
First line supervisors	37 months	14%

The average tenures of state employees in corresponding positions are much longer than the tenures of the service workers in the community service providers.

Fringe benefits

Fringe benefit percentages were provided by 38 providers in 2000. The mean value was 19.9%, the median was 19%. In the 2001 surveys 96 providers supplied fringe benefits. The mean was 20.7% and the median and the mode were 20%. Thus, there was no substantial change from 2000 to 2001 in fringe benefit percentages. The state fringe benefit percentage of 32.9% is substantially higher than that of the providers.

Change in wage rates

The Commission has a responsibility to compare the change in wage rates with the change in payment rates for services. The FY 2000 survey described in this report was intended to provide a base from which wage rate increases in the future could be calculated. Because of the different mix of providers responding to the two surveys the comparison will not be precise. These increases are greater than, and for aides much greater than, the rate of increase in the Consumer Price Index between 2000 and 2001.

Rate increases

Between fiscal year 2000 and fiscal year 2001 the provider components of the rates increased by 1.5% and the individual components increased by varying amounts, generally in the range of 5.5 to 7.5%. Comparing these increases with the wage differences in the table above, it appears that the providers have given their direct care employees wage increases at least as large as the rate increases they have been receiving.

DHMH report to the Joint Chairmen on wage and salary comparison

DHMH was required in language associated with their fiscal year 2002 operating budget to report to the Chairs of the Senate Budget and Taxation Committee and the House Appropriations Committee on a plan for increasing the wages and benefits of community direct support workers in the developmental disabilities field. This report was issued on January 1, 2002 and was based in large part on the Commission's wage and salary survey. The report calculates that state workers in corresponding positions are paid substantially more than the corresponding workers in community service providers, and that the state workers receive more generous fringe benefits. The percentage differences are shown in the following table.

Category	Percentage state rate exceeds community
Hourly wages for Aides	21.58%
Hourly wages for Service Workers	33.94%
Fringe benefits	10.9%[5]

The amount required to bring the Community Provider direct care wages and fringe benefits to parity with the state wages is projected by DHMH to be $81 million. This is to be accomplished over a 5 year period, and the $81 million figure does not include any allowance for COLA increases that may be provided to state employees over that period, or increases that may be required to account for increased average tenure of the community service workers. Both of these factors would be expected to increase the amount required above the $81 million.

Summary and conclusions

The providers appear to have been giving wage increases to their workers that are at least as large as the rate increases they have been receiving. It appears that the rate increases have allowed providers to fund increases in the wages being paid. In addition, the waiting list initiative provided additional funds to the providers

Turnover rates have increased slightly over the prior survey, and, while high, are in the same range as is reported for similar providers nationally.

Fringe benefits continue to be about 20% of wages.

DDA has prepared a report to the Joint Chairmen based on the results of this survey. The DDA report includes a comparison with State wage levels and is attached as Appendix B-3 to this Annual Report. It shows that the state wage and fringe benefit levels are substantially higher than those of the community service providers and that, at current levels, $81 million would be required to achieve parity.

[5] The DHMH fringe benefit was reported as 31.6%, and the Community Providers fringe benefit as 20.7%, for a difference of 10.9%.

APPENDIX B-3

DHMH Report to the Joint Chairmen

APPENDIX C

This appendix includes the following papers recently produced by the CSRRC on issues concerning mental health providers.

C-1. Financial Status of Mental Health Clinics

C-2. Update on the financial condition of psychiatric rehabilitation providers

C-3. Wage survey of psychiatric rehabilitation providers

APPENDIX C-1

Financial Status of Mental Health Clinics: Fiscal Year 2000

Introduction

The Community Services Reimbursement Rate Commission (CSRRC) is concerned with the financial condition of providers of community services to individuals with psychiatric disabilities. This concern has been exacerbated by reports of financial instability among Outpatient Mental Health Clinics (OMHC), with clinics closing, and others entering Chapter 11. The purpose of the study reported in this paper is two-fold: i) to identify issues related to the financial position of the providers, as required by the Commission statute; and ii) make recommendations regarding actions that should or could be taken to address or remedy particular issues.

The financial performance is based on 4 major elements: revenues, related costs, uncompensated care, and accounts receivable. Any imprecision in the definition or reporting of these elements will cloud the assessment of financial position, and hinder the identification of specific causes of poor financial performance.

A survey was designed to assess the financial condition of these providers. This survey was designed to address the following questions:

- are the providers making or losing money?
- are accounts receivable resulting in cash flow problems
- are the providers experiencing solvency problems?
- are bad debts contributing to the financial problems?
- what components of bad debts are of particular concern?
- are unfunded mandates contributing to financial problems?

This survey, which requested data for the fiscal year ending June 30, 2000, was distributed to the OMHCs by the directors of the Core Service Agencies (CSA) in the state, and 24 responses were received. The results of these surveys are summarized in this paper. The Commission would like to express its appreciation of the assistance provided by the CSA Directors in obtaining these survey responses.

It should be noted that many of the providers have other services in addition to their OMHC, for example, they may provide psychiatric rehabilitation services. The results reported below are generally for the organization as a whole, but results are also reported for the OMHC portion of the organization, where possible.

Medicare payments for outpatient mental health services involve large copayments. Medicare currently pays 50% of its fee schedule amount, with the copayment being an additional 50% of the fee schedule amount. It is reported that many of the Medicare beneficiaries who use the clinics are unable to pay such a large copayment. For clients who are eligible for both Medicare and Medicaid, Medicare will pay their 50% of the fee schedule amount, then Medicaid pays an

additional 12.5% copayment. The provider receives a total of 62.5% of the Medicare fee schedule amount and is required to accept this as payment in full for the services. This low level of total payment has been a source of much complaint. Cash flow has also been a source of concern. In the past payments from MHA through their contractor Maryland Health Partners (MHP) were delayed due to processing problems, but these problems appear to have been largely resolved. Payments from some private insurers are slow.

Survey results

All providers

Of the 24 providers responding to the survey, 16 (67%) reported losses. Of these 16, 8 (33%) reported losses in excess of 25% of their revenues. The mean loss was 10%, with the OMHC services losing almost 20%. The largest percentage losses were concentrated in the smallest providers, those with revenues of under $300,000 per year.

Cash flow is an equally major concern for the providers, as accounts receivable, from all sources, were reported at over 20% of revenues. This represents almost 2.5 months of revenue in receivables. This was very variable between providers, with some providers reporting many months in receivables, and others only about 1 month. Because of this high degree of variability, and based on discussions regarding this issue the Commission believes there may be issues regarding how providers are reporting their accounts receivable, some of which could have a tendency to inflate the reported amounts, so distorting the numbers.

Bad debts were reported to be 7% of total revenues and 11% of OMHC revenues, with two major components: i) unpaid copayments associated with Medicare patients; and ii) unreimbursed services provided to clients with insurance. Unpaid copayments for grey area clients and the cost of services provided to clients with no insurance were lesser issues, but are still of sufficient magnitude to be of concern.

Providers with profits between -25% and +25%

A similar analysis was performed on the providers with profits in the -25% to +25% range. This excluded 9 providers leaving 15 providers. Of these 15 providers remaining, 8 (53%) reported losses. The mean loss was 1%, with the OMHC services losing 5%.

Cash flow is a concern for these providers, with accounts receivable reported at 18% of revenues. This represents almost 2.2 months of revenue in receivables. OMHC reported even higher receivables (24%).

Bad debts were reported to be 6% of revenues, with OMHCs reporting 9% of revenues as bad debts. The major component of this was unreimbursed services provided to clients with insurance. Unpaid copayments for grey area clients, unpaid Medicare copayments, and the cost of services provided to clients with no insurance were lesser issues, but are still of sufficient magnitude to be of concern.

Unfunded mandates

Most providers were unable to provide any information on the cost of unfunded mandates. However, a few respondents did provide considerable detail in response to the question of what unfunded mandates were troublesome. Unfunded mandates mentioned included:

- reports required by CSAs and the state
- requirement to have a full time medical director
- training requirements for CPR, first aid, etc.
- documentation requirements
- case management

Particular factors resulting in losses

In response to the question on what particular factors result in losses the following items were listed:

- school based programs and meetings
- lack of information from grey area clients
- claims processing issues
- transportation of patients
- acquiring prescriptions drugs for clients who cannot afford them
- case management

Subsequent survey by Community Behavioral Health (CBH)

CBH performed a survey of the financial condition of their member providers for fiscal year 2001. 26 OMHCs responded to this survey. The results of the survey suggest that an even greater proportion of clinics lost money in FY 2001 than in FY 2000 and that the major contributing factors to the losses were:

- Inadequate physician rates
- Child and adolescent OMHC
- Medicare including dual eligible

Of the 11 respondents to the survey that operate child and adolescent PRPs, 10 reported that they were losing money on these programs. Other specific services that reported substantial losses were targeted case management and crisis residential.

Report on Maryland's Public Outpatient Mental Health Clinics

MHA commissioned a study of the public OMHCs by Health Management Consultants, LLC. The report on this study was issued in September, 2001. All 13 of the OMHCs were losing money in the time period studied - January 1999 through June 2000. The consultant concluded that the clinics would lose 15% of their gross revenues even if they were operating at reasonable standards of efficiency on each of the performance measures they studied. They suggested that "More than likely, this 15% shortfall should be addressed through a rate increase." They found particular problems with the rates being paid for services of psychiatrists and for child and

adolescent services.

Interpretation and conclusions

The response to the survey included about one quarter of the mental health clinics, so the results should be interpreted with caution. The survey respondents may or may not be typical of the entire provider population. However, the results are sufficiently dramatic that they raise major concerns regarding the financial status of the clinics, particularly when they are considered in conjunction with the results of the CBH survey and the study by Health Management Consultants of the public OMHCs. The losses are such that the financial viability of some providers may be threatened, and access could become an issue if financial conditions do not improve.

The Commission believes that MHA should have a system in place to monitor the financial condition of the provider system. MHA recently issued regulations requiring the submission of audit data. This data will be useful for the ongoing evaluation of the financial condition of the providers. MHA had a consulting group perform a detailed review of several providers. The report to be issued should cast additional light on the financial condition of these providers, and the underlying reasons why certain providers are having problems.

In drawing conclusions it is important to distinguish issues which might be caused by the rate system, and implementation issues (both MHA and provider implementation issues).

Two thirds of the OMHCs that responded to the survey are losing money, and this problem is compounded by poor cash flow, with excessive amounts of revenue in accounts receivable. The providers with large losses also have high amounts of unpaid Medicare copayments, suggesting that they may have high Medicare loads, and that this is a contributing factor to their financial condition. Anecdotal evidence suggests that Medicare beneficiaries may not be seeking treatment because of high out-of-pocket costs for copayments and for prescription drugs. Clients with insurance are resulting in bad debts of about 4% of total revenue, and this is a problem across all the providers. Providers have suggested several reasons for this unexpectedly high bad debt rate associated with clients with insurance. The reasons suggested include:

- the particular services provided are not covered under the insurance
- copayments are often unpaid
- clients are unwilling to provide insurance information because they do not want their employers to find out they are seeking mental health services
- the provider finds out after providing treatment that the client had insurance, and is unable to obtain payment because the service was not pre-authorized

Uncompensated care is clearly a major concern for the OMHCs, with the large copayments required by Medicare, and the low total payments made by Medicare and Medicaid for dually eligible clients being major concerns. However, there is substantial uncompensated care associated with patients with insurance. Uncompensated care will be discussed in more detail in an other paper to be produced by the Commission.

Based on the results of this survey, and discussions with knowledgeable individuals, the financial problems being experienced by providers are attributable to a combination of factors,

including slow payments from payers, inadequate billing and accounting systems of some providers, and Medicare's low payment levels, compounded by unpaid copayments from Medicare beneficiaries and other uncompensated care. Difficulty in obtaining required documentation on grey zone patients, e.g., proof of income, exacerbates these problems. Questions can be raised regarding the high level of accounts receivable, and additional information is required before definite conclusions can be drawn. For example, to what extent are the high receivables caused by delays in payments, either because of payer problems, or because of inadequate billing information provided by the providers, and to what extent are they due to the mechanics of how providers are reflecting payments?

Unfunded mandates are an issue that is clearly of concern to the providers, and is frequently raised in discussions. However, defining what comprises an unfunded mandate is difficult, and quantifying the costs of such mandates even more difficult. Few providers supplied any data on the costs they incurred for unfunded mandates.

Many of the OMHCs are suffering from major financial concerns. This appears to be due to a combination of conditions:

- The rates initially set by MHA were clearly much too low.
- This was compounded by glitches in the authorization of services and the processing of bills by MHP and the providers.
- Many of the providers did not respond sufficiently quickly or effectively in modifying their registration, billing, and collection systems when the funding system changed from a grant based system to a fee-for-service system.
- The management practices of many of the providers may not have fully adjusted to the incentives embodied by a fee-for-service payment system.

Some providers still have issues with billing. Some of these could be due to inadequacies in their billing and accounting systems rather than the MHP system, although one problem mentioned that appears to be an MHA/MHP problem is a incorrect social security numbers supplied to MHP by MMIS, which was estimated by one provider to occur in about 3% of cases. There may also be concerns with overall management systems, including: the registration of clients, the collection of financial and insurance information, the collection of copayments, the accurate submission of bills,
the proper relieving of accounts receivable, and the tracking of payments.

When the fee-for-service system was implemented there may not have been an adequate realization on the part of the providers and of MHA of the major shift in management processes and management thinking that was going to be required by the change in the payment system. The administrative problems experienced by MHP at the start of the new payment system concealed the slow management response from the providers, and this has led to a tendency for providers to continue to blame MHP where this may no longer be appropriate.

MHA provided a substantial rate increase on March 1, 2000. This rate increase was only in effect for 4 months of FY 2000, whereas it will be in effect for the whole of FY 2001. This should increase the revenues of the providers substantially from FY 2000 to FY 2001. However, the Commission is concerned with the impact of financial stress on providers on access to, and quality of, the services being provided to clients, whatever the cause of that financial stress.

Recommendations

The Commission's ability to assess the financial condition of the MHA providers, and particularly the OMHCs, is hampered by the lack of uniformly available, accessible data. Gathering information on the financial condition of the providers is very difficult. This survey received 24 responses, only about a quarter of the provider pool, and this level of response was achieved after intervention by the Core Service Agency Directors. It is important that MHA and the Commission have reasonably current data on the financial condition of the providers. The collection of audit reports from the providers will provide a basis for an annual evaluation of the financial condition of all the providers, which will be much better than relying on survey data from a small proportion of the providers. The recommendations presented below have four major thrusts:

- Increase payments for dual eligible clients

Uncompensated care and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern, as are copayments and coverage for gray area clients. As a partial remedy the Medicaid payments for dual eligibles should be increased to result in total payments of the Medicaid fee schedule amount. Cutbacks currently being made in gray area eligibility are likely to result in an increase in uncompensated care.

- Continuation of the work on specific rate issues

MHA should continue to examine problems with individual rates or classes of services, and work to remedy these problems. Rates for services to children are regularly raised as a concern, as are the rates being paid for psychiatrist services.

- Coverage for gray area clients should be maintained

The State is experiencing budget problems, and there have already been some cut-backs in gray area eligibility, with additional cut-backs under discussion. Such cut-backs would exacerbate the financial problems currently being experienced by the clinics and so are very inadvisable. In addition, the savings in the MHA budget from such cut-backs does not take account of the adverse impact of the reductions on other components of the system. For example, reductions in services could result in increased inpatient hospitalizations, increased use of the criminal justice system, increased emergency department use, and potentially the need to bail out financially precarious providers in order to preserve access, all of which increase State outlays in other areas. Therefore, the costs associated with these effects could cancel out the projected savings in payments to community providers.

- Ongoing data collection to identify financial problems

MHA should monitor the financial condition of the providers using the audits that are now required to be submitted by the providers, to ensure that financial issues are not likely to interfere with access to, or the continuity and quality of care. MHA should check on the financial status of providers who are reporting that they are in poor financial condition, and provide additional support on billing and other issues. The Commission understands that MHA is already providing some consulting assistance to providers in need of such help and that providers

may decline assistance that is offered. However, the Commission believes that a more formalized systematic analysis and review with targeted assistance is appropriate and timely. The Commission would offer its assistance to work with MHA in the development of such a process.

- Immediately identifying what types of technical assistance are required by providers and provide that assistance

MHA should conduct a focused survey of providers, possibly using consultants, to assess the underlying reasons for the poor financial performance. These surveys should involve multiple dimensions - accounts receivable management, billing, collections, computer systems, efficiency in the use of staff, uncompensated care, insurance coverage, claims processing, costs, and other issues that might be suggested by the providers - to determine what corrective actions may be needed, which providers are in need of technical assistance, and the nature of the assistance they require. Based on the results of the survey MHA should focus and expand its technical assistance program for providers. MHA should share its survey results and its resulting work plan with the Commission. This should be a priority project. The Commission understands that the role of the consultant providing technical assistance to the county clinics has been expanded to include other types of clinics.

APPENDIX C-2

Financial Condition of Psychiatric Rehabilitation Providers Update for Fiscal Year 2000

A detailed report on the financial condition of the psychiatric rehabilitation providers (PRP) was included as Appendix B-7 to the February 2001 Annual Report. This report concluded that the financial condition of the providers had improved from 1998 to 1999, and that the median and mean margins were about 8%. A detailed analysis of the financial condition of the providers for fiscal years 2000 and 2001 is planned once the Core Service Agencies have received sufficient audited financial reports from the providers, but to date the data has not been available for such an analysis.

Anecdotal evidence suggests that the financial condition of the PRPs in FY 2000 was similar to the two prior years. However, changes are expected in fiscal year 2001 and particularly in fiscal year 2002. In FY 2002 there have been reductions in the authorized frequency and duration of services, and rates were not increased from 2001. The wage survey indicates that wage rates have been increased substantially, and inflation has impacted on other costs as well. The combination of these factors is expected to substantially reduce the margins of the providers. These concerns will be compounded by reductions in gray area eligibility that have already been implemented, and other potential changes that are being considered by the state in response to budget shortfalls.

These concerns will be of particular importance for PRPs that have associated OMHCs, and where profits on the PRP services have been subsidizing losses on the OMHC services. The problems will be compounded by the reductions in Medicare payment rates that will be effective January 1, 2002. The Medicare rates for 2002 will be approximately 5% below the 2001 rates.

APPENDIX C-3

Psychiatric Rehabilitation Program Salary Survey

Introduction

The Community Services Reimbursement Rate Commission is required to compare the change in the wage rates paid by providers with the changes in the rates paid by the Mental Hygiene Administration. This paper provides such a comparison for psychiatric rehabilitation providers for the period 1998 through 2001.

Data source

The Maryland Association of Psychiatric Support Services, Inc. (MAPSS) recently published the results of a salary survey of psychiatric rehabilitation programs in fiscal year 2001. This survey followed the same format as one that was used in fiscal year 2000, and collected data on the starting and 3 year salaries and fringe benefits for five categories of employees. The Rehabilitation Specialist/Counselor position is the only one that is discussed in this report, as the Commission's interest is primarily in the wages paid to direct care workers.

The FY 2000 survey also asked for the fiscal year 1999 information for the Rehabilitation Specialist/Counselor position in order to provide a three year history when this data was combined with the data from the previous such survey.

The survey instrument was mailed to the providers on September 30, 2000.

The MAPSS report includes a brief narrative comparing rehabilitation counselor salaries with those of comparable state positions in the mental health associate classification.

The results reported below are based on the report "MAPSS FY 2001 Salary Survey", prepared by JoAnn Clarke and Herbert S. Cromwell, and dated March 1, 2001, as well as previous such reports produced by MAPSS.

Results

Comparison with State positions

The rehabilitation counselor position is the largest category, and the most relevant for the direct provision of care. The State considered that this was equivalent to Mental Health Associate II (MHA II), although a personnel consultant to MAPSS considered that it was more closely equivalent to Mental Health Associate III or IV. The following table shows the comparison of the salary results reported in the MAPSS study (including fringe benefits), and the State Mental Health Associate II and III reported (again including fringe benefits, imputed at 32.9%[6]). The fringe benefits paid by the providers averaged 22%.

	Starting salary, including fringe benefits	Starting salary, excluding fringe benefits	3 year salary, including fringe benefits	3 year salary, excluding fringe benefits
Rehabilitation counselor - Median	$25,753	$21,530	$29,506	$24,750
Rehabilitation counselor - Mean	$26,799	$21,998	$30,865	$25,272
State MHA II (in MAPSS report)	$30,313	$22,809	$33,879	$25,492
State MHA III (in MAPSS report)	$32,312	$24,313	$36,126	$27,183
Percentage by which the MHA II rate exceeds the provider mean/median[7]	13%/18%	4%/6%	10%/15%	1%/3%
Percentage by which the MHA III rate exceeds the provider mean/median	21%/25%	11%/13%	17%/22%	8%/10%

Change over time

The following table shows the mean starting and 3 year salaries, including fringe benefits, for the rehabilitation specialist/counselor position in each of fiscal years 1998, 1999, 2000, and 2001 to show the growth over time.

[6] This was the figure used by DHMH in a report to the General Assembly dated August 30, 2000. The figure used in previous reports as the State fringe benefit percentage was 26%.

[7] The median is less affected by outliers than the mean.

Year	Starting salary, including benefits	Increase from previous year	3 year salary, including benefits	Increase from previous year
FY 1998	$23,192		$26,116	
FY 1999	$23,756	2.4%	$27,042	3.5%
FY 2000	$24,980	5.2%	$28,542	5.5%
FY 2001	$26,799	7.3%	$30,865	8.1%

The following table shows the mean starting and 3 year salaries, excluding fringe benefits, for the rehabilitation specialist/counselor position in each of fiscal years 1998, 1999, 2000, and 2001 to show the growth over time, along with the state MHA II and MHA III starting salaries (excluding benefits) for comparison purposes.

Year	MHA II starting salary, excl. benefits	% chg.	MHA III starting salary, excl. benefits	% chg.	Rehab. Counselor, starting salary, excl. benefits	% chg.	Rehab. counselor, 3 year salary, excl. benefits	% chg.
FY 1998	$19,128		$20,499		$18,930		$21,290	
FY 1999[8]	$20,403	6.7%	$21,774	6.2%	$19,393	2.4%	$22,075	3.7%
FY 2000	$21,931	7.5%	$23,377	7.4%	$20,420	5.3%	$23,309	5.6%
FY 2001	$22,809	4.0%	$24,313	4.0%	$21,998	7.7%	$25,272	8.4%
change 1998-2001	$3,681	19.2%	$3,814	18.6%	$3,068	16.2%	$3,982	18.7%

The fee schedule for psychiatric rehabilitation services was basically unchanged from FY 1998 through February, 2000, so the wage increases were provided in spite of a lack of rate increases. While there were some changes in the supported employment rates, and the residential crisis rates, these applied to only a small proportion of the psychiatric rehabilitation providers, and a very small proportion of the services. The fee schedule that was implemented on March 1, 2000 provided an increase of about 5% in psychiatric rehabilitation rates. The increase in the wages of rehabilitation counselors from FY 2000 to FY 2001 was greater than the rate increase that was received by the providers between these two years.

[8] Estimated from the salary including fringe benefits using a fringe benefit amount of 22.5%.

Conclusion

The psychiatric rehabilitation providers have increased starting wages for rehabilitation specialist/counselors by 16% from FY 1998 to FY 2001. This is in excess of inflation in the general economy, but less than the increases in state starting wages. Over this same time period the fee schedule rates for psychiatric rehabilitation services have been increased by 5%. The wage increases provided were substantially greater than the rate increases received by the providers. The factors that probably enabled to providers to increase the wages are: 1) economies of scale resulting from greater volume of service; 2) changes in the mode of delivery of services; and 3) possibly increased use of part time staff who do not receive benefits.

The wage rates of the rehabilitation specialist/counselor positions continue to be lower than those of corresponding state positions. Over the 1998 to 2001 time period the state has increased their wages more than the providers, but the providers increased wage rates more than the state in the most recent year. The difference is in the range of 10 to 20 percent when fringe benefits are taken into account.

APPENDIX D

Status of 2001 Recommendations

The following are the recommendations that were included in the CSRRC 2001 Annual Report (without the rationale and background). For each recommendation there is a discussion of what activities have taken place, or are currently taking place, that further the recommendation, and/or the response of the state agencies to the recommendation. This is not intended to imply that the recommendation was the sole, or even the major, reason why the state agencies engaged in the reported activities. In that regard it should be noted that in order to be considered responsive to the Commission recommendations the design and structure of actions do not need to be exactly as the Commission recommended. Rather, the basic purpose and direction of an action need to be considered in order to determine responsiveness.

CSRRC Recommendations pertaining to MHA

1. As soon as practical MHA should conduct an assessment of the providers, possibly using consultants, the purpose of which would be to assess their performance in several dimensions including - accounts receivable management, billing, collections, computer systems, efficiency in the use of staff - to determine which providers are in need of technical assistance, and the nature of the assistance they require. Based on the results of this survey MHA should focus and expand its technical assistance program for providers and implement immediate remedies, as appropriate. This should be a priority project.

MHA has had a consultant review the financial condition of some of the public mental health clinics. This consultant has completed a detailed review of several clinics and has prepared a report documenting the results of this review. This consultant will be expanding its role to include work with other clinics, and to identify clinics that are in financial jeopardy.

2. MHA should continue to examine problems with individual rates or classes of services, and work to remedy these problems. In addition, uncompensated care and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern, as are copayments for gray zone clients and uncompensated care for clients with private insurance. As a partial remedy the Medicaid payments for dual eligibles should be increased to result in total payments of the Medicaid fee schedule amount.

MHA continues to meet with providers to discuss problem areas. Legislation to increase the Medicaid payment for dual eligible beneficiaries was introduced, but failed to pass in the legislature in the past session. Recent cutbacks in gray zone eligibility for clients with private insurance are likely to exacerbate the uncompensated problems experienced by the providers. MHA has contracted with a consultant to review specific rates, namely rates for services of a psychiatrist, children's rate, and mobile treatment rates.

3. To fulfill the need for data to monitor the rate system and the providers the MHA should have some form of ongoing information gathering.

MHA has regulations requiring the submission of additional data by the providers. These data include a wage and salary survey and audit reports.

4. MHA should monitor the financial condition of the providers, to ensure that financial issues are not likely to interfere with access to, or the continuity and quality of care. MHA should check on the financial status of providers who are reporting that they are in poor financial condition, and provide additional support on billing and other issues, as appropriate.

MHA is already providing some consulting assistance to some providers in need of such help and is broadening that support beyond the public clinics. The consultant will be working with the CSA directors to identify providers at risk, and to focus the assistance where it is most needed. The audit reports to be collected by MHA will assist in the identification of providers who are at risk.

5. A systematic approach to adjusting rates for the reasonable impact of inflation and other factors should be developed and implemented for MHA community services. In addition, the base rate in the fee schedule should be reviewed for adequacy on a periodic basis.

MHA established Advisory Groups to work on the design of an updating system. The purposes would be to assist in evaluating rate increases and the establishment of or changes in rates for specific services. The Commission considers that both these activities are part of an updating mechanism and the Commission is represented on one of these Advisory Groups. Work on this issue has, however, gone more slowly than we would like and now appears to be stalled. Legislation was introduced last year to establish an automatic updating system, but it failed to pass.

6. Data should be collected that allows for an assessment of outcomes and quality. The state agencies, the provider organizations, the Core Service Agencies and the Commission should work together to design this data collection process to serve the varied needs of the parties.

MHP has started to produce reports providing some outcome measures for the use of the CSAs. This process has been slowed by staff turnover at MHP.

MHA continues to collect consumer satisfaction surveys and report their results.

7. MHA should consider providing some incentive to providers to become accredited by national accrediting organizations and to encourage employees to become credentialed.

MHA provides deemed status to providers accredited by a national accrediting agency. This provides some incentive to the providers. MHA does not provide any additional payment to offset the cost of accreditation.

Commission Recommendations pertaining to DDA

1. DDA should develop a plan to determine the funding needed to increase the base rates being paid to community service providers with particular emphasis on the amount necessary to increase rates for wage rates being paid to direct care workers.

The legislature required in its budget language that DDA study the wage rates being paid by the community providers, and develop a workplan to increase them to the levels being paid by the state for corresponding positions over a 5 year period. DDA has promulgated regulations requiring that the providers complete the CSRRC FY 2001 wage survey, and is planning to work with Commission staff on the analysis of that data. DDA will use the results of this analysis in the design of the plan to increase funding.

2. A systematic approach to adjusting rates for the reasonable impact of inflation and other factors should be developed and implemented for DDA community services.

DDA is working on refinement of its rate setting methodology, but not specifically in the area of an updating system. DDA has been providing COLA adjustments in recent years, and has been increasing expenditures through the waiting list initiative. DDA has refined the client matrix and have revised the augmentation grant system.

3. The Commission is supportive of moving individuals from State facilities to a community setting when this is in the best interest of the individual.

There have been substantial increases in the funding for many of the community programs. The shift to community settings has not been happening as rapidly as would be hoped. This is partly because of workforce issues.

4. Data should be collected that allows for an assessment of outcomes and quality. DDA, the provider organizations, and the Commission should work together to design this data collection process to serve the varied information needs of the parties.

DDA designed and implemented a new cost report, which will allow for some limited analysis of relative costs and volumes of providers. DDA continues to use consumer satisfaction surveys, and is expanding this program to more providers.

5. DDA should consider providing some incentive to providers to become accredited by national accrediting organizations.

DDA has responded that they are opposed to providing deemed status to accredited agencies. The consultant to DDA on quality issues has advised against providing deemed status. DDA does not provide any payment to offset the cost of accreditation.

Conclusions

Both DDA and MHA are engaged in many activities which are aimed at correcting concerns raised by the Commission. The staff of both agencies have met with Commission representatives, and have been open in sharing data and plans.